

Group Interventions: Emerging Applications for Diabetes Care

Preface

Katie Weinger, EdD, RN

Human beings are social creatures who gather together for work and play. Thus, the emergence of groups as a health care delivery method is not surprising. Providing services to patients in groups may not be a panacea for what ails the health care system today, but emerging evidence suggests that groups may have an impact in making diabetes health services more accessible and perhaps more effective. In this From Research to Practice Section, we explore the use of group interventions in three areas of diabetes care: behavioral counseling, education, and medical care.

Mental health providers and behavioral therapists have long recognized the added value of groups when seeking improved psychological and behavioral outcomes for people with diabetes. Thus, an extensive research literature examines the effectiveness of groups dedicated to psychology and counseling for people with diabetes. Group interaction appears to provide emotional support while lessening feelings of isolation and stigmatism that are associated with some chronic illnesses. The broad spectrum of activities and ages affected by group interventions reflects the confidence mental health clinicians have in this form of intervention. Nicole van der Ven, Msc, (p. 88) thoroughly reviews the literature on the use of groups for counseling and support and as an adjunct to medical therapy.

Some therapeutic group interventions that were developed by psychologists also provide significant diabetes education, and van der Ven addresses these within her article. One example is Blood Glucose Awareness Training,¹ an 8-week course that provides important diabetes education regarding recognition of both hypoglycemic and

hyperglycemic symptoms and follows a typical psychoeducational format including group discussion, cognitive restructuring, stress management, and homework.

Research on the use of groups in diabetes education is less strong. Diabetes education began when, after the discovery of insulin, Elliot Joslin, MD, sent specially trained "wandering nurses" to patients' homes to provide patients and families with diabetes instruction.² Joslin also advocated group education, saying, "We can only scratch one back at a time, but we can teach many patients together, and each is likely to teach another patient. No wonder the diabetic teaching clinic is a success."² Since that time, the art of education has flourished; however, the science of diabetes education is only now developing.

Carolé R. Mensing, RN, MA, CDE, and Susan L. Norris, MD, MPH, have reviewed the art and fledgling science of using groups in diabetes education (p. 96). As they note, more studies done by qualified, well-trained researchers are necessary to provide successful diabetes education covering increasingly complex treatment options. Researchers in diabetes education need the same rigorous training as others in the behavioral sciences. The lack of trained researchers may help explain the paucity of well-designed diabetes education research examining the use of groups to improve self-management.

More doctorate-prepared researchers with postdoctoral research training will be helpful in increasing the quality and amount of research available. As diabetes education becomes more scientifically rigorous, researchers can investigate questions on educational models and teaching and learning approaches.

Other areas in need of investigation include identification of constructs specific to the fields of health education and diabetes education, adaptation of constructs and techniques used in psychology and other fields, and validation of assessment surveys and other assessment techniques.

The use of groups in providing medical care is relatively new. In my article on group medical appointments (p. 104), I describe five models of care that were developed to provide access to high-quality medical care for more patients. The use of groups for shared medical appointments appears to have found most acceptance within managed care settings. Four of these models have undergone initial testing with chronically ill elderly or diabetic populations within health maintenance organizations. A quality improvement review of the fifth model found that it was successful in helping a busy neurology practice reduce waiting time for appointments. Private insurers have yet to institute billing codes for group medical appointments. Thus, reimbursement and privacy issues may delay or prevent the widespread use of these new care delivery models outside of managed care settings.

Although some clinicians suggest an added value of groups in terms of health outcomes or quality of life, this elusive benefit has yet to be documented in the research literature. The underlying motivation for development of most groups in the treatment of diabetes and other illnesses has been not to save money but rather to make medical care more available and less frustrating for the average patient. Now that several models for group medical appointments are available, the next step will be to test the efficacy and effectiveness of these models in many settings through randomized, controlled trials.

Diabetes education is an extremely important component of all models of group medical appointments; however, these articles on group medical appointments could be easily missed by those interested in diabetes education. The problem seems to arise because researchers tend to describe what they are doing in terms of their specific fields of practice and may not be aware of the potential overlap with other fields. As we become more experienced in using groups in med-

ical treatment and education, we can reach better clarity and facilitate communication by using consistent terms to label innovative education and treatment approaches.

One cannot negate the impact of economic factors on the increasing prevalence of groups in diabetes treatment. Yet surprisingly few studies of the cost-effectiveness of groups exist in any of the three areas under discussion. Two cost-effectiveness studies found that diabetes group education realized similar or better physiological outcomes at greater savings compared to individual education.^{3,4} Mensing and Norris note the availability of reimbursement for Medicare-eligible patients when attending group diabetes education programs. This reimbursement may spread to other insurers and may provide an impetus for the development of more group education programs. Only one study of group medical appointments addressed costs. Beck et al.⁵ found that the cost of providing care through Cooperative Health Care Clinic group medical appointments for chronically ill elderly patients averaged \$14.79 less per patient per month than that in the usual care control group.

The variation in both roles and practice patterns among health professions often prevents direct adaptation of group use from one profession to another. Purposes, procedures, strategies, reimbursement issues, privacy concerns, and many other factors need individual consideration for each new use of groups. For example, although educators, physicians, and psychologists are all interested in helping patients with diabetes modify negative health habits and self-care behaviors, the amount of time each is able to spend with patients, the purpose of the provider/patient interaction, and the techniques each uses when discussing health care with patients vary significantly. This said, several principles for leading groups apply in most situations. Here, John Zrebiec, MSW, CDE, has provided tips for leading groups that health professionals from many disciplines will find useful (p. 108).

As we gain more experience with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which became effective April 1, 2003, it's

influence on the use of groups in the treatment of diabetes will become more clear. As a matter of principle, all patients must understand the purpose and procedures for each group and must know that 1) uncomfortable issues may be discussed in groups, 2) participants have the right to refuse to answer questions, and 3) because of participation of many patients, confidentiality cannot be guaranteed. When patients release personal information themselves, HIPAA regulations do not apply. However, clinicians must be extremely careful not to release personal information about patients during group discussions; only patients have that right.

To summarize, the use of groups in the treatment of diabetes is expanding at a rapid rate. We touch here on three areas: diabetes counseling and psychosocial support, diabetes education, and diabetes medical treatment. Diabetes education and medical treatment need more research to test the efficacy of group care compared to current individual treatment methods. Cost-effectiveness studies are rare, as are randomized, controlled trials that directly compare current models of group care with each other and with models of individual treatment. Most importantly, well-designed research is needed to help determine which group strategies and techniques are the most useful and which are not helpful for maximizing patient outcomes.

References

- ¹Cox DJ, Gonder-Frederick L, Polonsky W, Schlundt D, Kovatchev B, Clarke W: Blood glucose awareness training (BGAT-2): long-term benefits. *Diabetes Care* 24:637-642, 2001
- ²Barnett DM: *Elliot P. Joslin, MD: A Centennial Portrait*. Boston, Mass., Joslin Diabetes Center, 1998
- ³Rickheim PL, Weaver TW, Flader JL, Kendall DM: Assessment of group versus individual diabetes education: a randomized study. *Diabetes Care* 25:269-274, 2002
- ⁴Heller SR, Clarke P, Daly H, Davis I, McCulloch DK, Allison SP, Tattersall RB: Group education for obese patients with type 2 diabetes: greater success at less cost. *Diabet Med* 5:552-556, 1988
- ⁵Beck A, Scott J, Williams P, Robertson B, Jackson D, Gade G, Cowan P: A randomized trial of group outpatient visits for chronically ill older HMO members: the Cooperative Health Care Clinic. *J Am Geriatr Soc* 45:543-549, 1997