



Review

Educational group visits for the management of chronic health conditions: A systematic review



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ABSTRACT

Objective: Review the effectiveness of group visits (appointments of multiple patients) on quality of life, function, self-efficacy, utilization, and biophysical outcomes in randomized controlled trials of patients with chronic conditions.

Methods: We searched MEDLINE[®], Cochrane, CINAHL, and PsycINFO to January 2013 for English-language trials of educational group visits led by non-prescribing facilitators (e.g., peer educators).

Results: We report on 80 arthritis/falls ($n = 22$), asthma/COPD ($n = 10$), CHF/hypertension ($n = 12$), diabetes ($n = 29$), multiple conditions ($n = 4$), and pain ($n = 4$) studies. We found moderate evidence of improved short-term self-efficacy in patients with arthritis (10 studies) and diabetes (10 studies). We found no consistent evidence of improved quality of life; however a moderately strong body of evidence suggests peer-led community-based programs might improve quality of life and utilization in patients with multiple chronic conditions. Meta-analyses found short- (14 studies; mean change HbA1c = -0.27 , CI = $-0.44, 0.11$) and long-term (10 studies; mean change HbA1c = -0.23 , CI = $-0.44, -0.02$) glycemic improvement.

Conclusions: Group visits may improve self-efficacy and glycemic control. There was little consistent evidence of improved quality of life, functional status, or utilization.

Practice implications: Group visits represent a reasonable alternative for educating patients with chronic illness, though varied participation/retention suggests they should not be the sole alternative.

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1. Introduction

Health systems, payers, and providers are faced with the challenges of preparing large numbers of patients to self-manage the day-to-day aspects of chronic illness care. As care delivery rapidly evolves away from fee-for-service models and traditional face-to-face physician encounters, group visits—appointments where multiple patients are seen simultaneously—may offer an alternative means to provide chronic disease education and self-management skills training to more patients, and with fewer resources. Education delivered to groups of patients by non-prescribing health professionals and facilitators has gained traction because of their potential to efficiently engage patients in chronic illness self-management [1,2].

The Patient Protection and Affordable Care Act of 2010 incentivizes the formation of health care innovations—such as the Patient-Centered Medical Home—that build on a strong primary care foundation to provide timely access, and a coordinated, regular source of care for patients [3]. Incorporated into these new care models, group visits may be a way to deliver high quality health education while prioritizing improved health outcomes and better patient care experiences. Although group visit interventions have been used with greater frequency over the past few decades, there is little consensus as to whether, and for whom, group visits are an effective tool. Given differences in program structure and content, the broad array of chronic conditions in which group visit interventions have been studied, and the lack clarity on effectiveness, we conducted a systematic review to examine the effects of group visits on patient self-efficacy, quality of life, health outcomes, and health care utilization in patients with chronic illness (Appendix 1). We also sought to examine whether effects of group visit interventions depended on patient or program characteristics.

2. Methods

2.1. Data sources and search strategy

We conducted the original search February, 2012 and the updated search January, 2013 of multiple databases (MEDLINE® via PubMed®, Cochrane Register of Controlled trials, CINAHL (EBSCO), PsycINFO) using terms for non-prescribing practitioners and group visits, including but not limited to terms for group education, group program(me), group session(s) (Appendix 2). We obtained additional articles from reference lists of pertinent studies and by consulting experts.

2.2. Eligibility criteria and abstraction methods

We included English-language randomized controlled trials of educational group visits led by non-prescribing facilitators for patients with common chronic conditions: arthritis, history of falls, asthma, chronic obstructive pulmonary disease (COPD), hypertension, congestive heart failure (CHF)/coronary arterial

disease (CAD), diabetes mellitus, multiple co-occurring chronic conditions and chronic pain. We excluded group visit studies if any portion of the intervention focused on individual-level treatment plans or prescription changes (i.e., shared medical appointments), or focused exclusively on support groups or group exercise classes. Existing Cochrane reviews of group exercise summarize effectiveness of these interventions and represent a systematic evaluation of that literature [4,5]. In addition, a recent Cochrane publication reviews exercise and medication management interventions designed to reduce fall incidence among community-living older adults [6]. We excluded diabetes studies published before 1998 because the overall approach to adult diabetes care was qualitatively different after publication of the UK Prospective Diabetes Study, thereby rendering older studies less applicable [7]. Reviewers trained in critical analysis of literature assessed whether abstracts met inclusion criteria and dual-reviewed full-text articles for inclusion and quality (Appendices 3 and 4).

2.3. Data extraction

One research team member abstracted each included study for data on design, setting, population, findings, intervention structure, comparator(s), participation, and attrition (Table 2). We defined content delivered as follows: (1) self-management education: in addition to providing disease-specific information to patients, these programs teach patients self-management skills, such as goal-setting and contracting, and build skills to reinterpret symptoms. These interventions are often characterized by motivational interviewing and cognitive behavioral therapy techniques; (2) didactic education: content is informational and format is usually lecture-based (e.g., pathophysiology of disease); (3) experiential education: instruction based on demonstrations (e.g., cooking).

We found a breadth of measured and reported outcome categories and variation in outcome metric validity, rendering a full synthesis of all outcomes infeasible and uninformative (Appendices 5 and 6). We chose, instead, to focus on distal health outcomes measuring quality of life and functional status because these are likely to be important to patients and could conceivably be affected by group visit interventions. We included utilization and medication adherence outcomes when reported, though we anticipated that fewer studies would be powered to examine these outcomes. We also examined intermediate outcome metrics, focusing specifically on biophysical markers such as HbA1c, and on self-efficacy/patient activation measures. Self-efficacy refers to personal beliefs in one's ability to self-manage illness. In this review, we used the term broadly to include patient activation, coping skills, or illness beliefs. We chose to examine this set of outcomes because there are validated tools [8,9], and these metrics were commonly reported. Furthermore, there is a link, both conceptually and empirically, between the knowledge, skills, and attitude changes acquired during an educational intervention and intermediate health outcomes [10].

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