Group vs Individual Diet Visits

The Why, How, and What It's Proving

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Disclosures

No disclosures

Agenda

1. Definition of terms
2. What the literature says
3. History of VCU diet visits
4. Our reasons to switch to group visits
5. Trends/data/limitations seen since converting
6. Future direction

Defining Terms:
Group Visit and SMAs

Group Visit- aka SMA (shared medical appointment)

- multiple patients, often with similar chronic disease backgrounds, are seen as a group for follow-up or routine care
- lead by physician or physician and other multidisciplinary teams

3 general areas of focus

1. Increased access to medical care visits and opportunities to connect and bond with patients who have similar disease background
2. Improved knowledged for patients on their medical condition/disease, by witnesses and learning from those present in group
3. Enhancement of self-management skills for lifestyle and behavioral change

History of VCU Diet Visits

- Patients scheduled and seen on 20 min intervals (virtual or in-clinic); eventually transitioned to 30 min
    - limitation: late arrivals would regularly result in marginal time left for diet visit and/or rescheduling
        - Commonly resulted in latter half of the month's schedule becoming double booked to guarantee rescheduled patient's complete visit within calendar month

- Space confinements and nursing staff limitations
    - Shared spaced with nurse practitioners and rotating surgeon (including med students, fellow, and intern, at times) slowed room turnover
    - Two nurses assigned to bariatric team, negatively impacted transition time between patients

- Diet visits primarily focused on weight change and progress since last visit
    - limited time reserved for counseling, motivational interviewing, and education expanded beyond diet, physical activity and/or behavior recall

Our 'Why' of Converting to GDV

Driving Factors Behind Transition to Group Diet Visits:

- Rapidly growing patient population
    - 3 surgeons, 1 incoming; 2 NPs: 2 Dietitians

- Increase access to individual appointment availability for those who have/need:
    - Pre-op weight goals
    - Interpreter services
    - Technology barriers

- Reduce provider burnout
    - Minimize feelings of constantly having to "catch-up", whether on charts or seeing patients

- Allow for increase in time spent with patients
    - (both for 1:1 visits- went to 30 min vs 20, and group visits of 60min)

- Enhance quality of care/nutrition education provided
    - Thorough nutrition counseling and bariatric surgery fundamental education
    - Increased opportunities for patients to connect and support each other

4 Primary Goals

1. Improve quality of care and patient-physician satisfaction/ interaction
2. Enhance education and relationship building
3. Increase time for self-management education and skill-building
4. Improve weight loss rates

Goal 1: Improve quality of care and patient-physician satisfaction/interaction

Sadur et. al, 1999 Randomized controlled study

- Evaluated effectiveness of a cluster visit model led by multi-disciplinary team of DM nurse educator, psychologist, nutritionist, and pharmacist, for delivering outpatient care to adults with poorly controlled DM
  - 2 hourly monthly cluster over 6-months; 10-18 patients/month (185 patients total)
- Results: A1c decline of 1.3% vs. 0.2 % in control, self-care, self-efficacy improvements and increased satisfaction with the hospital

Wagner et. al, 2001 Randomized trial

- Evaluate impact of primary care group visits on process and outcome of care for patients with diabetes
  - Periodic one half-day chronic care clinics for groups of 8 patients with DM, total of 707 patients from general DM population of 14 primary care practices
- Results: improved microalbumin testing, A1c, and patient satisfaction, reduced emergency dept and specialty care visits

Beck et. al, 2015 Randomized controlled trial

- Compared group outpatient visits to 1:1 physician patient care among older chronically ill
  - 321 patients who were chronically ill were provided group visits for 1 year, 1:1 consultations with physician as needed
- Results: Less emergency department use, fewer admissions, greater patient and physician satisfaction

Goal 2: Enhance education and relationship building

Relationship Building

- Kirch and colleagues (2017) published a realist review of SMAs- the synthesis of SMA literature collected showed SMAs can provide more equitable provider-patient relationships than standard care, suggesting multiple patients with extended care time allow for informal, trusting relationships and even friendships, potentially leading to improved self-efficacy and motivation[4]

- Wadsworth and colleagues (2019) reported in their mixed-methods systematic review of SMA and patient-centered experience, that patients who attended SMAs had feelings of community vs. isolation, supporting emotional health from provided validation[5]

Goal 2: Enhance education and relationship building

Education

- Kirch and colleagues (2017)- Group visits provide platform for patients to share, confirm, and/or dispute information, which is likely improves patient's ability to apply information provided at visits and improve motivation through role modeling[4]

- Bariatric Times featured an article in 2012 by Megan McVay, PhD and Kelli Friedman, PhD, reviewing the benefits of cognitive behavioral therapy for bariatric surgery patients. Their research demonstrated:
  - CBT applied pre-op, reinforced nutrition education presented by surgical team, normalized fears and concerns within the group, and dispelled myths associated with surgery, ultimately helping patient prepare psychologically and behaviorally for the transition post-op[5]
  - CBT applied post-operatively, promoted adherence to lifestyle and behavioral changes, reducing post-operative complications and promoting increased weight loss and maintenance. CBT has also been beneficial with post-operative assimilation and early recognition of rare, but serious psychiatric disorders developed post-op[5]

Goal 3: Increase time for self-management education and skill-building

Trento et. al, (2004)- 5 year Randomized controlled study on DM care/education delivered in group setting vs individual visits

- 112 patients participated over 5 years (56 were divided into 6 groups, 56 continued with individual appointments)
- Sessions completed every 3 months with either 1-2 physicians and educator
- Results: improved quality of life, problem-solving ability, A1c, weight loss, and decreased BMI vs. 1:1 visits [7]

Cunningham and colleagues (2021) Systematic review on Group Medical Care of Health Service Performance

- Concluded per patient report that group visits provided greater satisfaction vs individual care
- Patients felt providers (PCP) were less 'rushed', improved communication, and provided more enhanced education[8]

Goal 4: Improve Weight Loss Rates

Butryn and Colleagues (2011) Review of Diabetes Prevention Program and Look AHEAD Studies [9]

- Two examples of behavioral treatment programs
- Three key components were reviewed– goal setting, self monitoring, and stimulus control
- Studied results of weekly group therapy visits for the initial period of 4-6 months
  - bi-weekly sessions continued thereafter

Weight Loss Results:

- Weight loss rate of 8-10% of initial weight was seen
- Rate remained constant at about 0.4 to 0.5 kg per week thereafter
- Of patients who attended 13-52 sessions over the 1 year period:
  - 28% had a weight loss of ≥10% of baseline weight
  - 26% had a weight loss of 5–9.9%
  - 38% had a weight loss of ≤4.9%" [9]

Braun and Colleagues (2016) Retrospective cohort study of *MOVE!* Multidisciplinary Weight Loss Program for Veterans[10]

- VHA National Center for Health Promotion and Disease Prevention developed a multidisciplinary weight management program titled *MOVE!* to assist veterans with weight management
- Implemented/studied at Michael E. DeBakey Veterans Affairs Medical Center (MEDVAMC) July 2007 to September 2008
  - 1hr group visits focused on behavior change and self-management strategies for diet and physical activity

Weight Loss Results:

- Veterans who attended ≥ 3 encounters (out of 4) lost 2 kg, whereas those who had 1 or 2 encounters had an average gain of 0.13 kg [10]

Current Group Diet Visit Process

Process for Group Diet Visits:

- RD schedules alternate days between group visits and traditional one-one visits
  - Total of four group visits daily (60 min) + two one-one virtual patients
    - Group visits hold max of 15 patients
  - Sixteen individual 30 min slots for post-op, technology barriers, interpreter services, pre-op weight goal patients
- Group Visit patients are sent survey questions and Zoom link via VCU survey platform
  - Survey questions assess diet and physical activity recall, updated weight, and progress made since initial surgeon visit or last diet visit

Topics Covered in Group Visits:

- Intro to Bariatric Surgery (anatomical/hormonal changes, differences in types of surgeries offered with our program, review of Forever Rules)
- Nutrition Fundamentals: label reading, food groups, portion sizes, meal planning
- Mindful eating, hunger cues/types, emotional eating/coping strategies
- Behavior change (non-weight victories, preventing/overcoming self-sabotage, work/life balance, sleep hygiene)
- Physical activity
- Preparation for surgery (post-op vitamin protocol and pre/post-op diet progression)

Results/Progress within our clinic

Education and relationship building

- Patients engage in conversation before, during, and after visits
- Share their tips, successes, and challenges with the group
- Increased rate of pts responding on their surveys to assess progress that they are implementing bariatric fundamentals, reading nutrition labels, etc.
- Feel inspired and supported by fellow participants to achieve their health goals
- Shared experiences among patients may also help combat social isolation from a disease diagnosis and reduce stigma associated with seeking care
- Increased social support with inclusion from other partners, family, friends during group visits
- Hear answers to questions they may have not thought to ask

Improve quality of care and patient-physician satisfaction/interaction

- Reduced physician burnout
- Extended time with patients
- Increased ability to provide team-based care
- Increased comprehension of patient's social context
- Ability to provide additional educational resources (video/website links, etc.)

Increase time for self-management education/skill-building

- Receive frequent feedback stating thoroughness of information provided during GDV
  - Many patients report 'note-taking' during class
- Decreased sense of urgency/rushing seen from both patients and RD
  - (class scheduling promotes time management)
- Increase frequency of goal setting and sharing within the group
- Patients demonstrate improved retention and application of behavior and nutrition recommendations
- Acquire additional knowledge, including but not limited to sleep hygiene and emotional eating and self-sabotaging management

Improve Weight Loss Rates

- No difference for preoperative and/or postoperative weight loss has been observed at this time
- Still collecting pre-operative weight trend data
  - Transition to GDV officially began 3 months ago
  - However, have noticed weight loss trends per chart review of patients who began group diet visits during 'trial period' 6 months ago
  - Further data needed to compare efficacy of 1:1 visits vs GDV

Clinic Limitations

- Strong wifi and/or broadband connection required
  - Loss of connection and/or poor connectability affects the patient's experience and ability to reap benefits of group visit
- Interpreter services
  - Zoom capabilities are restricted to only provider's language, however do offer some ADA options
- Education and/or technology barriers
  - Older population may not have access to or knowledge on how to use technology
  - Individuals who are financially restricted may have similar barrier
- Preoperative weight loss requirements
  - Patient may benefit more from 1:1 visits, providing individualized care to meet weight goal, vs. a more laissez faire approach with group
- Incomplete survey questions
  - No negative implication for patients who do not complete survey
    - To note, RD's will track number of missed survey and reschedule follow-up visits to 1:1 to measure progress
- Personal scale use vs. clinic scales
  - Personal weights reported may vary from clinic weights, skewing weight loss results
- Patients distracted at times (driving, doing house work, etc.)

Future Direction

- **Addition of long-term post-op group visits**
  - Per research- patients typically regain ⅓ of lost weight within 1 year of treatment ending; nearly ½ return to their original weight within 5 years[8]
  - Future goal: incorporate long-term post-op GDV (6 month post-op, annual, "Back on Track" sessions)
- **Improved method for distribution of Zoom link and survey questions**
  - Limited to e-mail and/or mychart
  - Move towards email and text message, letting patient know time, day, and type of visit they are attending with inclusion of Zoom link
- **Questionnaires to assess VCU patients' feedback on GDV and weight loss trends**
  - Evaluate patient-provider relationship and patient satisfaction
  - Evaluate weight loss trends from initial visit to DOS since transition to GDV, compared against traditional 1:1 visits offered
  - Evaluate retention of pre-operative teaching and recommendations

Resources

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