Group Visits a Success for BP, but Not Diabetes

VITALS

Major Finding: After one year, mean systolic blood pressure was 7.3 mm Hg lower among the group visit patients compared with the usual care patients. Differences between the groups in terms of HbA_{1c} levels were not statistically significant.

Data Source: A randomized controlled trial.

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Compared with usual care, group medical visits produced meaningful improvement in blood pressure control but not diabetes control, according to a randomized controlled trial involving patients with both conditions.

The few randomized controlled trials of group medical clinics (GMCs) for diabetes patients have reported conflicting results, and no trials concerning GMCs for hypertension have been published, said Dr. David Edelman of Durham (N.C.) Veterans Affairs Medical Center and his associates.

In an editorial comment accompanying the report, Dr. Andrea Sikon and Dr. David L. Bronson of the Cleveland Clinic Foundation called shared appointments "an innovative alternative to the traditional patient-physician encounter."

Since most such group clinics include time for private one-on-one consultation with the primary care physician and allot considerable time for patient education with professionals other than the physician, they have the potential to improve patient access to medical care, improve clinician productivity without adding to the existing workload, improve patient education, and improve "the bottom line for the practice," Dr. Sikon and Dr. Bronson said (Ann. Intern. Med. 2010;152:745-6).

Dr. Edelman and his colleagues randomly assigned 239 patients with comorbid diabetes and hypertension at two VA medical centers to receive primary care as usual during individual visits or in group visits involving six to eight patients. A total of 211 patients completed the study.

Each GMC met every 2 months for approximately 90 minutes with the treatment team. At every GMC visit, patients' blood pressure was checked and home blood glucose values were collated so the treatment team could devise individualized plans for medication and lifestyle management for each patient. There also was an educational component during each group visit to address topics chosen by the patients.

Part of each GMC visit involved interaction with the entire group, and part involved a private consultation with the internist or pharmacist.

After 6 months, mean systolic blood pressure was 5.7 mm Hg lower in the GMC group than the usual care group, a significant difference. This benefit persisted throughout the study, and at 1 year, mean systolic BP was 7.3 mm Hg lower in the GMC group (Ann. Intern. Med. 2010;152:689-96).

This magnitude of treatment effect is similar to that reported in a large international clinical trial of antihypertensive and lipid-lowering medication, Dr. Edelman and his associates said.

Mean HbA_{1c} levels also were lower in the GMC group at both 6 months and 1 year, but the difference did not achieve statistical significance, they reported.

Control of diastolic blood pressure was a secondary outcome in this study. As with systolic BP, diastolic BP was significantly lower (by 3.8 mm Hg) in the GMC group than in the usual-care group.

Adverse events such as lightheadedness and falling during hypoglycemic episodes were significantly less frequent in the GMC group. The GMC patients also had 0.4 fewer visits to the emergency department per patient-year.

GMC care cost $460 a year per patient. "If found to be cost-effective and efficient, GMCs could be implemented in a wide range of settings and become important in the remodeling of long-term care in the United States," they added. ■