INTRODUCTION

Barriers to care become an accumulated and compounding burden for the patients in poor communities. Such health disparities, operating across many dimensions including geography, race, class, and gender add to the burden of diabetes appreciated in resource poor communities. Camden, NJ is one such community.

Group diabetes visits (GDVs) were initiated to provide a team approach to ongoing patient-centered diabetes (DM) care and offer a model for sustaining behavioral change after diabetes self-management education (DSME).

CAMDEN: DEMOGRAPHICS, DIABETES, AND DISPARITY

CAMDEN, NJ is a city of nine square miles located along the Delaware River, directly across from Philadelphia. According to the 2010 Census:

- Population: 77,346 residents - 48% African American - 47% Hispanic/Latino
- Persons below poverty level (2007-2011): Camden- 38.4% New Jersey- 9.4%

According to the Camden Health Database:

- Number of Diabetic Patients who visited the hospital (2010): 3,117 individuals
- Total Charges
- Number of Diabetic Patients who visited the hospital (2010): $24,954,213
- Number of Diabetic Patients who visited the hospital (2010): $200,828,878

Poverty, in addition to racial and ethnic disparities in DM care, is associated with decreased access to healthcare and worse clinical outcomes.

Group Diabetes Visits (GDVs) were investigated as a novel method for delivering DM care in an urban, resource poor community.

SMART GROUP VISITS

Diabetes group visits provide routine diabetes follow up visits, continuing DSME, and offers patients a community setting for education and peer support.

DM Group Visit Structure

Pre-work: MA contacts patients in advance of the appointment for reminders of insurance referrals, labwork, current BG logs, and reminders for specialty appointments. (Fig. 2).

First 45 minutes: The health care team: MA, CDE and physician meet with the patient sequentially at individual stations with warm handoffs.

Second 45 minutes: CDE and PCP facilitate a group discussion and question and answer session. This work is completed by non-physician staff and is logged in a special SMART visit progress note (Fig. 3).

SMART Staffing

Certified Diabetes Educator- Patients meet with CDE to develop and work on behavior change goals and problem solve issues common in a poor urban community. The CDE also facilitates the DSME component of the GDV.

Medical Assistant- The MA is responsible for pre-visit work: chart preparation, reminder calls, and scheduling of bloodwork. During the visit the MA is involved in taking vitals, reviewing medical history, and helping patients record questions for the Q&A session.

Primary Care Provider- The provider meets individually with all of the patients to review their charts and make medical decisions on medication management. The provider facilitates the Q&A with patients by eliciting responses from members of the group and ensuring that the information shared is accurate.

Endocrinologist- For the first 6 months of the GDV an endocrinologist was on staff to model diabetes related clinical decision making for the PCP. After which, the endocrinologist moved to a support role for the PCP.

SMART Prep Work

3 Weeks Before Class

- Staff mails reminder letters and schedules patients for bloodwork
- Staff verifies if patient’s labwork is current and calls patients to remind them to work on BG logs

2 Weeks Before Class

- Staff schedules patient for blood draw
- Staff pulls prep notes and makes reminder calls to patients

Friday Before Class

- Patients called and reminded to bring binder, BG logs, and co-pay if needed

Day Before Class

- Staff mails reminder letters and schedules patients for bloodwork

RESULTS

Thirty Patients with previous DSME participated in the GDV

- African American 72%
- Hispanic 11%
- White 17%

- Male 50%
- Female 50%

- Age: 54.21 ± 13.87 years

Attendance

20 visits: 83%
30 visits: 90%

Over the two year time period 14 GDV visits were held. The majority of the population was African American with an even male to female ratio. Attendance varied by individual but over half of all participants participated in at least two classes and a third participated in three or more.

CONCLUSIONS

- Poverty, in addition to racial and ethnic disparities in DM care, is associated with decreased access to healthcare and worse clinical outcomes.
- GDVs were investigated as a novel method for delivering DM care in an urban, resource-poor community.
- GDV allow for physician directed, team based medical care, peer-to-peer support and continued emphasis on behavior change.
- GDV were associated with a trend in HbA1c reduction.
- Combining education and medical components of a visit improves glycemic control in an underserved patient population.