

Establishing and Maintaining Successful Chronic Pain Group Medical Visits Using an Empowerment Model Integrated Center For Group Medical Visits



..... A step by step guide...

Jeffrey S. Geller, M.D.

Eileen T. Dube, M.Ac., MS-PREP

Jeffrey Kowaleski, M.D.

Art on title page is a picture created by Jennifer Klein a group coordinator with our chronic pain group participants in 2006. It was done as part of a project we called “what does pain look like?” Our group coordinator Jennifer Klein led this project using free style, art supplies, while listening to music. The group and Dr. Geller then looked at all the paintings individually and determined that often pain looked dark and confused and solitary. At the same time the group noticed how beautiful the pictures looked, and how much diversity there was. At the end participants did not feel as if they were alone or confused and thus perhaps some of the darkness was lifted.....

Table of contents:

Prologue	3.
I. Introduction	
A. Chronic Pain	3.
i. Chronic Pain Defined	
ii. Ethnic Disparities in Chronic Pain Management	
B. GMV: Efficient and Effective	4.
C. Our Empowerment Model	5.
i. History	
ii. Empowerment Defined	
iii. A Different Approach to the GMV	
iv. Effective	
II. Anatomy of an Empowerment Model GMV	9.
A. Group Session	10.
i. Registration	
ii. Check-In	
iii. Activities	
B. Individual Medical Visit	14.
i. Initial Assessment	
ii. Medical Visit	
a. The First Visit	
b. Follow-up Visits	
c. Individual Evaluation	
1. Health	
2. Loneliness/Relationship Building	
3. Trying New Things	
III. Group Dynamics	

A. Facilitation	18
B. Maturation of a Group	18
C. Group Demographics	19
D. Socio-Cultural Considerations	19
i. Language	
ii. Poverty	
iii. Religion	
IV. Logistics of Initiating a GMV Program	
A. Human Resources	20
i. Staff Assignments	
ii. Empowered Employees	
iii. Staff Attributes	
a. Ideal Qualities of the Provider	
b. Ideal Qualities of the Group Coordinator	
B. Organizational Considerations	23
i. Administrative Support	
ii. Recruiting Patients for a New Group	
iii. Group Size	
iv. Group Space	
v. Location & Transportation	
vi. Meeting Time	
vii. Equipment	
viii. Electronic Medical Records	
C. New Patient Enrollment	27
D. Suggested Interval Visit Schedule (Addendum B)	29
E. Financial Sustainability (Addendum B)	30
F. Special Thanks	31
V. Resources	32
VI. References	36

Empowerment Group visits as treatment for pain: Prologue

Affecting more than 50 million Americans, chronic pain is a complex process in which the mind, body, spirit, and social environment interact to produce a continual feeling of pain. Treatment plans that intervene at multiple aspects of the chronic pain cycle, including the Empowerment model (EM) group medical visit (GMV) developed by Dr. Jeffrey Geller, are more likely to succeed. Facilitating the development of a sense of community, this novel approach enables patients to believe that change is possible. Empowered by new relationships and the confidence to try new things, patients' lives improve in a variety of self-reported quality of life measures.

The following document is a manual on how to create a chronic pain GMV program in a poor Latino community using the Group Visit Empowerment Model. Along with discussing the basics of the Empowerment theory, this manual describes the components of a GMV, group dynamics, and the logistical details- from human resources to finances- needed to initiate a GMV program in your practice. Although this manual contains details specific to GMV's for poor Latino chronic pain sufferers, the EM "core" of this document can likely be applied to any practice situation.

I. Introduction: The motivation for group medical visits for pain reduction.

A. Chronic pain

i. Chronic Pain Defined

Though a subjective experience, pain has been defined as: "an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage" (International Association for the Study of Pain). With duration as the most commonly used criterion for diagnosis, pain is typically considered chronic when it lasts for more than 6 months. Chronic pain can have two origins: 1) nociceptive pain from continuing inflammation from a prior tissue injury and/or 2) neuropathic pain from an injury to the peripheral or central nervous system (Basbaum, Bushnell, & Devor, 2005). However, chronic pain is more than just a biological phenomenon as the patient's body, mind, spirit, and social situation interact to create a self-sustaining cycle of suffering. Thus, treatment efforts like our EM GMV that intervene at multiple points in the cycle are more likely to be successful in helping the patient manage their pain and perhaps even break the cycle.

ii. Ethnic Disparities in Chronic Pain Management

Minority patients with chronic pain are less likely to receive adequate management of their pain for a variety of reasons (Green, et al., 2003). For one, it is well documented that those in our society who are poor or who comprise ethnic

minorities have less access to quality healthcare (Agency for Healthcare Research and Quality, 2007). Furthermore, minorities are less likely to receive appropriate analgesics and, when prescribed opiates, they often cannot find near-by pharmacies that carry them (Morrison et al, 2000; Green et al, 2005). Finally, they tend to have poorer health literacy thereby inhibiting their ability to interact with their providers and advocate for themselves (Agency for Healthcare Research and Quality, 2007).

For Hispanics, in particular, disparities in healthcare are even more pronounced. Hispanic adults were nearly 5 times more likely than white adults to have: 1) below basic health literacy; 2) received poorer quality of care in 23 of 38 core report measures of quality; and 3) worse access to care than non-Hispanic Whites in 7 of 8 core report measures (Agency for Healthcare Research and Quality, 2007). Speaking a language other than English affects access to resources including health insurance: twice as many non-English speaking Hispanics as English-speakers were found to be uninsured (38.2% vs. 16.5%). Hispanics with chronic pain- particularly young, unemployed males with limited education- are less likely to seek care for their pain from their primary care physician (Nguyen et al, 2005). Lastly, part of your success in life in the Latino culture is not being alone; community and family are very important. Thus, a Latino suffering from chronic pain may have more significant social loss than a non-Latino. Our EM GMV's may help alleviate this loss.

B. GMV's: efficient and effective

A group medical visit (GMV), also known as a shared medical appointment, is a relatively new approach toward the out-patient clinic where the individual medical appointment with a provider takes place in a group setting. Though there are a variety of different GMV models, all have the goal of providing group support and effective medical treatment in a more efficient manner. Improving patient-provider access, GMV's address individual needs and common concerns and allow for group education.

Due to their more efficient use of a provider's time, GMV's can be a worthwhile endeavor to use in physician-limited environments. Some practices have found that they can eliminate a 3-month backlog of appointments (Hooper & Antonides, 2003). Given the limited resources often confronting community health centers, GMV's are an option that may be particularly valuable in such situations.

A recent Family Physicians Inquiries Network review of GMV use in the management of chronic pain found that there was moderate evidence for its use as part of treatment of a variety of chronic pain conditions (strength of recommendation: B; Gaynor et al, 2007). They went on to note that GMV's have added benefits beyond improved clinical outcomes including improved efficiency and providing a broader patient-provider relationship. Additionally, we have found that our own groups have improved health related quality of life (See Section I.C.iii).

C. Our Empowerment Model

The 'Empowerment Model' has demonstrated the ability to help patients manage their pain and to help them break the bio-psycho-social cycle of chronic pain. The Empowerment Model by requiring participant input at many stages of development also ensures an embedded cultural and illness induced suffering competence. Utilizing GMV's, we provide a culturally sensitive approach for this poor and predominantly Latino community.

i. History

This approach has roots going back to 1996, during my residency program, and then further back as part of a faculty development fellowship project focusing on integrative medicine and group visits. As a resident in 1996, I began to give weekly health lectures to an outreach group "¡Si Tu Puedes!" ("Yes You Can!")- a group of about 15 older, uninsured Latina women who met each week for two hours to do arts and crafts together. It was while working with this community that I first realized the power of the group experience. Though I would bring a prepared medical topic each week, the group quickly began asserting itself by requesting topics that interested them and developing discussions with shared experiences instead of a one-sided lecture. More importantly, however, I noticed the markedly improved health of the social participants compared to the lonely and depressed patients I saw individually in my clinics. This led to 2 years of unbilled group visits with my patients at the local library, a conference room at the local hospital, and even outside at a public park.

With the observation that the group experience seemed related to better health outcomes, I began researching the effects of loneliness on health and even published in this area. In 1999, through a Center for Disease Control and Prevention grant (REACH 2010), I continued to explore the utility of groups as a means of reducing loneliness in patients with diabetes and heart disease. Having found that diabetics in the area frequently were not seeing their doctors or did not have adequate timely medical follow up, I set up my first medical group visits once a week in a room at a local funeral home that had been converted to office space. Patients would tell me what they felt they needed to do to be healthier, or what they wanted to do to be happier, and I would try to accommodate. After a year of visits filled with music, dancing, Tai Chi, pot lucks, etc....., I reviewed the data from this project and found that patients attending the groups not only reduced their loneliness and depression, but they also lost weight and had better glucose control, with dramatically improved health related quality of life based on sf-36 reports.

From 1999 to 2004, I found success with groups targeting risk factors for heart disease, adult and pediatric obesity, and stress related illness. I moved from the funeral home into our main health center conference rooms, and the numbers of patients participating in the groups steadily increased. In 2004, armed with the data proving the financial sustainability of groups, I was able to convince administrators to dedicate a large portion of the floor plan of a federally funded health center expansion at one of our sites to GMV's.

In 2002, I started chronic pain groups to serve patients with fibromyalgia. At this point, my groups had evolved to the stage where I needed someone else to lead the group activities to free myself for the one-on-one visits, and I instituted the role of Group Coordinator (albeit part-time) within my staff. During the course of the next year, my groups underwent further development due to a large year-long grant from the clothier Eileen Fisher. Funding a women's wellness group for chronic pain patients, the Fisher grant allowed us to explore new aspects of our GMV's. For one, it allowed us to conduct a pilot study studying improvements of patients' health-related quality of life (HRQoL measured by SF-36) over the course of their participation. (See I.C.iv for discussion of results). Additionally, the grant empowered our groups, because it provided the financial resources to pursue one of the long-standing wishes of our groups which included hiring an acupuncturist. Finally, and most importantly, this grant facilitated our model into its current sustainable format by allowing us to hire a full-time Group Coordinator.

Since the completion of the Fisher grant, the GMV program at has greatly expanded. Ranging from heart disease exercise groups, weight loss groups, smoking cessation support and hypnosis groups, buprenorphone groups, asthma education groups, toddler groups, afterschool obesity programs, prenatal groups with yoga, and groups at homeless shelters we currently run 38 weekly GMV sessions led by eight different providers. The New Balance Foundation has been instrumental with supporting our pediatric obesity programs. We find that by being larger we are more efficient and can benefit greatly from the economy of scale. We now have a second full-time Group Coordinator (GC)(one of each gender) to handle all of the meetings. Several groups are now bi- or tri-weekly. (The provider for these groups only attends one session a week but is always available if needed.) As a great sign of its empowerment, one of the chronic pain groups asked us to hire an exercise instructor (EI) a couple of years ago. Because of his overwhelming popularity, our instructor is now a full-time employee leading most of our exercise groups. Lastly, we should note that many of our groups- including those for chronic pain and heart disease/weight loss- have become so popular that we are no longer accepting patients from outside the health center.

ii. Empowerment Defined

Merriam-Webster defines empowerment as the promotion of self-actualization or influence; wherein self-actualization is the realization of one's full potential (Merriam-Webster online). At ICGMV, our interpretation of empowerment is much more concrete and simplified: to us, empowerment refers to the ability of our patients to build new relationships and try new things. As this model was borne out of the observation that loneliness is an indicator of health status, social interactions are central to the EM GMV. Furthermore, we feel that building new relationships and trying new things go hand-in-hand. Stuck in the bio-psycho-social cycle of chronic pain, patients need the support of someone close in order to go outside their comfort zone and try something new. The group - full of similar people undergoing similar ordeals - provides the necessary understanding and support.

Every aspect of the GMV (discussed in section II) promotes empowerment. In one-on-one interactions, we make the patient feel special, invested, and important. With the group as a whole, we encourage its autonomy and its decision-making power. Above all, we believe. We believe in the strength of the group, we believe that the patient knows what is best for them to do to feel better, and we tell them so. Inspiring hope, we get our patients to believe that they can experience change in their body.

iii. A different approach to the GMV

Of the three most commonly used GMV models, our Empowerment Model (EM) most closely resembles the “drop-in group medical appointment” (DIGMA) due to the patient’s ability to “drop-in” to our sessions at their discretion. Though patients may “drop-in”, the experience of our meetings is fundamentally different. Unlike DIGMA’s, an EM GMV has no end date and is not physician-directed or patient education-centered. The overarching goal of our EM GMV’s is to develop a sense of community within the group in order to dispel the sense of loneliness associated with chronic pain. Although we do occasionally run short educational discussions (as requested by someone in the group), the majority of the education comes from the participants themselves sharing their own life experiences with the group. (For further explanation of the DIGMA and the other common GMV models, consult the AAFP GMV Tutorial in the Resources section.)

iv. Effective

We believe that the EM approach to GMV’s is an effective treatment method for chronic pain patients, especially for those who are lonely, depressed, or inactive. Since starting our groups, nearly all of our patients have had improved levels of self-reported pain (0 → 10 scale). We frequently have patients who improve to the extent that they progress into our more rigorous heart disease/weight loss groups to do more strenuous exercise. Patients often lose weight and keep it off while they participate. They make new friendships in the group that often move outside of the meetings. Above all else, our patients are happy and want to come. The popularity of our groups - due in large part to the patients’ referrals of friends and family to the group - are a testament to that.

In terms of more quantitative proof that our method works, a 2003 pilot study conducted under the Eileen Fisher grant showed improvements of self-reported HRQoL (See I.C.i). Using the SF-36 survey tool, we studied the effects of 6 months of participation in a Wellness EM GMV consisting of Tai chi, health discussions, group relaxation, and low-impact exercise on a group of 42 women. Participants showed improvement in all 8 items of the survey (Figure 1, Table 1). Overall wellness improved by about 20% over baseline after those 6 months. Those who participated 2-3 times a week (“high frequency participants”) improved much more in the areas referred to as ‘well-being’ (pain, vitality, and physical function) than those who participated less than once every 2 weeks (“low frequency participants”) (Figure 2).

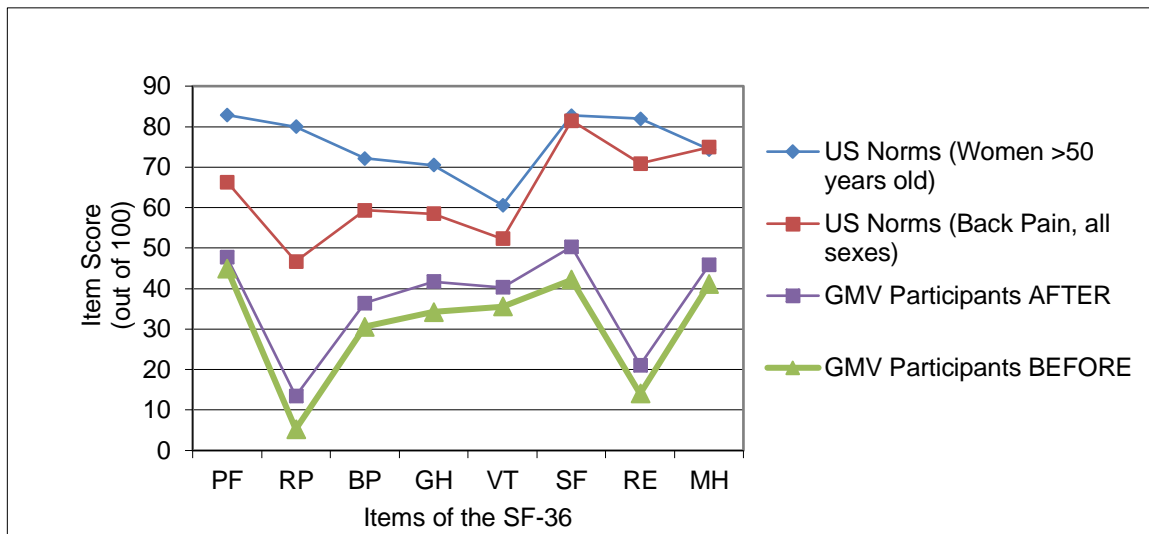


Figure 1. Mean scores in all items of the SF-36 among all participants of a six month-long “Wellness” chronic pain GMV program compared to US Norms. Scores are out of 100.

Table 1. Improvements in HRQoL after 6 months of a Wellness EM GMV as measured by the SF-36 survey tool.

Health Related Quality of Life Measure		Result
Role-Emotional (RE)	Problems with work / daily activity as a result of emotional problems	Group improved by 50%
Role-Physical (RP)	Problems with work / daily activity as a result of physical problems	Group improved by 156%
Social Functioning (SF)	Interference with normal social activities due to physical or emotional problems	Group improved by 19.2%
General Health (GH)	How one evaluates personal health and believes the direction it is likely to change for the better.	Group improved by 21.3%
Mental Health (MH)	Amount of time with feelings of nervousness and depression versus peacefulness, happiness, and calm	Group improved by 10.3%
Bodily Pain (BP)	Well-Being	Self explanatory
Vitality (VT)		High participants improved by 29.9%
Physical Functioning (PF)		Feeling tired and worn out versus full of energy
		High participants improved by 25.4%
		Ability to perform all physical activities from bathing or dressing to vigorous workouts
		High participants improved by 22.4%

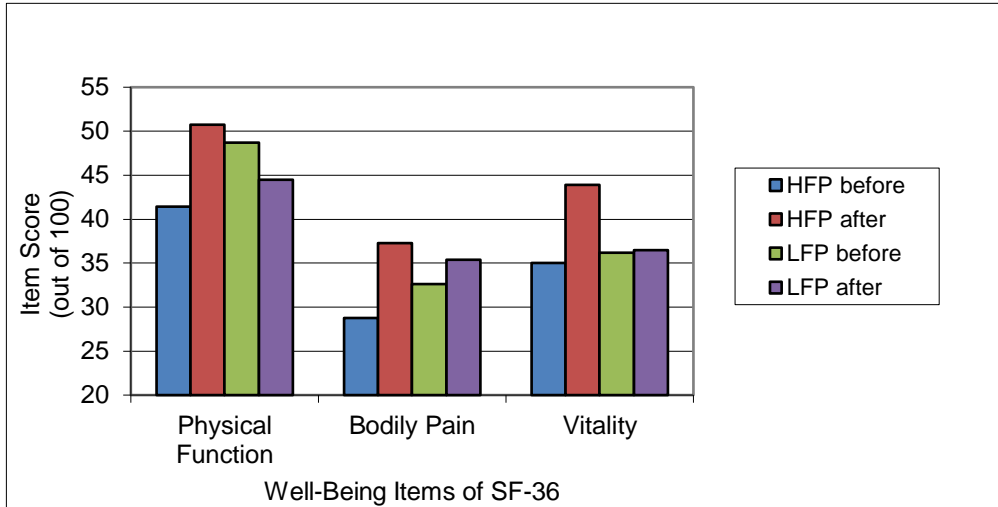


Figure 2. Mean scores in the three “Well-Being” items of the SF-36 before and after six months of participation in a “Wellness” chronic pain GMV program among high frequency participants (2-3 visits per week) and low frequency participants (less than once every 2 weeks). Scores are out of 100.

II. Anatomy of a GMV

Our GMV consists of three main parts: registration with our full time patient service representative (PSR), the group experience, and an individual medical visit (IMV). All participants of the group experience needing to see the Doctor for an IMV must register noting that not everyone will be seen for an IMV at every group meeting. The group experience comprises of check-in and activities portions, and the IMV consists of an initial assessment with a medical assistant (MA) and a medical visit with the provider (P) (Figure 3). When someone registered to be seen one-on-one for an IMV, the MA calls patients one at a time away from the group experience to collect vital signs and history as they would at any medical visit.

KEY:

Registration

Group Experience

IMV

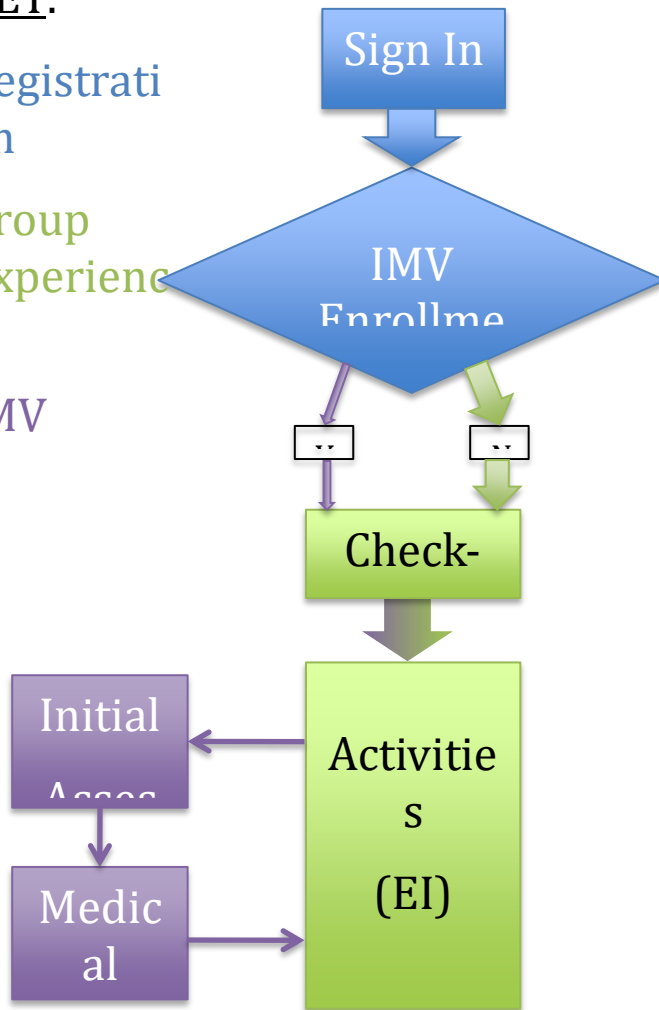


Figure 3. Flowchart showing the components of a GMV. Abbreviations in parentheses signify which staff members are present for each portion: EI = exercise instructor, GC = group coordinator, P = medical provider, MA = medical assistant, PSR = Patient Service Representative.

A. Group Session

i. Registration

When a returning patient arrives for a GMV, they sign in with the PSR at the reception desk and are asked if they want to see the provider that day for what we call a “discretionary visit”. New patients are required see the provider for an initial assessment. When everyone has signed in and the check-in has started, the PSR compares the IMV history of patients who decline discretionary visits to our suggested interval visit schedule (SIVS; See IV.C for discussion of the visit schedule protocol) to identify those who are due to see the provider for an “interval visit”.

The PSR then balances time limitations with the protocols of the SIVS to determine how many interval visits are available and can be filled that day.

Though we try to follow our schedule protocol, we need to be flexible. That is, an interval visit may be moved forward to accommodate a patients and give them more time with the physician when new and discretionary visits are low so that we can maintain flow on future days that may be too busy. Similarly, an interval visit may be delayed when the new and discretionary total is high in order that each of these patients receive ample time with the provider. The PSR balances these considerations and provides a patient list to the MA.

Only patients seeing the provider will be registered and pay their insurance co-payment (if their insurance has one). (See IV.E for information about billing.) New and discretionary visit patients who know they are seeing the provider when they sign in, pay at sign-in. Interval visit patients find out that they are being seen after the group experience has started and it is known that there is time for a visit and thus pay on their way out.

ii. Check-In

Once everyone has signed in, everyone circles up in the group space for the first 5 or 10 minutes for check-in. Led by the provider (if present) or the GC, check-in allows the members of the group to connect with each other. New patients entering an established group are encouraged to tell their story. They find it cathartic. The rest of check-in is variable. We may simply go around the circle having everyone introduce themselves and share some quick personal fact. We may highlight those patients who are making positive changes, whether it is from medications, life circumstances, or a lifestyle change they decided to make. The provider or GC may open things up for a discussion and see what people want to talk about. Patients may mention things ranging from their battle with pain or an upcoming surgery to asking for tips about cutting down their coffee intake. Other times, we will introduce a topic like an unusual medical fact or an easy way to get exercise at home to spark some conversation. Though we sometimes present a short educational topic, we try to do this in a short entertaining and interactive manner to keep patients interested. Whatever is done during check-in, it needs to be positive. GC's and providers need to be vigilant and not allow negativity to dominate discussions.

Regardless of what the day's check-in entails, this portion of the group experience is all about dis-inhibition. Dis-inhibition means encouraging patients to open up with the group using experiences or projects. We want them to be comfortable with the group and confident enough in themselves to share their stories, feelings, and opinions. **Dis-inhibition is the first and perhaps most important step in becoming empowered.** To do this each participant needs to have identified why they are special, with whom they are invested, and treated like they are important.

When a new group starts up, the GMV staff needs to actively cultivate dis-inhibition. In the first meeting, for example, check-in may take up the majority of the meeting. We spend time understanding why each person is there and give them an opportunity to briefly share their story. As a provider, you will need to assess what activities this group can do and show them how a GMV is not a typical doctor's appointment. The provider needs to promote the belief that this is a *safe* place where different things can happen. After the third or fourth visit, participants will start to *believe* that they can experience change in their body. This is another necessary step towards empowerment. This belief that change is possible comes from seeing others in the group that are succeeding, and from being part of a group that is trying new things. Dis-inhibition may also be a result of being happier.

Over time, dis-inhibition will be established within the group and you will not need to actively cultivate it. However, when a new patient joins the group, you may have to manipulate the flow of check-in to establish a feeling of comfort for this person and make sure they are involved. For example, a simple way to do this is to ask the new participant non-threatening questions that are unique identifiers such as, "Where is your pain?", or "What makes your pain better?" Then simply ask the group if anyone shares these pains or features. This creates a simple sense of belonging which will reinforce that a new participant is not alone and is in the correct place for support and healing.

iii. Activities

Once check-in is complete, the provider (if present that day) departs for IMV's, and the activities portion of the group experience begins. Except for the first few meetings of a new group, activities take up the majority of the GMV time. The type of activities we have done have varied throughout the evolution of the group, and currently consist of minimal impact aerobic exercises and resistance weight training led by an exercise instructor or our group coordinators.

When the group first starts, we do a short activity right after check-in specially designed to distract from the pain and continue the process of dis-inhibition. Although dis-inhibition is a constant theme over the course of a group, it is important to establish the environment at the onset. Examples of dis-inhibition activities have included:

- Silliness - things like having everyone stick out their tongues at each other is an instant dis-inhibitor
- Rubbing / massaging each other's shoulders
- Chanting
- Laughing- a great tool to create a good environment. You might say, "You know the less you concentrate on pain sometimes the better you feel so let's just start laughing." It takes about 10 minutes, but then everyone is laughing. Some

people are even crying, they are laughing so hard. When the group becomes dis-inhibited, they will provide the humor, too.

- Have the patients sit together and tell them when they look at someone and when they see each other's eyes then they have to change position. This is adaptable, even for someone in a wheelchair. After this exercise, you might even use this opportunity to place a positive suggestion like "by looking in each other's eyes you understand each other better." It sets the stage for relationship building.

Although the time needed for dis-inhibition exercises and extended check-in may be prohibitive during a group's first few meetings, the majority of the typical GMV consists of single activity. Activities need to be fun and the group needs to want to do them. Though you will have suggestions, the group needs to be empowered to make its own decision. If people do not like what they have been doing, ask for their ideas. You are not providing a curriculum, but facilitating the creation of a community. Examples of some popular activities include:

- Art - a good means for helping the patients express their experience of chronic pain. They may be asked to depict what their life was like *before* pain or what does the pain *look* like?
- Non-art activities - puzzles, meditation, and hypnosis, for example.
- Physical activities - particularly helpful for patients to relieve their pain during the visit. Appropriate activities include low impact, gentle movement exercises such as, yoga, Tai Chi, and qi gong. Instruct patients to do only what they feel comfortable doing and to rest if they need to, or encourage them to tell you if it is too much and to let you know their limitations. We have found that chronic pain patients in these groups enjoy being challenged to do a bit more and to work up a bit of sweat. This is fine, but remember, above all else, keep things fun!

In addition to activities, planning a project as part of establishing a group allows connection with the greater community and within the group community. Through the process of choosing a project we can learn a great deal about the participants investment in the local community and their pain. This accelerates the creation of relationships and is thus one of the greatest ways to encourage empowerment.

Projects that have been done within the community have included establishing a walking group, writing a book, and creating public service announcement-type videos about the dangers of drugs (made after a patient's son died of an overdose) and how to be a good mom in Lawrence. The project might take place outside of the medical center, but it may be planned or discussed at the group meetings. As the group develops, there are fewer projects and the group focuses more on activities. However, if you notice fewer people coming, projects can help to bring the group back together.

The types of activities you will be able to run at your practice may be very different from what we currently do at ICGMV and what our groups have done in the past. For one thing, the activities that we did at first ran themselves. That is, before hiring GC's, we could only do activities that I could set up and then walk away from in order to do IMV's. If you start your GMV program with additional staff to run the activities, you will have a larger selection of things to do when the group is first meeting. Regardless of the evolution of your group's activity selection, there should be an element of spontaneity in the activities portion. This element of surprise, however, should not detract from the rhythm and flow that your group will develop. Examples of spontaneity might include taking a field trip, supplying snacks, or trying some new type of exercise. And, once again, activities need to be fun. Only if your meetings are fun will people really want to come and thus be sustained.

We have included a sample group experience schedule for the first three meetings of a 1.5 hour-long chronic pain group:

Class	Group
1 st	<ul style="list-style-type: none"> - Introduction- name, years suffering, place of origin - Feeling energy along the Liver and Gallbladder Meridian - Deep breathing - Introduction to Tai Chi - Yoga (35 minutes)
2 nd	<ul style="list-style-type: none"> - Introduction- names, favorite place in the world - Feel Dantian (chanting) - Guided imagery- to favorite place in the world - Tai Chi (10 minutes) - Yoga (40 minutes)
3 rd	<ul style="list-style-type: none"> - Introduction (<i>What did you eat for breakfast?</i>) - Nutrition (<i>based on response to introduction</i>) - Self-hypnosis- feel warmth in hands (10 minutes) - Tai Chi (10 minutes) - Yoga (50 minutes) - Assessment: (<i>Did you like Tai chi and Yoga?</i>)

B. Individual Medical Visit

Once the PSR creates a patient list for the session, the MA begins calling patients one-at-a-time into the adjoining rooms for IMV's. Although we may take established patients during check-in to expedite the process, patients still in the introductory phase should not be taken until activities start. Thus, when a group is

still young, IMV's would not start until check-in is complete. After the Initial Assessment, the patient returns to the group until the provider is ready to see them for the Medical Visit.

i. Initial Assessment

In the Initial Assessment, the MA takes vitals, does a chronic pain evaluation, and takes a brief history if the patient is being seen for a discretionary visit. The location and severity of the patient's pain is documented on our Chronic Pain Evaluation Sheet (See Appendix A), a simple form that aids us in tracking progress over time. Ideally, this form would also include assessments of more psychosomatic symptoms including anxiety, depression, headaches, and trouble sleeping, but we have not implemented this into our protocol. Vitals and other collected data are entered into the EMR system. When complete, the MA places the patient's chart - consisting of just a billing form and Chronic Pain Evaluation Sheet - into the provider's inbox outside his room.

ii. Medical Visit

Similar to the MA and the Initial Assessment, the provider calls patients one-at-a-time away from the group activity for a Medical Visit. These visits are inherently different than a "typical" doctor's appointment. Although the provider still may do physical exams and/or order blood work and scans to evaluate pain, the impetus of the meeting is unique - reducing loneliness and facilitating empowerment.

a. The First Visit

From the get-go, the patient's one-on-one time with the provider is different from any other visit they have had; the first part of the evaluation is a social history focused on relationships. Demonstrating that we really care about the individual, this history shows that we believe that they can feel better. Typical questions may include:

- Who do you live with?
- Are your parents still alive?
- Do you have any children?
- How are your relationships with your spouse, parents, and children?
- What was going on in your life when this pain started?
- Is there someone that you can talk to everyday for support?
- What sort of work do you like to do? Or How do you want to live?
- And finally: "What do you think you need to do to help fix your problems?"

In addition to the social assessment, the provider may do a brief physical exam and will then make sure the patient has access to any durable medical equipment (canes, walkers, wheelchairs) they may need. We have found that these items are often

overlooked in chronic pain patient care. Additionally, to assess the entire chronic pain situation, we open a dialogue about the pharmacological management of their pain. We do not, however, prescribe medications at the first visit with the goals of both showing our commitment to future visits and deterring prescription abusers. We usually wait until a patient has shown connection to the group or commitment to activities or exercises before further pharmacologic therapy. We hope it is clear that we like them and want to see them for reasons outside of their illness and that is an important part of their medical management. Lastly, the provider asks if the patient needs anything to make coming to the group easier and tells the patient that they will meet again in a week or two so they can get to know each other more.

b. Follow-up Visits

Subsequent visits are run in a particular manner to promote empowerment. Even if the patient has a non-chronic pain chief complaint (such as during a discretionary visit), the provider needs to discuss the patient’s social environment. Following up on something from the previous visit is a great way to show the patient that you think what they said was important. By bringing up the patient’s life at the *beginning* of the visit, you are showing that you care about them and things in their life more than their illness or complaint. The provider also goes over changes in the patient’s pain levels and weight on the Evaluation Sheet. Regardless of whether congratulations are in order, this is an opportunity for some EM encouragement using the “consistency” motivational tactic. Consistency is all about showing the patient that making a lifestyle change (such as cutting down on soda, high calorie foods, or television) is consistent with prior commitments. An example of consistent dialogue that also empowers the patient:

- You’re a good person, right? -Yes.
- You want to feel better and be happy? –Yes.
- You want to lose weight? -Yes
- What do you need to do to lose weight? -*Drink less juice.*

This dialogue shows the final important aspect of every one-on-one meeting- believing in the patient. In the Medical Visit, this means asking the patient questions like:

- Why are you here today?
- How do think you are doing?
- What do you need to do to feel better?

These last two questions are particularly important in empowering the patient, because they instill confidence and make the patient feel important and smart.

A summary of the goals of the first three “establishing” IMV’s:

Visit	Individual Visits
-------	-------------------

1 st	<ul style="list-style-type: none"> - Social history intake - Physical exam to document pain - Assess entire chronic pain situation
2 nd	<ul style="list-style-type: none"> - Build relationship - Work towards diagnosis of pain - Blood tests, radiographic orders, review old charts, etc.
3 rd	<ul style="list-style-type: none"> - Define particular goals for symptomatic relief - Define particular measures of relief (pain level, function level) - Assess improvements - Review value of program (and consider pain medications)

c. Individual Evaluation

While promoting empowerment in the Medical Visit, the provider is still conducting an evaluation of the patient. This is important for the success of the program, for providing care, and for billing purposes. To the latter end, we keep meticulous records of these visits (especially the traditional medical elements) to document that we are still providing care as a non-GMV provider would.

1. Health

Above all elements of the EM, the provider still monitors the patient's health. Since the provider is either the patient's PCP initially or assumes the role over time for a specific problem, the provider will monitor anything that a non-GMV provider would. For our patients, this typically means checking in on pain management, diet, exercise, depression, sleep habits, and control of glucose, hyperlipidemia, and hypertension. Additionally, be cognizant of the patient's activity level as they may feel ready to move to one of the groups with more activity.

2. Loneliness / Relationship Building

Loneliness is assessed in the group setting and during the Medical Visit. As patients arrive for the GMV, you may notice who arrives early and look for evidence that they are making friends. We find that those who are looking for friendships tend to find them. One tell-tale sign that a patient is no longer lonely actually occurs if they miss a meeting and other group members notice. A good sign is when another patient knows why the person is missing. The friendships that are built in the groups tend to be deep because of the shared experience of chronic pain and the shared socio-cultural background.

Loneliness is also assessed during the social environment part of the Medical Visit. We usually start the meeting by asking if the patient has any friends in the group. A positive response is a chance to further the patient-provider relationship by asking

more about the friendship. If the answer is no, the provider needs to be encouraging and remind the patient that they have likeable qualities and they are a good person and that there are people in the group that they might befriend.

3. Trying New Things

As the ability to try new things is part of our definition of empowerment the introduction of new activities is a vital part of our model of care and group facilitation. In our experience, it is the act of trying something new, and considering the outcome a success, that most encourages one to try the next thing. You can test for this part of empowerment while listening to the patients in the group during check in or at the individual visit. The goal is to change a patient who says they cannot sleep because they can no longer lie flat on their back to a patient who says I cannot lie flat on my back so I use the cushions from our couch under my knees.

Most of this 'trying new things' element occurs in the group portion of the visit, but you may also begin to notice that patients are more interested in trying new things on their own to improve their health. They may ask about trying vitamin D to help their joints or to become a vegetarian before increasing cholesterol meds during the individual visit. When you detect patients trying new things, it means that they have hope; they believe that having less pain is possible. We work with patients to develop a plan that is safe and honors their interest in a new approach.

III. Group Dynamics

A. Facilitation

When participating in check-in, the provider is not meant to dominate but to facilitate. This may be difficult at first as many patients tend to defer to the provider when present. Rules are few and are owned by the group. A few simple rules may be proposed during the first meeting for example: raise your hand to talk, one person talks at a time, and no swearing. If there is someone who is outspoken and dominating in the group, you may let it go and allow the group to regulate it. If several weeks pass without group regulation, you may gently ask if there is someone else who would like to say something. After a group has become well established, leaders tend to develop among the participants. The leaders tend to be people whose pain has improved. The provider should be respectful of these leaders but keep the focus on keeping this a positive experience and safe community for all participants. Continue to introduce fun short new ways of saying hello and checking in even if a comfortable pattern has begun.

B. Maturation of a Group

It has been our experience that after a year and a half or so, the group will develop to the point where it is empowered, and the individuals look to each other for

support and understanding. They become like a family and essentially run things themselves. It is at this point that the group could be handed off to another provider. This enables the provider with experience starting a group to build a new group. Making sure that a group does not fall into a “rut” is also important as a group needs to continue to try new things and welcome new participants. By having a new provider with new ideas for activities this is enhanced.

C. Group Demographics

In the past, we found it helpful to create groups with certain demographics such as diagnosis or gender. That is, grouping similar types of people together made some patients more willing to share with the group. Additionally, some conditions should have their own GMVs due to the nature of the shared experience of the condition. For example, a group consisting of fibromyalgia patients tends to be younger and look healthier than an osteoarthritis group. Regardless of whether you group demographically or not, you should strive to have a certain amount of diversity with at least one patient in every group who is doing well, one who is struggling, one who is improving, etc.

D. Socio-Cultural Considerations

i. Language

Our patient population is a mix of those who speak English, Spanish, and both. Though we are able to conduct some groups in one language or the other, we frequently need to have bi-lingual groups. In these situations, the provider must be bi-lingual and ensure that everyone’s comments are translated.

Although not typical, language differences have the potential to undermine the group. That is, be aware that English speakers may feel like they can help those who speak Spanish. This may happen if the provider is Caucasian and his/her first language is English or because those who speak English might be doing better. This type of provider may need to be extra sensitive to this possibility.

ii. Poverty

The community that we serve is quite poor. With poverty and the fear thereof being significant barriers to empowerment, we take specific steps to promote the well-being of our patients. For example, we make a point of occasionally providing some snacks, a meal, or flowers. Considering the limited healthcare access in the community, we feel this really helps to create a positive community atmosphere as our patients appreciate what we do for them so much more.

iii. Religion

Considering that religion is such a strong component of the Latino culture, people may want to pray in the GMV setting. We let people pray if they want, but we guard against things becoming too religious and dominating the proceedings. If we see people looking uncomfortable, we simply change topics.

IV. Logistics of Initiating a GMV Program

A. Human Resources

i. Staff Assignments

In our program, there is a provider and a GC assigned to every group. Although the provider may not be at every meeting, the GC will always be there to lead the group. Additionally, since our chronic pain groups have chosen to always do some form of low-impact exercise for their activity, we often hire part-time exercise instructors (EIs) who conducts the exercises for of our groups. Lastly, our PSR's and MA's are assigned to specific groups so that there can be continuity and relationships built better with the patients.

ii. Empowered Employees

Empowerment is for everyone - patients and staff alike. Just as we want our patients to feel special and try new things, we want a happy, healthy staff, too. We need to serve as models to our patients showing them the benefits of an empowered life. As the "boss", I encourage staff members to tackle problems and make decisions without always needing my approval. If things go wrong, I embrace the staff member, and acknowledge a good effort.

We encourage empowerment in our employees starting with the interview process. We try to find out what is special about the candidate and see how they do with a group - regardless of the position for which they applied. We have candidates introduce themselves to the group and have the group try to get to know them. While we will not have a PSR or MA candidate do much more with the group, the GC candidates will lead an activity or exercise, and a potential EI will lead an entire exercise session. (Interviewing is also empowering for the group as we ask for the group's input after the candidate leaves.) We gauge the candidate's comfort level and see how they function in a new situation. We look to see if they can build relationships even within the context of this process. Finally, when we hire somebody, we tell them that we hired them for these relational qualities.

iii. Staff Attributes

As previously discussed, we want our staff to be examples of living an empowered life. We want them to be dis-inhibited themselves as to provide dis-inhibition

among our patients. Furthermore, we want happy people to promote the positive environment of the GMV.

In terms of more concrete attributes, our employees need to be bi-lingual. Our predominantly Latino patient population requires it. Although it is possible to run GMV's through a translator, we strongly discourage this. A Group Coordinators ability to talk to everyone in the group is a key component to the environment being created.

Finally, experience in health care, GMV's, or the theory of empowerment is not necessary for non-provider staff. For example, our best MA's over the years have come to us without prior experience (or bias), and we have trained them under our EM with great success.

On top of the general qualities of all of our staff, the EM GMV requires more specific traits of the two leadership positions.

a. Ideal Qualities of the Provider

The provider for a chronic pain group does not need to be a pain expert - you will become one. The role of the GMV provider (in addition to providing medical care) is to create a special kind of environment that encourages empowerment of both the group and the individual. Specifically, the provider needs to:

- Establish and maintain the belief among the patients that change is possible.
- Allow the patients to be comfortable and confident enough to say some very personal things such as asking for assistance with self-care.

A provider who is likely to be successful using the EM needs to have or develop a number of special characteristics:

Provider Characteristics	
Committed	The provider has to make an investment in the group and be committed to being on time and to participate fully when present.
Confidence in the group	The provider creates an environment in which the group can come to see its own wisdom and power. This is created, in part, by deferring to the group's experience and knowledge over your own opinion. When issues arise, turn to the group for the discussion. There are, however, still times that something arises in the course of the group discussion that should be addressed individually with patients. These should be addressed in the private part of the visit.

Confidence in the patients	The provider holds the belief that the patients know what they need to heal. When a patient wants to try something new that they think will help, the provider should encourage this (without promoting unhealthy decisions, of course).
Honest	The provider should not refer to hypothetical patients. If you have not seen or experienced something the group wants to know about, say so. The provider is building trust for patients that feel they may have been failed by the medical system previously.
Inspirational	A big part of the EM is getting the patients to believe in the GMV program, their particular group, and the patients themselves. It takes a special quality to be able to continually inspire a patient population that is commonly inactive, depressed, and lonely.
Emotionally aware	The provider should be able to recognize emotions to prevent negative thoughts to dominate conversations. Creative reframing of a situation into a positive light (e.g. referring to someone who has had many hardships in their life as a 'survivor') is an important skill to build.
Positive	Sometimes lonely patients express concern that they do not have many friends or are not good at making friends. Emphasize something you see in your interaction with them that is positive, such as letting them know you see that they are a good listener and honest. Suggest that they seem like someone who could make a lot of friends in the group.
"Atypical" Dis-inhibited	Just as a GMV is not a typical doctor's appointment, the provider should not be a "typical" doctor. The provider should be happy and dis-inhibited as an example of the goals for the patient. Wearing more casual clothing (e.g. khakis instead of suit-separate pants, short-sleeve shirts in the summer, no ties, no white coats) makes a contribution to the environment you are establishing, too.
Willing to let go	The provider should be comfortable being in the group, talking and being part of it. At the same time they have to be willing to let go of the need to lecture or even to finish a thought or sentence. It is the power of the group that is central to success.

b. Ideal Qualities of the Group Coordinator

The role of the GC is to facilitate the group experience. They lead the check-in if the provider is not present, and they lead activities in the absence of an EI. The GC should make each participant feel important, special, and invested in the group.

There is no required previous work experience for our GC's. My first GC was my receptionist at the time, and my two current GC's came in without any background in exercise instruction but had taken exercise classes at a gym. Similarly, I do not require a college degree for the position. Above all, it is the person's personality

that is most important. Thus, there are specific characteristics that we look for in our group coordinators:

Group Coordinator Characteristics	
Culturally competent	This is more than simply speaking the language of the patients. This means understanding the social mores and experience of being from the culture. Often this means someone who has lived as a member of that socio-cultural group.
Ability to think under pressure	Situations may develop during the course of group interactions that require the GC to think under pressure. We like to assess this ability by asking an unexpected question during the job interview as it is a similarly pressured situation. I usually ask “what is seven times seven?” as it is something that the candidate should know.
Medical common sense	They do not need to have an experience in health care, but they do need to have the medical common sense to identify conditions, such as chest pain, that require proper medical attention.
Living empowered	We look for people with a history of trying new things, who embody empowerment. While many employers are reluctant to hire people who change jobs frequently, we are open to hiring people who have a history of multiple one-year-long jobs (after a careful check of references to verify that they were not fired). We have found that those who are interested in trying new things all the time are satisfied and find success in our program <i>because</i> this job is changing all the time. Additionally, we have to be very open-minded in regards to candidates, because the job description is so vague.

B. Organizational Considerations

i. Administrative Buy-In

You will likely need to get administrative buy-in in order to establish a GMV program. Let them know that things are likely to go slow in the beginning but that this is a proven, financially-sustainable model. As a sign of good-faith, however, you may need to take on some of the risk of the new program. This could mean being paid per patient instead of salary, applying for grant funding, or even working for free at the beginning. We have provided some resources at the end of this document for creating buy-in and facilitating change in your organization.

ii. Recruiting Patients for a New Group

When starting a group, it is best to start with your own patients. They already have an established relationship with you and seeing you at the GMV becomes just a different way of seeing you. Additionally, we have the benefit of being part of a large health center network that promotes GMV’s. When establishing a new group, we

simply email the providers the relevant information so that they may refer participants to us. Flyers are also a good way to publicize a new group to patients and the community.

For the initial group, you may want to focus your attention on those you feel will benefit the most particularly including the lonely, depressed, or inactive. You should try to get a mix of people at different stages of their illness and it is advised to include at least one person who is doing well.

The message to the patients is that this program is different than anything they have tried before. Because we are built on the concept that the patients and the group have power, we are fundamentally different than anything they may have previously tried. This marketing also sets the stage for the belief that change is possible.

The patients who participate in these groups tend to self-select based on interest and willingness to partake in activities and share experiences. They may need some encouragement initially, however. When patients are being assessed for coming to the groups, we ask them about their pain. Then we let them know that there are others in the group who are similar or have had similar experiences to them. We encourage them to come for a couple of weeks, talk to the other participants, and see what they think.

We find that it is usually not a problem to find patients because we offer to take over the pharmacologic management of their chronic pain. The creation of a sense of scarcity (indicating the group is almost full or full) can be an effective technique, too.

Once patients come and start to feel better (usually within the first 4-6 weeks), they will become your best advertisements and will invite family, friends, or whomever they meet that may be interested. It typically takes 3-6 months to actively establish a core group of patients. At this point, the group becomes self-sustaining.

iii. Group Size

We have found that you need at least 6 participants in order to successfully establish and maintain a group. In our experience, if you have 6 people who are interested, you can usually get at least 4 of them to come. With less than 4 patients, the group tends not to feel like a group and it does not thrive.

The upper end of the group size is determined based on the size of the space and the activity. We find that our chronic pain groups generally start small and grow to no more than 25 or 30 active participants.

iv. Group Space

The facilities for GMV's (Figure 4) are separated from the rest of the health center. We have our own entrance, reception desk, and waiting area. Connecting the waiting area to the group space is a large hallway that allows for the movement of patients during transition times. Though the transition/waiting areas are wide enough for patients in wheelchairs to easily maneuver (a necessity), we have found that we would ideally have more space to make transitions smoother.

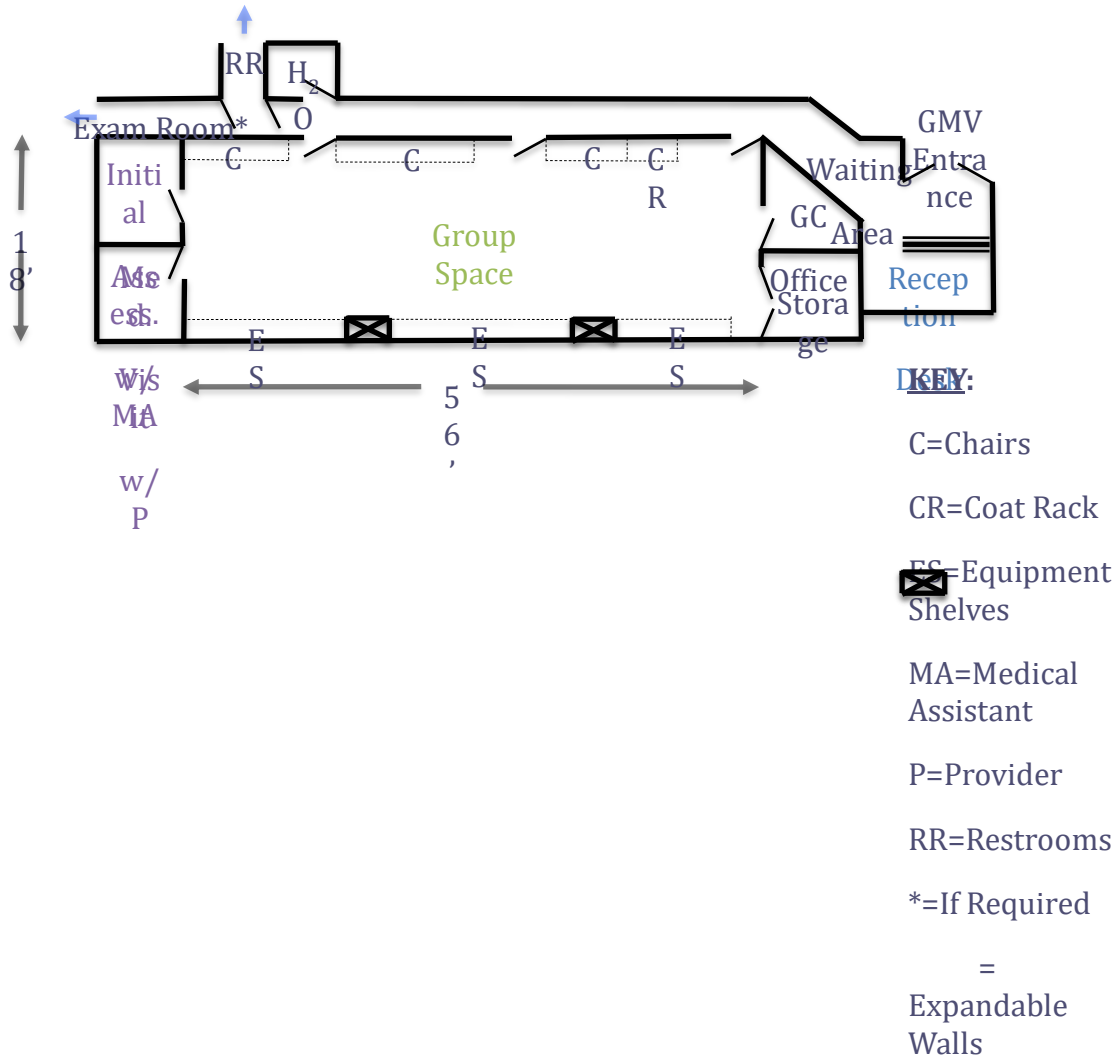


Figure 4. Scale layout of group space at ICGMV.

The group space is a large room, 56 feet long by 18 feet wide. One wall is lined with chairs (light and easy to move, some with arms, some with padding) that may also be used for exercises. The opposite wall contains shelves for exercise equipment between two expandable walls. These walls are not used for our chronic pain groups. The room has a high ceiling to provide a better sense of air. There are also two small rooms at the far end of the room for the IMV portion of the GMV- one for the initial assessment and another for the medical visit.

In the rare event of the need for further examination, there is an exam room located in the non-GMV portion of the health center. Additionally, restrooms and a water cooler are close-by. Though our health center does not currently have a day care center, we would choose to have one to allow more parents to come to our groups. This is particularly important in our community with many single parent families. We did this in the past with great success attracting young parents to groups.

v. Location & Transportation

Being centrally located in an area that has easy access is important for chronic pain patients to assist in getting out of the house. The convenience of a location near shopping plaza's where other errands can be completed helps facilitate them to coming in. Additionally, the shopping plaza provides substantially more parking than a typical doctor's office, which we require at transition times for large groups. Lastly, many patients do not own a car and rely on public transportation; a bus route stops right in front of the ICGMV office.

There are also patients who qualify for transportation to medical visits. The insurer that we work with (MassHealth) allows transportation to 1 visit per week. Patients often share rides with each other. In terms of creating a sense of community, carpooling is a great indicator of the group's success and is encouraged.

vi. Meeting Time

We have found that late morning and early afternoon are the best times for people with chronic pain to meet. We currently have two groups that meet from 11am-noon - one meets Mondays, Wednesdays, and Fridays while the other meets Tuesdays and Thursdays - each with a different provider assigned to it. Each provider attends one meeting for his/her group per week. Concurrently, a fellow from our HIP fellowship (we train physicians who want to learn integrative practices like group visits to help the underserved) is leading a small Stress Related Illness Tai chi group that meets Tuesdays and Thursdays at 3pm.

Additionally, we have noticed over the years that participation levels decline during the summer months. Thus, we frequently have to cut down on the number of weekly meetings for a group or combine similar groups that meet on different days.

Although our groups currently meet for an hour, my groups used to meet for 1.5 hours before I hired GC's. Before having someone to run the activities portion of the GMV, I needed extra time to establish the activity for the day before stepping away to do IMV's.

vii. Equipment

There are a variety of materials to consider having on hand for group activities including art supplies and a stereo system. Additionally, we have a considerable amount of exercise equipment in the group space including dumbbells, small

medicine balls, exercise steps, inflatable exercise balls, elastics, and yoga/exercise mats.

viii. Electronic Medical Records

Though not empowering per se, we find that the provider's use of the EMR during the IMV has many positive aspects. For one, the ability to instantaneously retrieve a chart relieves the provider from needing to know each patient's history and provides a starting point based on the last visit. More importantly, however, EMR allows the provider to transcribe the patients' own words - particularly those about their social situation and behavioral changes that they plan to make - directly into the note for that week. The patients' observation of this note-taking reinforces to them that the provider listens well, finds the social information important, and believes in the patient's intelligence and determination. These reinforcements, in turn, promote the sense that the patient is special, invested, and important - all important steps to becoming empowered. The EMR also allows for research and quality improvement to be more easily approached. Often a quick search of participant charts can help affirm that participants are coming and improving with this model of care. Also we have the participant's whole history available should medications need to be administered or prescribed.

C. New Patient Enrollment

In order to join one of our groups, patients must be referred from their PCP. The referral may come from the actual GMV provider, another ICGMV provider, or a provider from outside the health center. Once referred, patients of the GMV provider may start the group immediately. Patients of non-GMV providers - those both inside and outside of the ICGMV - must start on a day when the GMV provider is available. This allows the provider to do a medical assessment of a patient's ability to participate. This is most important in an exercise group with patients who may have heart disease. Thus, with these patients, we try hard to make sure they first come when the GMV provider is available.

Referrals are either handed to the patient or entered electronically into our system. If a patient receives a paper copy, the responsibility to schedule a first visit is entirely in their hands. However, if the referral is electronic, the GMV staff is notified and will begin contacting the patient within one week. However, considering that only 40 to 50% of referred patients end up coming, we follow an Enrollment Contact Protocol (Figure 5) that we developed to save ourselves from endlessly calling patients. The patient will receive up to three phone calls to try to schedule their first visit before a referral letter is sent at which point the scheduling responsibility is put on the patient. When patients are contacted, they are assigned to an appropriate group based on an over-the-phone pain and activity assessment (Figure 6), and scheduled for their first visit. This initial placement is not binding, however, and we allow patients to move to a group with a more appropriate activity

level after the first visit. Patients are given two chances to come to a scheduled first visit before we mail them a schedule and put the responsibility on them.

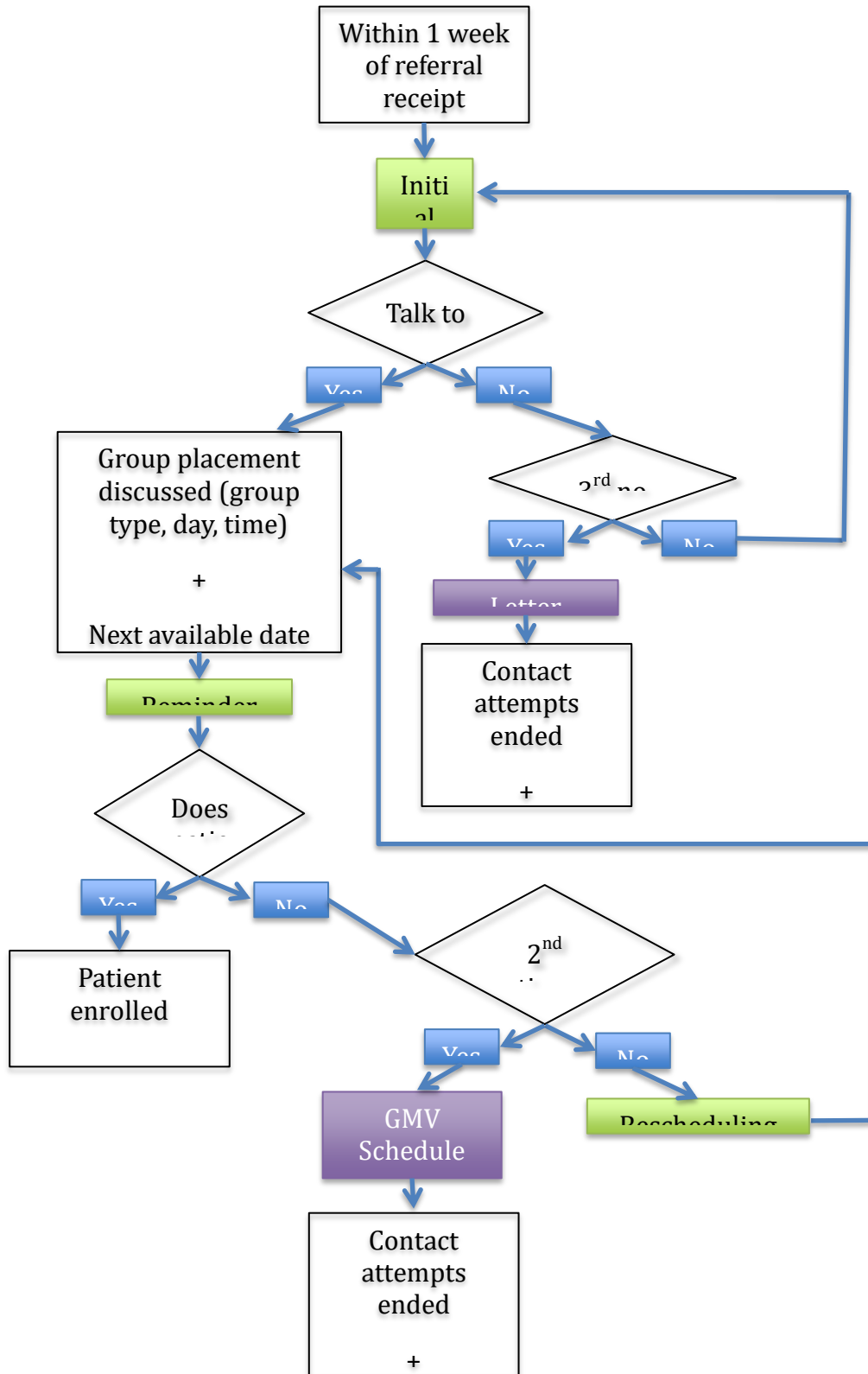


Figure 5. Enrollment Contact Protocol. "Status" signifies referral status in computer system.

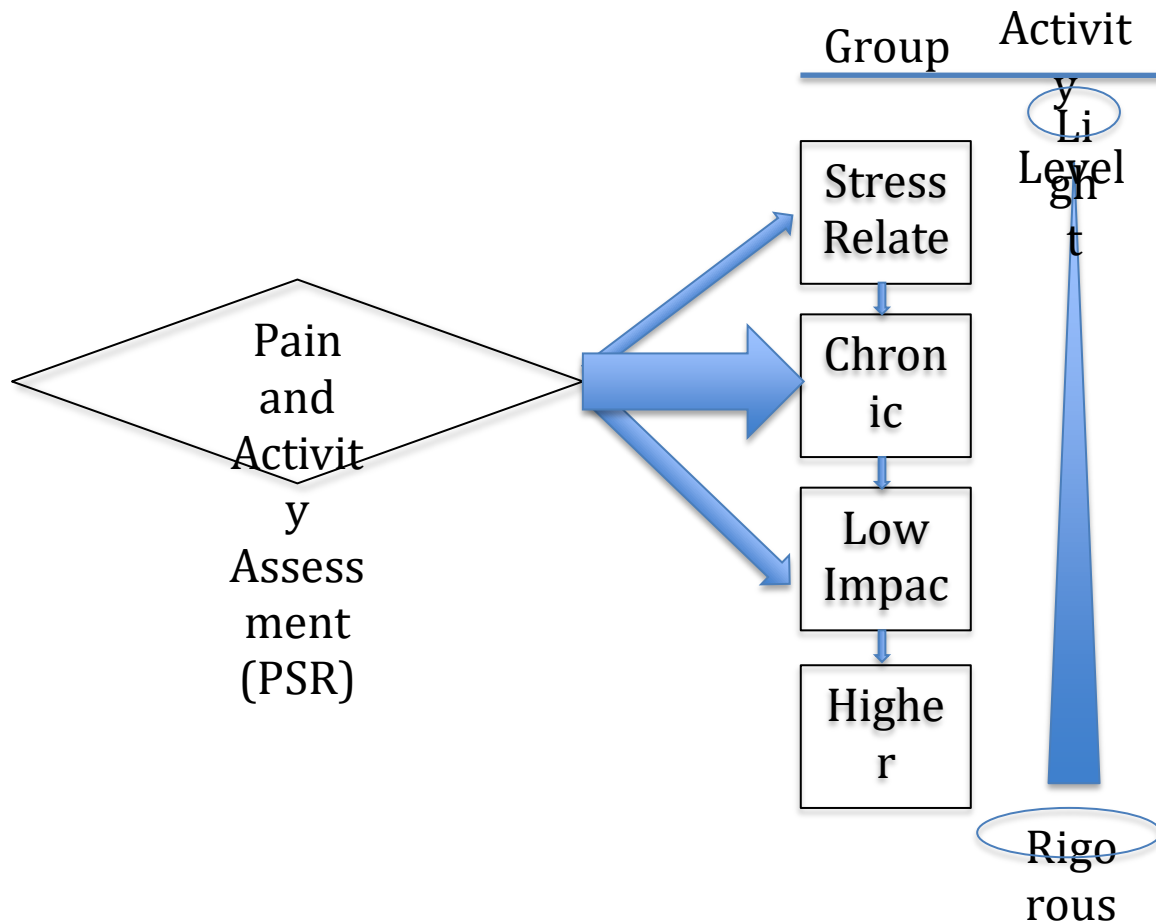


Figure 6. Flowchart of group assignment based on over-the-phone pain and activity assessment. The majority of patients are assigned to one of our two chronic pain groups.

D. Suggested Interval Visit Schedule

Though patients can see the provider whenever they choose (termed a "discretionary visit"), we have developed a scheduling protocol to make sure we: 1) effectively incorporate a new patient into the group; and 2) adequately monitor all of our patients. When a patient is first joining the group, we like to see them three times in the first month: at the first visit (no exceptions) and at weeks 2 and 4. We have found that seeing a patient this frequently at the onset is necessary to establish them into the group. In these first IMV's, they see that the provider cares about them and wants to get to know them more. This novel patient-provider relationship, different from any they have had before, makes them feel special,

invested, and important. (See II.B.ii for discussion of the specifics of the empowering Medical Visit.) Following the establishment period, we like to see our patients every 6 to 8 weeks if they do not see us in the interim for discretionary visits. Additionally, if a previously-established participant returns to the group after a long absence (several months or more), we make sure to see them that day.

Though our visit schedule is “suggested”, we absolutely require all new patients to see the provider on their first visit. After the first visit, we can be more flexible. As previously discussed, we have to balance the program’s financial needs and time constraints with the SIVS (See II.A for discussion of this trade-off). In another frequent scenario, we will not see the patient for their second or third visit at weeks 2 and 4, respectively, if they have an appointment with another provider that day. Lastly, many patients are referred to us for only a limited number of visits, and we may see this patient less frequently than we would like.

Given the flexibility of the SIVS protocol, all patients- both new and continuing- average six IMV’s per year.

E. Financial Sustainability

At the ICGMV, the finances of our GMV’s are linked to the IMV. That is, we bill patient’s insurance for a standard visit (#99213), but only when the provider sees the patient one-on-one.

Our finances are dictated by several factors. For one, our GMV provider assumes primary care of the chronic pain patient. You also need enough patients to make things work both logistically and financially. Though 40 to 50 people may become associated with a group, for whatever reason, only around 20- our target number- come each week. Correspondingly, we see our patients according to our SIVS on average of six times a year to make sure we are monitoring their illness effectively. By knowing this we can make predictions and adequately financing the program. Additionally, our overhead costs are low, because our staff is smaller and less expensive than that of a typical Family Medicine practice and because we operate out of a low-rent community health center.

In our specific situation, I need to see 2.6 patients per hour to break even. On average, I usually see four to five people per GMV meeting. As previously discussed, the number of IMV’s each session is managed by our PSR after everyone registers (See II.A.i). We are able to see more patients than typical for a Family Medicine physician because of a variety of factors. For one, we train our MA’s to do a thorough but pointed Initial Assessment (See II.B.i). All collected data is simultaneously entered into the EMR and is then immediately available for the provider to review. Finally, we follow our patients so closely with our SIVS that we do not need to spend as much time with them. Simply put, we know our patients very well, so they are easier to care for.

Though patients join our groups because of chronic pain, we do not limit our one-on-one discussions and billing to just the one topic. As we address many aspects of

a patient's health when they see us, we never have a shortage of diagnoses for billing purposes. Insomnia, depression, and obesity counseling, for example, are three of the more common billing diagnoses.

In general, the financial timeline of a group has three sections. For the first six months, expenses will be greater than income. Once you establish a core group of patients (approximately three to six months), your budget will have a surplus and you will begin paying off the debt established in the first six months. At around a year into the program, you will have paid off your debt and the program will become sustainable.

When you are first starting a GMV program, one of the first things you should do is to figure out your budget. Along those lines, once you start, you may need to keep your own financial records for the GMV program separate from those of rest of the practice. Finally, applying for a grant is a good way to bridge the financial gap from start-up to sustainability. As mentioned you would want at least a 6 month operating cost. Figure out your vision first and then find grants that are flexible and supportive the first year as your patients determine what they need to get well. When it is the patients driving the activities and the ideas and the format then you truly will be leading and empowerment group.

F. Special Thanks:

One thing I have learned about group visits is that they cannot be done alone or without support. Specifically I would like to thank: Anthony Valdini, M.D. for his support during residency and my fellowship year to help with research on loneliness and for providing me the time to develop these early programs. Glenn O'Grady M.D. , for his belief in my work and our Lawrence community. Jennifer Torres for being the first -receptionist / group coordinator / dance instructor / research assistant etc.... for our group programs when we started in the funeral home. Eileen Dube, for choosing our program as her Capstone project and thus putting empowerment ideas into words that made sense and ultimately became this resource. Jeffrey Kowaleski, for taking these words and organizing them into discrete organized concepts that could be followed more easily. Thanks to current and past financial supporters of our programs New Balance Charitable Giving Foundation and Eileen Fisher. I would especially like to thank my sister, parents, and wife for empowering me in my life and career with their support. And of course, the most special thanks to the patients of the Lawrence who actually created their own programs for healing and living with chronic pain through our empowerment model.

Jeffrey S. Geller, M.D.

Resources

Chronic pain:

Cepeda, M. S., Cousins, M. J., & Carr, D. B. (2007). *Fast Facts: Chronic Pain*. Oxford, UK: Health Press.

A quick reference guide, summarizing the pathogenesis and treatment of the most common pain syndromes.

American Pain Foundation

<http://www.painfoundation.org/>

A non-profit organization serving people with pain through information, advocacy, and support. This website provides a wide variety of resources for patients, including treatment guides, newsletters, and information on alternative approaches for pain management (such as yoga for chronic pain curriculum)

Partners Against Pain

<http://www.partnersagainstpain.com/>

A site developed by Purdue Pharma, L.P. that provides resources for patients, caregivers, and healthcare professionals including education, assessment, and tools.

International Association for the Study of Pain

<http://www.iasp-pain.org/>

Multidisciplinary professional organization focused on pain treatment and research. The website provides resources for pain curricula, clinical guidelines, and training.

Group Medical Visits:

American Academy of Family Physicians

Resources for Redesigning Your Practice: *Group Visits (Shared Medical Appointments)* [http://www.aafp.org/online/en/home/practicemgt/quality/qitools/pracredesign/january05.html](http://www.aafp.org/online/en/home/practicemgt/quality/quality/qitools/pracredesign/january05.html)

A guide to understanding and implementing group medical visits.

Barud, S., Marcy, T., Armor, B., Chonlahan, J., & Beace, P. (2006). Development and implementation of group medical visits at a family medicine center. *American journal of health-system pharmacy*, 63, 1448-1452.

Schmucker, D. K. (2005). Introduction to group medical appointments. *The Journal of medical practice management*, 21 (2), 89-92.

Noffsinger, E., Sawyer, D. R., & Scott, J. C. (2003, March). Group Medical Visits: a glimpse into the future? *Patient Care*, 18-40.

Kuiken, S., & Seiffert, D. (2005). Thinking Outside the Box! Enhance Patient Education by Using Shared Medical Appointments. *Plastic Surgical Nursing*, 25 (4).

Activities for Dis-Inhibition:

All Cooked Up, a series of books published by DestinationImagination. Email to bcdi@shaw.ca for more information or online at: <http://bcdi.org/resources>

Loneliness:

Booth, R. MedGenMed, 2(2), (2000). [formerly published in Medscape Psychiatry & Mental Health eJournal 5(2), 2000], *Loneliness as a Component of Psychiatric Disorders*. Retrieved December 17, 2008, from Medscape General Medicine: <http://www.medscape.com/viewarticle/430545>

Cacioppo, J. T., Ernst, J. M., Burleson, M. H., McClintock, M. K., Malarkey, W. B., Hawkley, L. C., et al. (2000). Lonely Traits and Concomitant Physiological Processes: the MacArthur social neuroscience studies. *International Journal of Psychophysiology*, 35, 143-154.

Cohen, S., Doyle, W., Skoner, D., B., R., & Gwaltney, J. (1997). Social Ties and Susceptibility to the Common Cold. *Journal of the American Medical Association*, 277, 1940-1944.

Geller, J. S. (2004). Loneliness and pregnancy in an urban Latino community: associations with maternal age and unscheduled hospital utilization. *Journal of psychosomatic obstetrics and gynaecology*, 25, 203-9.

Geller, J. S. (2000). Loneliness: an overlooked and costly health risk factor. *Minnesota Medicine*, 83 (4), 48-51.

Geller, J., Janson, P., McGovern, E., & Valdini, A. (1999). Loneliness as a Predictor of Hospital Emergency Department Use. *The Journal of Family Practice*, 48 (10), 801-804.

Lauder, W., Sharkey, S., & Mummery, K. (2004). A Community Survey of Loneliness. *Journal of Advanced Nursing*, 46 (1), 88-94.

Orth-Gomer, K., Unden, A., & Edwards, M. (1988). Social Isolation and Mortality in Ischemia Heart Disease. *Acta Medica Scandinavica*, 224, 205-215.

Hispanic Healthcare:

National Hispanic Medical Association

<http://www.nhmamd.org/>

The NHMA is a non-profit organization of licensed Hispanic physicians dedicated to enhancing the health of Hispanics and other underserved populations. The website provides information about policies, cultural competency, and a variety of resources including an online symposium on pain management.

National Alliance for Hispanic Health

<http://www.hispanichealth.org/>

The NAHH is a non-profit organization dedicated to enhancing the health and well-being of Hispanics.

Community Health Centers:

National Association of Health Centers

<http://www.nachc.org/>

The NAHC is an organization providing resources for community health centers in the United States. The website includes tools for communication and policy information.

Facilitating Organizational Change:

Nutbeam, D., & Harris, E. (2004). *Theory in a Nutshell: a practical guide to health promotion theories* (2nd ed.). Australia: The McGraw-Hill Companies.

A resource for understanding and facilitating changes in health behavior, organizational behavior, and public policy.

Hypnosis Training:

American Society of Clinical Hypnosis: <http://www.asch.net/>

The ASCH is the national organization of healthcare professionals interested in the use of clinical hypnosis. They provide resources, training, consultation, certification, accreditation, continuing education, networking and referral services for clinical hypnotherapists.

New England Society of Clinical Hypnosis: <http://www.nesch.org/>

A regional component of the ASCH, this organization provides introductory training, study groups, and seminars in clinical hypnosis for healthcare professionals.

References

Agency for Healthcare Research and Quality. (2007). National Healthcare Disparities Report. Retrieved December 3, 2008, from <http://www.ahrq.gov/qual/qdr07.htm>

Barud, S., Marcy, T., Armor, B., Chonlahan, J., & Beace, P. (2006). Development and implementation of group medical visits at a family medicine center. *American journal of health-system pharmacy* , 63, 1448-1452.

Basbaum, A., Bushnell, C., & Devor, M. (2005). Pain: Basic Mechanisms. In D. M. Justins (Ed.), *Pain 2005 - An Updated Review: Refresher Course Syllabus* (pp. 3-9). Seattle: IASP Press.

empower. (n.d.). Retrieved May 05, 2009, from Merriam-Webster Online Dictionary: <http://www.merriam-webster.com/dictionary/empowerment>

Gaynor, C. H., Vincent, C., Safranek, S., & Illige, M. (2007). Group Medical Visits for the Management of Chronic Pain. *American Family Physician* , 76 (11), 1704-1705.

Green, C. R., Anderson, K. O., Baker, T. A., Campbell, L. C., Decker, S., Fillingim, R. B., et al. (2003). The Unequal Burden of Pain: Confronting Racial and Ethnic Disparities in Pain. *Pain Medicine* , 4 (3), 277-294.

Green, C. R., Ndao-Brumblay, S. K., West, B., & Washington, T. (2005). Differences in Prescription Opioid Analgesic Availability: Comparing Minority and White Pharmacies Across Michigan. *The Journal of Pain* , 6 (10), 689-699.

Hooper, D., & Antonides, J. (2003). Shared Medical Appointments Save Money for Capitated Groups. *Capitation Management Report* , 10 (2), 20-24.

International Association for the Study of Pain. (n.d.). IASP Pain Terminology. Retrieved March 21, 2009, from http://www.iasp-pain.org/AM/Template.cfm?Section=Pain_Definitions&Template=/CM/HTMLDisplay.cfm&ContentID=1728#Pain

Kuiken, S., & Seiffert, D. (2005). Thinking Outside the Box! Enhance Patient Education by Using Shared Medical Appointments. *Plastic Surgical Nursing* , 25 (4).

Morrison, R. S., Wallenstein, S., Natale, D. K., Senzel, R. S., & Huang, L.-L. (2000). "We Don't Carry That" — Failure of Pharmacies in Predominantly Nonwhite Neighborhoods To Stock Opioid Analgesics. *The New England Journal of Medicine* , 342 (14), 1023-1026.

Nguyen, M., Ugarte, C., Fuller, I., Haas, G., & Portenoy, R. K. (2005). Access to Care for Chronic Pain: Racial and Ethnic Differences. *The Journal of Pain* , 6 (5), 301-314.

Noffsinger, E., Sawyer, D. R., & Scott, J. C. (2003, March). Group Medical Visits: a glimpse into the future? *Patient Care* , 18-40.

Schmucker, D. K. (2005). Introduction to group medical appointments. *The Journal of medical practice management* , 21 (2), 89-92.