VIEWPOINT

Group Medical Visits: The Future of Healthcare?

小组医学访视：医疗的未来?

Visitas médicas en grupo: ¿El futuro de la asistencia sanitaria?

Katherine Gergen Barnett, MD, *United States*

Author Affiliation
Boston Medical Center, Massachusetts. Dr Gergen Barnett blogs for *The Huffington Post* and *Health Affairs* and is a contributor to *The Boston Globe*.

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Correspondence
Katherine Gergen Barnett, MD
gergenbarnett@gmail.com

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We are at an interesting crossroads in today's medical healthcare system. The Patient Protection and Affordable Care Act (ACA) passed in 2010 and, further supported in the *King vs Burwell* Supreme Court Decision earlier this summer, has the laudable intention of getting every citizen covered by health insurance. We have made enormous gains in this realm, and as of last month more than 90% of Americans are covered by medical insurance.[1] A seemingly obvious consequence of these gains is that more people than ever are seeking primary care. As a primary care physician who believes strongly in prevention of disease and promotion of wellness, this of course strikes me as excellent news. The downside is that, for a variety of reasons, there are not enough individuals choosing primary care as a future profession,[2] leaving very few of us on the frontlines to care for this swell of patients with an increasingly prevalent set of chronic illnesses such as diabetes, obesity, hypertension, and chronic pain. Additionally, while the ACA promised to move away from fee-for-service—where financial incentives are based on numbers of people seen and procedures performed—to pay-for-performance, which offers incentives for good health outcomes, the medical system has yet to traverse this transition in many places in the country. The unwitting outcome is that primary care providers are pushed to see more people in less time and reimbursed for numbers over quality, leading many healthcare professionals and patients dissatisfied.

The news is not all dire, however. A growing body of evidence suggests that group medical visits may be effective for some patients in treating chronic medical conditions including diabetes[3] chronic pain,[4,5] and depression[5] and may also reduce burnout among providers.[6] While the group medical visit model can vary, there are some shared elements that exist, including individual medical attention for each group participant, teaching time (didactic and interactive), time for patient self-management, and time for the group to connect and socialize. Groups usually range from 8 to 12 patients with 1 to 2 clinician facilitators.

In this issue of *Global Advances in Health and Medicine*, Geller and Delichatsios illustrate two more exciting and promising models of group medical care. Geller and his colleagues discuss the empowerment model—defined here as "the ability to try new things and make lifestyle changes" in its use to treat chronic pain in an underserved, primarily Latina female population at the Greater Lawrence Health Center in Lawrence, Massachusetts. Through the weaving together of complementary and integrative medicine approaches such as low-impact yoga, empowerment-based choice of curriculum, occasional meetings with a physician, and regular interval meetings with no start or end date, Geller's group visits resulted in statistically significant changes in the following SF-36 categories for the women enrolled: Role-Physical, Bodily Pain, General Health, Social Function, and Mental Health, with largest improvements in the Role-Physical and Role-Emotional areas. Delichatsios and her colleagues discuss group medical visits (defined in her piece as shared medical visits) in an academic center in Boston, Massachusetts, that use a novel approach in caring for individuals living with obesity and its related comorbidities—such as cardiovascular disease, diabetes, degenerative joint disease, gastroesophageal reflux, and sleep apnea—the culinary approach! Delichatsios's article helpfully lays out some of the nuts and bolts of their approach, including how the group was set up, who facilitated the groups, and the delicious menu that accompanied each of the medical topics covered. She documented that half the participants in these groups felt that they would be willing to pay out of pocket for future such groups and many would prefer this kind of care to a regular physician visit. (The dark chocolate when discussing osteoarthritis certainly did not hurt!)

The two articles beautifully bring the field of group visit research further along. They also show that groups can be run in different ways with different applications and be successful. With so much research to support them and such an invitingly broad array of applications, why aren't group medical visits more common?

As someone who has been teaching and practicing medical group visits for more than 10 years, I have heard many reasons from practitioners for this gap, including lack of knowledge about how to set up groups, concern about how to facilitate groups, uncertainty about how to bill for groups, and, if in research, questions about how to measure the success of groups. I have had the good fortune to attend and teach trainings on group medical visits but have found that these kinds of workshops are not common

enough. Answers to these questions must be increasingly made accessible and taught. And for those who are conducting group visits, stories of success (and failures) must be shared. This is part of the road toward the future of improving healthcare and the health of those of us providing healthcare. Kudos to Geller and Delichatsios for doing the work and sharing their stories.

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