THE PEDIATRIC GROUP VISIT EMPOWERMENT MODEL MANUAL:
A Comprehensive Guide to Using Group Medical Visits to Support Lifestyle Change in Children with Obesity in Underserved Communities

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With gracious support from:

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Empowerment Group Medical Visits As Treatment for Pediatric Obesity (POEM-GMV)

Prologue: 'How did you get those teenagers to come to your groups and change how they live?'

One of the main questions proposed when visitors come to see our medical group visit programs, or when I am lecturing or consulting about group visits is, "How do you make people come to your group visits?" At first it was very surprising. I would talk to others starting groups to find out that they had wonderful curriculums, project ideas, and staff, but that after an initial success they were not able to get their patients or community to come and take part. Slowly, I learned that this is actually typical of group visit programs, especially when dealing with chronic illnesses such as chronic pain, heart disease, diabetes, obesity, stress or loneliness.

Chronic conditions such as obesity require a lot of lifestyle change as part of the treatment, and frankly, these changes aren't much fun or comfortable. I have come to realize that the answer to getting and maintaining patients at group visits is this: Ask people what they need to improve their health in the context of their community and culture, and then help guide the group without preconceived agenda or too much attachment of your own ideas. This may be fairly easy to say, but the execution requires an uncomfortable lack of control and patience. It also requires a good amount of facilitative skills.

This manual is therefore a guide for moderators and facilitators on how to get children to willingly participate and flourish using an empowerment model. In this model, the group as a whole is responsible for deciding the activities and plans for improving their overall health. This manual will take you through the process needed to create empowerment in the participants so that each participant (including you) feels essential and important to the group. The empowerment model approach may lead to ideas and agendas that are not at first intuitive (especially to the scientific mind), such as going to the beach to treat diabetes, or dancing *bachata* for exercise, or making tacos to fight obesity. However, you may already intuit people will attend these groups *because* the activities appeal to their interests more than a repetitive or tiring exercise class or a solitary at-home regimen. The cornerstone of this model is building relationships by having fun together doing meaningful activities and having meaningful conversations about health change in the context of community. Our hope for you is that as you facilitate your new group, you will learn the power and strengths of the participants. You will become part of the group and influence health as part of the community that has formed.

Introduction to Group Medical Visits (GMVs): efficient and effective for many conditions!

A group medical visit (GMV), also known as a shared medical appointment, is a relatively new approach towards delivering primary care in an outpatient setting. It has been used for over 20 years at Greater Lawrence Family Health Center (GLFHC). Here, the individual medical appointment with a provider takes place in a group setting with those sharing a similar medical condition often chronic such as chronic pain, heart disease, diabetes, addiction, anxiety, pregnancy, or as in our focus, obesity. Alternatively groups can provide a specific service or activity such as exercise, yoga, acupuncture, mindfulness education, or a cooking demonstration which may pertain to multiple conditions simultaneously. Participants and providers guide patients to choose if they may benefit from those healthy opportunities. Though there are a variety of different GMV models, all have the goals of providing group support, effective medical treatment in an efficient manner, and improving patient-provider access. GMVs address individual needs and common concerns and allow for group education, support, sharing of ideas, provision of greater service, and cultural competency.

Due to their more efficient use of a primary care provider's time, GMV's can be a worthwhile endeavor to use in physician-limited (underserved) communities and environments. The increased efficiency allows for a better budgetary impact that can provide some of the resources needed by such a community. These include exercise opportunities, mentorship or training, and food projects such as community gardens and farmer's markets. Some practices have found that they can eliminate a 3-month backlog of appointments with the efficiency of the GMV programs (Hooper & Antonides, 2003). Given the limited resources often confronting community health centers, GMV's are an option that holds particular value.

Opened and Enclosed Group Models

GMV's can be put into two general categories for which we created the nomenclature: opened, and enclosed. The category is determined before beginning the GMV by analyzing the condition, the patient population, and the environment in which the GMV will be conducted. In an enclosed model there is a more defined and controlled atmosphere. Usually there is a specific target population as well as a predetermined number of participants who are preselected to participate. The number of group sessions is also determined beforehand. An example of an enclosed model would be a five-week group program for eight diabetic children. Each week may review a different key aspect of living with diabetes including: a cooking class, education, review of healthy lifestyle, a discussion with family members about feelings with a behavioral scientist, and a review of medications with a pharmacist. As it has a definitive curriculum, it is a strong model for education and tends to do well in a community with few barriers to health. In other words, this works in a community where opportunities for health are abundant with regards to food, safety, healthcare, and education. Enclosed educational style groups work best where a participant can easily implement the suggestions taught from his/her group.

In contrast to the enclosed model, an open model has no predetermined curriculum or time frame (see Table 1). These models usually have either a specific treatment, illness, or group of patients who are invited to participate. For example, a chronic pain group for young women may have many different types of illness represented, while a pediatric obesity group has the simple qualification of being overweight without regard to etiology. Therefore, an open group visit is usually a self-selected group of participants and admission is rolling. The curriculum is then based on the input of the participants who have come, and advances as the needs of the group become clear. Often these needs are not simply educational but experience, resource, or service driven. There is no specific agenda *per se*, but rather, there are overriding principles that are used to guide the time. (These principals will be discussed later in this manual in detail). Participants can enter and leave at any time, and there are no pre-defined numbers of sessions. In fact a group may go on indefinitely. This model is better suited for, and more effective in, communities that have financial, cultural, social, economic, or multiple combinations of barriers to health. It is a preferred model in a community where education is simply not enough to create lifestyle change, but where empowerment is needed to create sustained change.

Open Model	Enclosed Model	Mixed Model
Patient -driven curriculum	Provider- driven curriculum	Both
Rolling admission	Specific start date	Specific start date
Ongoing visits	Specific end date or goal	Both
Consistent staffing	Invited lecturers / activities	Both
Participants self selected	Participants are selected-invited	Both
Skill based curriculum	Information based curriculum	Both
Introverted facilitator style	Extroverted facilitator style	Both

Table 1. Differences in the opened and enclosed group visit models.

In regards to pediatric obesity, there is some evidence that shows that obesity programs using shared visits or GMVs are having some success in triggering weight loss (Goodpaster et al., 2011). Additionally, multidisciplinary and family-centered approaches are also possible in the empowerment group visit model. These tend to be more effective in the treatment of pediatric obesity (Okely et al., 2010). Taken together, the evidence supports the ‘open’ model of group visits over the enclosed model, as it seems the longer the participation in the obesity program the more likely the patient experiences successful results. This has been our experience as well with our success rarely occurring in the first two months, but sometimes requiring years of empowerment group practice.

The Spirit of the Empowerment Group Visit Model: An Opened Model with a Patient Centered Approach to the GMV

Though our Empowerment Model group visit programs began before the more recognized Kaiser group visit models reported by Edward Noffsinger, people may be more familiar with that model of care. These are physician-centered models with the emphasis on facilitating efficiency in both education and medical visits. In my opinion, this is a great improvement over traditional models of individual care with their inefficiencies. The Empowerment Model (EM) differs in that it is a patient-centered model in which the main efficiencies result from connectedness, continuity, group support, and shared knowledge. The closest of the Kaiser-type group models to the Empowerment model might be the DIGMA (drop in group medical appointment) where the patient can have better physician access and can control how often they would like to have appointments. They can receive the efficiencies of education, vaccination, and other programming similar to EM groups but have to rely on what is offered. The DIGMA model, however, lacks continuity of participants, which is a very big difference in terms of learning about participants' needs and culture and the creation of a comfortable environment. In a DIGMA, the patients presenting to the group will be different every time, where in the EM they will be the same each time and thus all know one another. EM differs from DIGMA in that the EM group drives health care delivery though facilitation of building a sense of community and direction. Both groups maintain opportunities for individual attention, which is also vital in healthcare.

The experience of EM meetings therefore is fundamentally different from DIGMA, as the EM is neither physician-directed nor solely education-centered. One tendency to avoid in creating open model group empowerment visits is planning out a curriculum well in advance of beginning the program. Preparing and creating a curriculum may seem like a very logical and appropriate step that is typical of the mentality of a conscientious medical care provider; however, it is often a recipe for failure when in a disempowered community. This was the experience we had when starting GMV. Having a prepared agenda decreased the ability of the provider to listen to what the group needed or wanted. This was a hard lesson that continues to be a challenge every day when working with empowerment group visits. We often naïvely believe that the solution to obesity is simple: Eat less, exercise more, watch less television, eat less junk food, and reduce stress. The straightforward thinker would, therefore, offer a five week program with five two-hour sessions on each of these topics run by the appropriate educator. Throw in an exercise class or cooking demonstration and the weight will fall off easily, right?

However, world literature as well as our own 15+ years of experience has shown that education alone is ineffective to address our current epidemic of obesity and prevent the associated co-morbidities of heart disease, cancer, and chronic pain. Simply put, nutrition, disease-specific education, and stress

reduction education alone do not work in the long run. We will now share what has worked for us and specifically offer our findings from conducting EM group visits with children.

You only have to think about your own life and choose any area that you would like to improve and you will find that empowerment is a bigger factor than education most of the time. Let us say you see your doctor and they identify that you need to be more active and then recommend a group medical visit to increase the exercise in your life. If your group has an educational approach you would start with a lecture about the benefits of exercise, followed by some instruction on safe exercises, a review of over-the-counter medications for common muscle pain, and a really good program would then give a list of places to exercise in your community. This is not a bad thing, but it has not addressed any of the barriers to exercising. A more empowerment based group model would answer the questions about whether "there is enough time in your life to do the exercises. Do you have the space for what you want to do? Do you have access to an activity that you enjoy? Can you afford a personal trainer? Do you want someone yelling at you to give them 10 more pushups? Is the community safe for going outside at night?" These barriers and concerns can only be addressed with your input to the group. The group focus can then be finding you a safe enjoyable place to exercise. Or better yet, the group visit facilitator and group space and time could be used to offer you the type of exercise you enjoy. That is exactly what we have created for children in our POEM-GMV.

Our History

The Empowerment Model has roots going back to the mid-1990's. In 1996, I began to give weekly health lectures to an outreach group "¡Sí Tú Puedes!" ("Yes You Can!") – a group of approximately 15 older, uninsured Latino women who met for two hours each week to do arts and crafts together. While working with this community, I realized the power of the group experience. Though I came prepared with a medical topic each week, the group quickly began asserting itself by requesting topics that interested them and developed discussions with shared experiences instead of a one-sided lecture. I immediately noticed the markedly improved health of these participants in the social context of the group as compared to the patients seen individually in clinic, who appeared more lonely and depressed. This led to two years of a *non-reimbursed trial of* group visits with office patients at the local public library, a conference room at the local hospital, outside at a public park, and even a converted funeral home.

With the observation that the group experience seemed related to better health outcomes, I began research on the effects of loneliness on health that led to publication of award-winning research in the Journal of Family Practice (Geller, 1999). In 1999, through a Center for Disease Control and Prevention grant called 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, the first formal medical group visits were started once a week at a local funeral home in a room that had been converted to office space. Patients shared what they thought they needed to become healthier, or what they wanted to do to be happier. Not all of these requests would be accommodated, but the group

would work together to overcome obstacles. After a year of visits filled with music, dancing, Tai Chi, pot lucks, etc., the data from this project showed that patients attending the groups not only reduced their loneliness and depression, but also they lost weight and had better glucose control along with dramatically improved health-related quality of life based on SF-36 reports (Geller, Orkaby, & Cleghorn, 2011).

From 1999 to 2004, groups targeting risk factors for heart disease, chronic pain, adult obesity, pediatric obesity, and stress-related illnesses were started. These generated enough revenue to move the programs into our main health center conference rooms and the numbers of patients participating in the groups steadily increased. In 2004, the budget data proved the financial sustainability of group medical visits, which convinced Greater Lawrence Family Health Center administration to dedicate a portion of the floor plan at one of our federally-funded health center expansion sites to use for GMVs.

Our first pediatric obesity medical group visits was started in 2000. These groups were called the 'FUNK' model instead of the Empowerment Model because due to their age we could not truly allow our children complete freedom to create the curriculum. We created the sensation of empowerment by giving the participants choices instead of a *carte blanche* approach. This was needed, as the ideas offered by children in our program were often not possible due to constraints of our community and funding. Starting in 2005, the New Balance Foundation became instrumental with supporting our pediatric obesity programs. We were able to more fully offer children the activities and opportunities they needed to find health in our community and to grow our program significantly to reach more patients. Increasing the size of the program allowed for better efficiency and improved economic benefit; this has allowed the program to be largely self-sustaining and has allowed for hiring of more staff. We now have part-time exercise instructors, and a full-time Group Coordinator (GC), who handles the meetings and coordinates volunteers and activities and monitors behavior.

After receiving the generous support from New Balance Foundation, we changed the name from FUNK to the Pediatric Obesity Empowerment Model, or POEM. We chose this name to reflect the metaphoric idea and message of a poem. When a group of people hears a poem there are multiple interpretations, feelings, and impressions by a reader. When a group of people shares an experience and are asked to write a poem about that experience, there would likewise be very different approaches, perspectives, emotions, and styles. This is the value of the empowerment model that really fosters support for the various needs of an individual so they may succeed in their community. In essence, we are helping each participant in writing the poem that will become his or her successful life story.

Our POEM-GMV Research Studies

The 'Empowerment Model' developed at Greater Lawrence Family Health Center has demonstrated the ability to help patients manage chronic illness and obesity, improve health outcomes, and increase quality of life for many patients in an underserved community. The Empowerment Model approach facilitates the development of relationships and community among patients. These relationships create an environment in which the patient is empowered to try new things and believes that change is

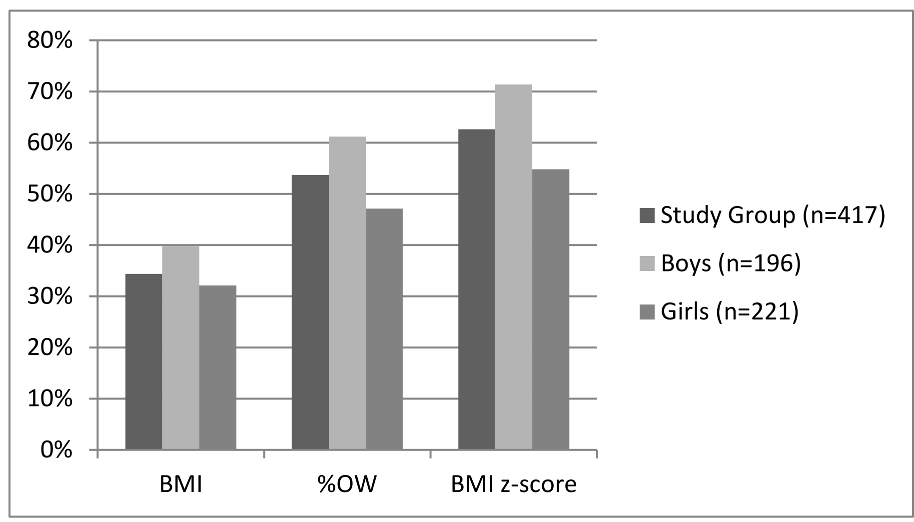
possible. Through generous support from the New Balance Foundation, we further developed the POEM for children with obesity and have been able to evaluate our effectiveness with a research study called POEM-GMV. This manual discusses in detail how to start a POEM in a poor, predominantly Latino community using the Empowerment Model. While the details provided are specific to a poor Latino population, the main principles of the Empowerment Model and group visits can likely be applied in any population where there are barriers to health and wellbeing.

Measures of Efficacy: What results can you expect?

With IRB approval from the University of Massachusetts Medical School we have evaluated our POEM-GMV program. Full details from this data are available at this reference: **Pediatric Obesity Empowerment Model Group Medical Visits (POEM-GMV) as Treatment for Pediatric Obesity in an Underserved Community** Jeffrey S. Geller, Eileen T. Dube, Glavielinys A. Cruz, Jason Stevens, Kara Keating Bench. Childhood Obesity. October 2015, 11(5): 638-646.

Over a three year period from 09/01/2008 through 08/31/11 we collected data on 584 referred patients at our health center of which 417 came to a minimum of two visits. Pre- and post-measurements and data was collected to evaluate outcomes. We found that the majority of these participants had consistent participation for over a year and a half. 63% of participants had better weight outcomes than comparison to WHO data using BMI z-score, 54% of participants lost or maintained weight using a normalized measure of percent overweight, and 34% had absolute reduction of BMI. (see Figure 1)

Figure 1. Percent of POEM-GMV participants who lost 'weight' comparing absolute (BMI), normalized (%OW), and comparative measures (BMI z-score).



In our study group there was statistically significant improvement in many lifestyle factors including increased exercise, sleep time, and empowerment, with decreased beverage consumption, restaurant meals, and television viewing. By far, however, the factor most associated with obesity and most reduced by our intervention was stress level (see Figure *2)*. An important area of future research and

relevance to these outcomes is this piece. The overall result of our program may have many positive social implications. It is the social aspect of the program which may have the most benefit in the end as the original design was to decrease loneliness which would indirectly have positive effects on well being. This may be the mechanism for decreased stress and weight loss.

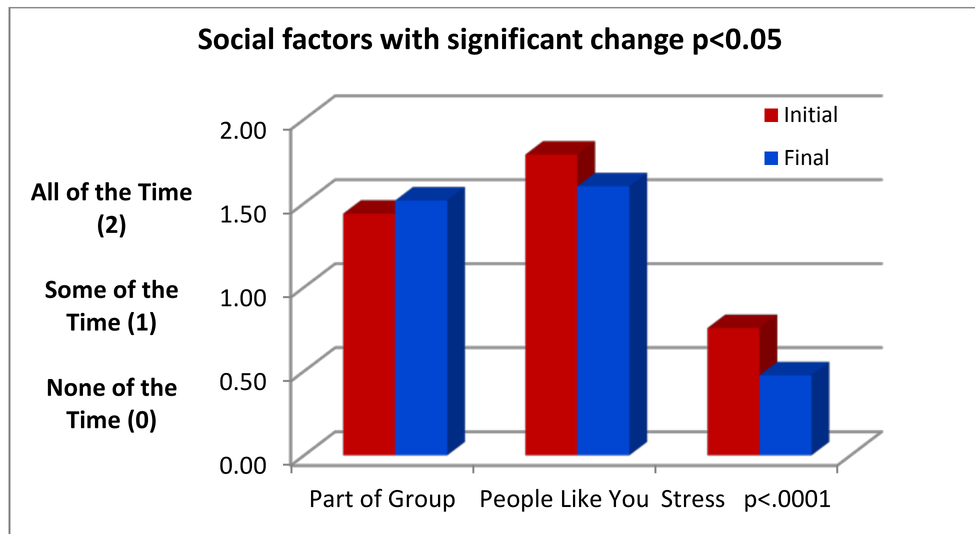


Figure 2. Stress is statistically significantly reduced in participants of the POEM program.

Obesity and Empowerment: Definition, Context, and Measures of Success

Pediatric Obesity Defined

Pediatric obesity is a serious public health problem that has both short-term and long-term adverse health consequences. Obesity is defined using body mass index (BMI), which is calculated using height and weight and is an indicator of a person's relative amount of body fat. Approximately 17% of children and adolescents age 2-19 are obese, and rates are even higher in Latino and low-income populations. Among this age group, obesity is defined as a BMI that is at or above the 95th percentile when compared to other children with the same sex and age using the CDC Growth Charts (Barlow et al., 2007). The causes of obesity are complex and involve a number of interacting social, environmental, and genetic factors. Treatment plans that address these multiple factors that contribute to obesity and those that are multidisciplinary seem to be more effective in treating obesity in children.

Consequences of Pediatric Obesity

Pediatric obesity has a number of health and psychosocial consequences. Obese children are at a higher risk for having health problems such as high blood pressure, high cholesterol, insulin resistance, type 2 diabetes, fatty liver, and musculoskeletal problems (Freedman et al., 2007; Whitlock et al., 2005; Han et al., 2010; Taylor et al., 2006). Obese children are also more likely to experience lower self-esteem and social discrimination; these problems can persist well beyond childhood (Whitlock et al.,

2005; Dietz, 1998; Swartz et al., 2003). Pediatric obesity can also have other health consequences in later adulthood. Obese children are more likely to be obese adults, and this obesity is likely to be more severe (Biro et al., 2010; Freedman et al., 2001). Obesity in adulthood is a serious concern as it increases the risk for health problems such as cardiovascular disease, diabetes, and some cancers (NIH, 1998).

Prevalence and Disparities in Pediatric Obesity

Obesity disproportionately affects the poor and some minority groups. According to the results of the 2007–2008 National Health and Nutrition Examination Survey (NHANES), approximately 17% of children and adolescents aged 2–19 years are obese (Ogden et al., 2010a). Certain ethnic groups are disproportionately affected. Latino children have a higher prevalence of pediatric obesity than white children. According to results from the 2007–2008 NHANES, an estimated 20.9% of Latino children and adolescents are obese (Ogden et al., 2010a). Early childhood risk factors for obesity are more common in Latino children compared to white children (Taveras et al., 2010). Studies also suggest that Latino male children may be particularly prone to morbidities related to obesity (Stovitz et al., 2008). Socioeconomic disparities in pediatric obesity also exist that increase stress, limit access to healthy foods, limit opportunities to exercise, and negatively impact other health factors. Children from lower income families have higher rates of obesity than those from higher income families: 21.1% of those living below 130% of the federal poverty guideline are obese compared to 11.9% living at or above 130% of the federal poverty guideline. (Ogden et al., 2010b). According to a 2008 CDC survey, 1 in 7 (14.3%) low-income pre-school age children (age 2-4) are obese, and these rates are higher (18.5%) for low-income preschool age children who are Latino (2009).

Empowerment Defined: The ability to try new things

There are many definitions of empowerment and so it is important to describe how we will be discussing it in this model. Empowerment generally implies the notion that you can do whatever your heart desires. This connotes the sense that one has power and can use that power to do whatever they need to improve their situation or lives and be happy. While it is ideal for all people to feel this, general understanding of empowerment is not easily applicable for the people we serve or the target of this intervention. For our purposes empowerment will be defined more specifically as: THE ABILITY TO TRY NEW THINGS. This is a very functional definition that allows use in impoverished communities as well as the affluent. Empowerment is a very good gauge in assessing individuals', medical groups', and communities' ability to succeed.

Here is an example: If you ask a patient to try to eat a pomegranate because it is healthy, perhaps some of them would love to but cannot afford one, another patient can afford one but there is no supermarket in their town, another person bought the pomegranate but it was too messy, and a final person did not have the manual dexterity to open the pomegranate. By our definition, all of these examples are disempowered people. An empowered person can buy, open, and eat the pomegranate. They may not like it, they may not actually even take any of these steps, but they could if they so desired. They have that ability. If on the other hand all participants came back the following week and

reported they all tried a pomegranate, then you could be confident this group is empowered relative to pomegranate eating according to our functional definition.

Measuring Empowerment

Evaluation is an important process in the maintenance of a group. It is helpful to think about groups as living beings unto themselves. Like all living things, a group has to go through a maturation process that involves trial and error, learning from mistakes, finding role models to follow, and creating their own paths to progress. If the ultimate goal is group and individual empowerment, then you need a way to measure it. By virtue of our definition of empowerment, an empowered group would be willing to attempt new activities. We have two ways of measuring this in practice. One is to ask participants to go around the check-in circle and answer this question, "Have you tried anything new this week?" or as one of our providers likes to ask, "What is new and good in your life?" You will very quickly get a sense of empowerment this way. A second, more preferred way that is more telling with less social anxiety involved is to bring something new for the group to do and see what happens. Offer something a bit more unusual like Karaoke, drum circle, new vegetable (like a hot pepper), beet shakes, etc., and ask everyone to try it. If they do try this, then the group is likely empowered. After working with this empowerment model for some time, you will have a sense for this right away. When kids say, "Hey can we try hockey?", or do more exercise, or do some cooking, then the group is indicating they are willing to try something new. Once a group is empowered you can take the next step in doing self-motivated projects to fully develop both independence and the feeling of possessing the power to change.

How to start a POEM-GMV

The POEM-GMV has been replicated in several settings, but it appears most successful when incorporated into a federally qualifying community health center model (FQHC). The FQHC model will be the basis for this discussion, however enough general information will follow that should be helpful in any setting. 'Getting started' is a unique one time opportunity in the life of a group. For easier discussion, this will be broken into three parts; one that is more about the key components required before getting started, clearing the way for successful participation, another about the structural pieces that should be in place for the human resource and financial success of a program, and a final piece that is more about the facilitation of people in the group, empowerment, and management of the group itself. Though many of these parts interplay simultaneously it is helpful to look at the individual pieces and be thoughtful about how to best address these components in the context of your location, community, resources, and time considerations.

Key Components for POEM-GMV Success

There are many key components for successful groups. Some of these components are more important when initially organizing a group, while some are more important later-on in the maintenance of a group. Of all of these that will be shared, being consistent with staff, participants, goals, experience, and expectations may be the most important aspect of group visits! This may not be achievable initially.

Key Components for Successful Groups

- Comfortable environment
- Provision of a good Experience
- Clear Expectations / Goals / Reason
- **Consistency**
- Financial Stability
- Accessibility

<u>Comfortable environment</u>

A comfortable environment is not only a physical space, but a psychological space as well. There is a diversity of opinion and experiences that will come into the group space. Initially, as people are not known to one another there will be some apprehension of sharing ideas and decreased authenticity while describing one's goals and life experiences. The creation of a comfortable, safe, social space will be described later-on in sections dealing with empowerment and group facilitation. The physical space can enhance safety and comfort but will likely have some limitations due to the location chosen for the group visit program. Important considerations should be for protection and privacy as one is more likely to be relaxed in a safe location. A private entrance, windows that have blinds, a room that can sub-divide, a connected private office space for individual consultation all contribute to creating comfort.

The facilities for Greater Lawrence Family Health Center's GMVs (*see Figure 4*) are connected to, but 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.

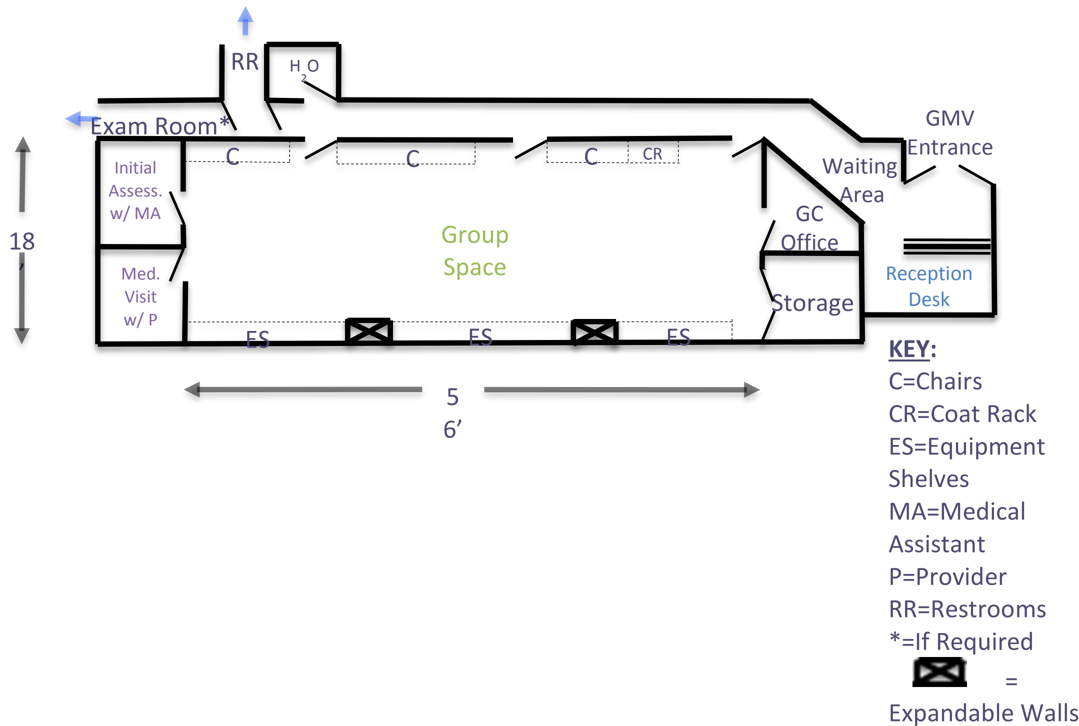


Figure 4. Scale layout of group space at GLFHC.

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 that can create smaller spaces within the large room. These expandable walls are typically not used for our pediatric obesity groups as we prefer a large open space. The room has a high ceiling to provide a better sense of space for activities and movement. There are also two small rooms at the far end of the space for the individual physician visit and the other for the assessment by the medical assistant. 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.

Provision of a good experience

A good experience is the reason that a participant will return. Good is not synonymous with fun, but rather connotes that a participant received some value or meaning from the time spent together. This sense requires the input of the individuals in the context of the group. It comes from a sense of connection. When a group has chosen a direction, that path needs to be taken seriously and supported. Achieving this will require group facilitation skills and there will be greater details on this topic in that section.

There are a variety of materials to consider having on hand for group activities including art supplies, a stereo system, and exercise equipment to include dumbbells, small medicine balls, exercise steps, inflatable exercise balls, elastics, and yoga/exercise mats. Children also enjoy a variety of sports equipment: baseball gloves for a team and a full complement of balls, bats, racquets, bases, and small

collapsible soccer goals. The favorite sport equipment by far, however, is a beach ball. The floors are rubberized to prevent slipping during exercise.

Clear expectations/goals

Clear expectations do not only refer to the participants, but the program as well. Expectations for behavior should be made clear to participants, parents and guardians, and all staff. The POEM-GMV program is not mandatory, but is voluntary and so anything that compromises safety of participants is not accepted. Most of the participants are referred to the program after a physician's visit and they believe that this is a weight loss program. Though it is true that the goal of a POEM-GMV is weight loss, the overall goal of the group should be much broader allowing for successes that do not relate only to absolute changes in weight. Making weight a priority can be disengaging and can interfere with the provision of a good experience. The explicit goal of a group, therefore, is being healthy. This goal can include actions taken which are physical, mental, and overcome the social determinants of health. It opens a group up to more opportunities for success.

Consistency

This is perhaps the most important factor underlying the success of all group programs. The same location, time of day, policies, group flow, and activities allows participants to work the program into their lives. Consistency also helps with the creation of empowerment as it requires social cohesion and the formation of meaningful relationships. These relationships are aided when the same participants and staff are coordinated so that they see one another frequently. The same reception staff, transportation group, clinicians, instructors, medical assistants, and nurses meeting with the same children over time create connection and mentorship. The same participants spending time with one another and working on projects with one another also creates meaningful relationships.

Financial stability

The group visit model follows the American Academy of Family Physicians' recommendations for billing. If group participation is robust, the group visit model can be financially sustainable. There may also be local foundations, trusts, or corporate sponsors who may be willing to help support the start-up costs of such a program.

Accessibility

A program can only succeed if participants are able to come, so location and transportation options are important. Offering transportation can double the size of your program. Locating a program near schools or in a location near public transport can help with participation. Parents and care-givers may not feel the community is safe for walking and so coordination of pick-up and drop-off is essential. The group site at GLFHC is centrally located in a large shopping plaza frequented by our patient population. The shopping plaza provides substantially more parking than a typical doctor's office. Many families in our community do not own a car and rely on public transportation; a bus route stops right in front of our GLFHC office. Children get to GLFHC either by walking from school, being

driven by family members, or taking public transportation. The majority of our participants receive transportation , which is supported in part by New Balance Foundation.

POEM-GMV Structure and Flow

The basic structure of a POEM-GMV can be seen in the figure below. Though the schedule can be flexible, most groups start with a check-in, followed by an activity, and then a focus on a group project. Registration happens in parallel to the group schedule during check-in, with medical assistant-facilitated patient intake happening during the activity, and the individual physician visit happening during the activity as well.

Registration

When a group participant arrives for a GMV at GLFHC, they sign in with the patient service representative (PSR) at the reception desk. The PSR has a list of all expected participants for that session. Please refer to the American Academy of Family Physicians for their recommendations on how to properly bill for group visits. When everyone has signed in and check-in has started, the PSR does the insurance verification to ensure payment for interval visits. The PSR then balances time limitations with the protocols to determine how many interval visits are available for individual physician visits for that session.

The basic empowerment model

- Registration
- 1 hour and 15 minutes.
  - 10-15 minutes check-in (group bonding)
  - 10-20 minutes group exercise
  - 20 minutes activity (group fun / learning)
  - 10-20 minutes project (group problem solving)
  - 5 minutes check out and plan for next meeting
- Meetings weekly
- Rolling admission /recruitment
- 10-20 participants
- 5 minute individual physician visit

The Idealized Check-in

In the beginning, the check-in portion of the group experience is all about dis-inhibition. Dis-inhibition means encouraging patients to open up with the group using experiences or activities. We want participants 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 be treated like they, and their ideas, are **important. It is important to note that patients are neither encouraged nor asked to share Private Health Information (PHI).**

When a new group starts up, the group visit staff needs to actively cultivate dis-inhibition. In the first meeting, for example, check-in may take up the majority of the meeting. As a provider, you will need to assess what activities this group can do and show them how a POEM 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 who are succeeding and from being part of a group that is trying new things. Dis-inhibition may also result from being happier.

Over time, dis-inhibition will be established within the group and you will not need to actively cultivate it. At that point the check-in becomes more about connectedness and creating direction for curriculum. 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, "what is your favorite thing to do?", or "What makes you feel happy?" Then simply ask the group if anyone shares these ideas or features. This creates a simple sense of belonging that will reinforce that a new participant is not alone and he or she is in the correct place for support and healing.

The Specifics of Check-in

This is the first 10-20 minutes of a group visit where all participants sit in a circle to discuss varying topics. The group faciliatator will use the ideas generated during check in to plan agendas for the group going forward. By using the group to discuss a topic there can be insights into what the group likes to do and what the group knows about health. This information can be used to create curriculum. There is one part of the curriculum that you have probably been wondering about. When do we talk about obesity and teach about healthy lifestyle habits? Check-in can be that didactic time. After about the fifth week a group is enjoying an activity, participants know the name and a little about each other person. It is starting to become the favorite part of the week for many in the program.

This is when it is appropriate during check-in time at the beginning of a group to ask serious questions about health such as: "Has anyone in the group ever been picked on?", "Is anyone in the group interested in being healthier?", or "What is the healthiest food you have eaten this week?" It is important not to create stereotypes or re-enforce stereotype threat. Group leaders need to be careful to avoid questions such as "Has anyone ever been picked on because they are overweight?" or assuming participants want to lose weight. These sorts of question will never fail to raise interest and create "teachable moments." For instance, if someone says the healthiest food they ate that week was juice, corn, or potatoes then you could ask the group if anyone ate healthier. You could play a game putting the healthiest food in order. Another thing to do, however, is to wait until the next check-in and show a picture of the amount of sugar in juice, or have the group do jumping jacks to burn off the equivalent of one sip of juice (that's 20 calories or about two minutes of exercise). This would be something new and would not make any of the participants shy to give ideas in the future.

> *Helpful Hint: sometimes if the group is full of energy a little exercise at the beginning is best with the check-in to follow.*

Group Exercise

We have learned from experience and research that each group requires a 20- to 30-minute period of rigorous exercise. This is still an empowering endeavor as the participants can help determine what type of exercise this will be. Usually groups like to do competitive running games or obstacle courses. We have found that rigorous exercise creates more of a bonding experience than slower or lower intensity exercise. The group exercises are designed by our exercise instructor or group coordinator to encourage relationship building and trying new things. Children are often split up into pairs to pass weights back and forth or count sit-ups for each other, or into groups of three to jump rope. Most activities that involve sprint running are done in teams where each team will try to beat its own time. These teams are selected at random each week as we generally do not allow children to group themselves. The timing of the exercise may vary. At times it is clear that a group has too much energy and cannot focus on check-in so we may do the exercise first. At other times the content of the check-in and the activity are congruent and benefit from uninterrupted attention. In that case the exercise can be left for later.

The First Activities in a New Group

When the group first starts, we do a short activity either right after check-in or exercise. This activity reflects the desires of the group and is specially designed to 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. 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 with healthy goals*.

The Activity in an Established Group

In an established group, less time is needed for dis-inhibition as most of the participants are comfortable with one another. At this point the 'trying new things' becomes the predominant motivation for this 20-30 minutes of activity. It also becomes the part during the program where we do what the group participants would like to do. Later in this manual we will use the example of a group that wants to play soccer. The activity can have a similar theme week to week, but must incorporate something new with each try. So you might try soccer with two balls, blindfolds, or no goalies as each of these would be something new. The common experience of trying something new does build relationships, but ideally you will learn how to incorporate relationship building as the new element. Better examples would be having players hold hands in pairs as they run (or tying legs together like a two legged race), pass three times before scoring, or say something nice about the person before

they pass the ball. This would be something new and would help build relationships and thus be empowering.

Over the years we have done hundreds of activities. I am torn between telling you what we have done or letting your groups develop unbiased. Suffice it to say we have written songs, illustrated books, danced, played games, cooked food, planted seeds, held talent shows, engaged the participants in meaningful community activities, and have simply "hung out and chilled." Art is a very popular activity that is a good means for helping the participants express their experience of life. They may be asked to depict what is healthy in their life by writing books for recipes, painting to decorate the space, molding clay, creating stop animation videos, and acting out in plays.

Other examples of popular activities include:

- Non-art activities - puzzles, meditation, cooking, cooperative games, improvisation games, building garden beds, planting seedlings, hypnosis, talent shows, sharing YouTube videos.
- Physical activities – Sports (all modified for our space) yoga, dancing, Tai Chi, team building exercises, construction contests, and martial arts are things for which we have instruction available or bring in instructors to assist.
- Community engagement – cleaning parks, volunteering at senior centers, performing talent shows, creating and maintaining community gardens, and going for walks. Field trips can be great activities, but make sure you follow your organization's policies and procedures before taking patients off-site.

How to facilitate a POEM-GMV visit

Facilitation of a POEM-GMV visit is a very important set of skills. In our program there are various times when interaction with participants is needed. Some of the interaction will happen in the group setting in front of the whole group and some interaction happens during individual visits or when the activities are happening. Facilitation of the group is mainly required during the check-in in order to get all participants voices involved, during the activity to make sure opportunities are fairly distributed, and during the project time to help with group decision making. Facilitation of the individuals of the group is important during the individual provider visits where an assessment of empowerment and motivation is of interest, and often used to address those issues that are better not discussed in a group and to guide specific participants.

'Nuts and Bolts' of Group Facilitation:

- Empowerment of the group and individuals
- Creating a culturally competent and realistically helpful curriculum
- Group cohesion and meaning
- Dis-Inhibition
- Keeping the shy and introverted engaged
- Individual clinician visit
- Group decision making.

The Empowerment of Children

Children differ from adults in several ways with respect to empowerment. Truth be told, children tend to be more willing to try new things than adults are. However, children will encounter more barriers and thus have less opportunity to utilize their empowerment than adults. Children are continuously

trying new things with others: new schools, new teachers, new classes, and new friends. Most of their individual experiences, feelings, and environmental experiences are new: first love, new baby brother, first blizzard or hurricane. Each of these experiences and events keeps them open to the idea that new things are all around them. On the flip side, they have very little influence on the myriad of meaningful decisions that affect their lives. They do not choose their schools or teachers, are assigned new classes, and often cannot go visit friends on their own or prepare their own food. This limits their ability to try new things that they like, and can also remove some of the opportunity for self-pride and growth that could come from making those decisions and receiving credit for them. Children are also learning about conformity and appropriate expression, which distracts from the freedom of exploration.

Clinical pearls and lessons learned:

1. **If you want to help empower a group of children, the first step is to get their input**.

2. **If you force a child to do an activity such as exercise, it will hurt empowerment and will not be seen as fun.**

3. **You cannot make someone happy or solve all of their problems, but you can point out why their lives have meaning and help make a meaningful plan**.

4. **Small, consistent, long-term changes and commitment are the secret to big and possible change in the future**. (Give gentle pushes)

Creating an Empowering Curriculum for Children

Each group of children seems to differ greatly in the level of empowerment they bring with them. Some groups are willing to jump right in and try new things immediately, while others are more cautious and require a great deal more time. The environment can help in creating and bringing out empowerment and creativity. Our environment is largely centered on one room, the group space. We recommend a large space that can accommodate exercise and loud music or noise. You don't want to be in the position of having to tell children to be quiet when they want to BE LOUD. The space should be easy to clean since cooking, gardening, painting, eating, and exercising can, and will, lead to accidents. Hard rubber flooring is preferred though portable rugs may be used from time to time. Portable stackable chairs are a must, and try to find some that do not easily fall backwards (there are always a couple of 'leaners' in each group). There should be ample storage space that can be locked and keep things that may distract out of sight.

We have had three different spaces over the years for the POEM group and through this experience, though it may be surprising to hear it, less is better. This is most important when starting a new group; in fact, nothing but an empty room would suffice on a first visit. This helps get at the core of the children being relaxed and creative, building relationships, and being willing to try new things. If there are too many exciting things for the children to look at (computer video games, sporting equipment, or art supplies), it will distract from their getting to know one another properly. The program starts

as an empty palette full of potential. This allows you to explore what the participants *REALLY want* to do AND what they *REALLY need* to do. Perhaps more importantly, it helps the children build relationships. You can think about it this way: when you go to camp and it rains you tell stories, share about yourself, and share the common complaints about how boring things are. All of these activities are helped by less distraction. The difference with our model is that things will, and do, get better using the group's feedback. We continuously create an environment that at the end of a year the group can look back and say, "Look how far we have come together."

Beginning A New Group Curriculum Starts at the First Visit

Some of the best behavior you will ever receive from children is on the first day of a new group. It is very important to take advantage of this. With the initial goal of the group being dis-inhibition, things can get away from you quickly and extroverts and high attention seekers will rule. The first visit should be in a very simple space. I like to start by asking the group, "What do you need to know about each other to be friends?" I love this question, because it implies that we will all be friends eventually and it states that making friends is an important goal of the group. The responses usually only come from a few participants, but can vary greatly usually including many superficial attributes: "What's your favorite color? What is your favorite sport? How old are you? What school do you go to?" I let the group choose some of these questions and we go around the circle with some connections generated (i.e. same school, age, favorite color….) but at some point, usually when it is my turn to introduce myself, I myself contemplate the superficiality of these questions to the group. I pick from the questions offered and often will say, "Just because you are 10 years old and like the color blue doesn't mean I know you, REALLY know you. Does it? I want some why questions, for instance, why are you here and why is your favorite sport soccer?" This gets the ball rolling as participants will say, "My mom is making me come," or "I am overweight," or "I don't want to be here!" or "I am here to exercise." This is an important moment, which is why so much time is devoted to this first visit in this manual. In whatever words seem appropriate, you need to ask, "What would you rather be doing?" Listen to these answers very carefully because usually everyone is talking at once and realizing they have similarities: they usually would all like to do similar things (hang out, play computer games, sports, etc.), they start to identify a common enemy (obesity, school, adults, the concept that they can't do what they want all the time), but most importantly THEY REALIZE THEY SHARE DISEMPOWERMENT. Again, sharing PHI is not encouraged.

Group Cohesion and Meaning Come While Forming the Curriculum

The above happens in many shapes and forms, but essentially you are creating a grass roots movement against obesity. This gives meaning to the group. Your next step is to harness this energy. By listening carefully to what was said at the first visit you can plan your <u>second visit</u>. The second visit contains the same registration format and check-in as the first visit. Have the children interview any new participants using questions that really help them meet and know this new

person (why are you here, who do you live with, etc…), and then participants introduce themselves answering those same questions. You will have a trick up your sleeve, however. After about 15 minutes of check-in you bring out the surprise. The surprise is that you will do one of the things the participants said they wanted to do at the first visit. If you noticed that a boys group likes soccer, then bring a soccer ball, or show a video of the best soccer goals ever. You should say, “I heard at our last visit that some of you like soccer, so how can we play?” There are two very important things to be careful of: this is not a democracy. Democratic voting favors the extroverts and you need to remember **group success is dependent on your ability to keep the quiet, introverted participants happy and involved**. Second, make sure this is presented as something new. Likely there are barriers to playing soccer (no sneakers, no field, ball too hard for indoors), and you and your group will need to figure out ways around the barrier. It is the figuring out of these smaller barriers which is the most essential activity of an empowerment group. For example, we have had groups play soccer with balloons using their hands, and using balls of socks, all of which are group-generated solutions to the problem of not having space.

Subsequent visits will build upon the previous visits. Participants will begin to have ideas as the group goes on, but don’t take them lightly. For example one might ask, “Can we listen to music while we play soccer?” It may be more subtle, like someone saying to another participant, “I wish we had music to listen to.” The check-in is the time to address these issues, but at any time during a group, the activity can be stopped and you can ask the group if they would like music. I again remind you that this group visit is not a democracy. You may end up listening to music with social stereotypes or negative images that way. Instead, at the next group bring in a CD player, smart phone, or even better a record player (that would really be something new) and play some music that *you* like. A group of adolescents may not appreciate this music selection (kids nowadays don’t even like the Beatles!!), but you can show your flexibility by not bringing your music the next time. Keep listening to the guidance of the group until you are bringing in music appropriate to the activity that is enjoyable.

Dis-Inhibition

Dis-inhibition is an awkward word, but it is hard to come up with a more precise term. Ideally we have every participant comfortable sharing how they really feel. However, there is a discomfort around strangers that prevents an honest expression of what one truly desires. This discomfort sets the stage for peer pressure and a “group mentality,” both of which can push a direction for your groups based on stereotypes and stereotype threat. There are several things that can be done to prevent this: create a group that has many similarities, create a safe space where individual ideas are emphasized, and create bonds of trust between participants and facilitators. These can be achieved through pre-group participant selection and planned check-in activities for the first several group visits. Though diversity is in general applauded we have found that it is better to group children together by sex, age, and interests (if possible). We have found that keeping the boys groups separate from the girls group is important before age 14. We have found that grouping children ages 5-8, 8-12 and 13-18 creates a comfort area of understanding. Because our programs are large and diverse we sometimes will move participants to a group that would be more meaningful or fun for them. There are many activities to

help with this often called "Ice Breakers." We try to use ones that can build connection and are meaningful.

Examples of dis-inhibition activities have included:

- Silliness – having everyone stick out their tongues at each other is an instant dis-inhibitor
- Improvisation games – having children finish each other's sentences to create a story.
- Pairing children up and having them draw a picture of another child's home or family.
- Playing with a beach ball keeping it up in the air and making up a game.
- Chanting or drumming – using chairs, cans, or your body to demonstrate.
- 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.
- Icebreaker games - have the patients sit together and tell them to look at someone and when they see each other's eyes then they have move and exchange position with that person. This is adaptable, even for someone with physical or developmental disability.

Keeping the Shy and Introverted Engaged

As mentioned earlier in this text, keeping the shy and introverted engaged can be a major facilitation challenge in group visits. In general, extroverts love group process and will enjoy sharing and participating with a large group of people. Introverts tend to prefer to be thoughtful prior to speaking and can desire quiet. This fundamental difference can lead to a lot of problems: only hearing the ideas of the extraverts, conflict between participants, difficulty creating a comfortable space, difficulty making group decisions. Here are two helpful hints to help the perspective of the facilitator: 1. The main effort of the facilitator is in keeping the introverts engaged by preventing extroverts from dominating discussions. 2. In general, think of the extroverts as the power for the group and the introverts as the direction for the group.

Unfortunately we cannot cover this topic in complete detail, because this skill is also an art form that requires some practice. Part of the art is determining the introverts and extroverts and realizing that people change over time. As an introverted or shy participant becomes more comfortable, they will become more extroverted. We often see that not all people will want to share, not all people will want to be quiet, some people want to contribute immediately, and others would like space and time to process prior a contribution. Fortunately, there are many ways to help facilitate the relationships between introverts and extroverts:

Facilitation skills to help shy or introverted participants

- Break into small groups during check-in
- Delay decision making on a topic until all voices are heard
- Use degrees of agreement when making decisions
- Use writing or art as other forms of communications
- Get input from participants individually during the activity or individual visit
- Choose quieter versions of activities

Break into small groups: This is a good idea during a check-in or the activity as it can allow a shy participant the opportunity to talk and be heard, focus on a smaller set of inputs, and get to know a small group better. This can help build relationships as often the extrovert will report out the introvert's ideas when the small groups come back together in a larger group. There are many ways to divide a group, but resist the urge to allow a group to arrange itself as some participants inevitably will feel left out. Using random assignment usually works well, but also feel free to connect specific participants to one another.

Use art to help with group process and communication: There is a different space that an individual and group enters when it is singing, writing, cooking, listening to music, painting, drawing, or doing some form of art. This does not refer so much to the creativity as the relaxation that occurs. Often, participants will let down their guard and speak to one another more easily while they are pre-occupied with a focused attention. There is also a special connection that can form as art has no right or wrong approach. The encouragement and insights into a person are tremendous as is the calmness which can fill the room.

Find time to meet individually: Often during the group there are moments during the activity or project which do not require the full attention of the facilitator. At these times it is reasonable, in a way that does not draw too much attention, for a facilitator to approach a quieter participant and get their input on a topic that may have come up during check-in, or gather additional ideas for an activity or project. This input can then be introduced at a subsequent check-in in a way that does not disclose or threaten the participant. For instance if a shy participant confides that they do not like loud music, a facilitator could say, "I have heard from some of you that the music may be too loud during exercise." This would not be opened for debate, but rather a facilitator then makes a decision to have softer music that session.

Facilitation of Group Decision Making

It is important that all present in a group have a voice in the making of decisions. However, it is not important that everyone agrees on the direction or choices that are made, but rather that all feel included. In this way, each participant can share in the accomplishment of successes and the learning that comes from a less favorable outcome. Group decisions are required with an empowerment curriculum because the curriculum requires the group's input for direction. Ideally, everyone in a group would want to do the same exercise, activities and projects, but in reality, that is rarely the case. Here are some suggestions:

1. Delay making decisions for some time to allow for thought and discussion. This is helpful to those who are quieter and like to process information. Often it is those participants which have the more thoughtful ideas. By letting participants know that a decision will not be made at this time, the stress can be relieved considerably and a friendly conversation is more common.

2. Keep questions open and change a topic if things become too controversial. Certainly it is not the goal of empowerment to avoid confrontation, but you are trying to build a sense of common spirit. Conflict can create stress among participants and may not be helpful in the initial phases of group cohesion. There are so many common experiences that need to be confronted, it is better to focus on those.

3. Be open to a group changing its mind about a decision. After all, one of the empowering principals of this experience is to try new things.

4. Do not expect complete agreement on a topic. It is very unlikely that everyone in a group will want to do the same thing. Instead use 'degrees of agreement' when finding an individual's preferences. This means putting responses to an idea in terms of a scale from 0 to 5 or 0 to 10. Resist asking for a yes or no vote or show of hands. Perhaps making apple sauce gets 10 responses of 9/10 and 3 responses 5/10, while playing soccer gets 6 responses of 8/10 and 7 responses of 7/10. The facilitator can decide that soccer would be a less stressful outcome that all participants can be happy doing, and has avoided some participants voting 'no.' It is not empowering doing an activity that you explicitly said you did not want to do!

5. Consider making voting anonymous by having people close their eyes, or write ideas on paper. Children are very susceptible to peer pressure and seeing how others vote may influence their own decision making.

Individual Physician Visit

An individual visit with each participant on their first visit and then every 4-6 weeks thereafter is essential. The individual visit with the physician is needed to:

1. Help identify and create areas of lifestyle changes
2. Provide introverted or shy children a chance to participate

3. Measure progress and outcomes
4. Support participants ideas for lifestyle change
5. Provide the service revenue to maintain the program

The individual visit consists of the participant's self-report of lifestyle and empowerment. We have a medical assistant who collects this data in a non-judgmental way. It is available for review by the physician group leader. This visit takes place during the exercise or activity portion of the group visit. Most children enjoy the exercise and group activity so much that they try to rush the visit with the physician. Health metrics are collected and noted in the computer medical record. Our specific lifestyle questions are fairly typical with regard to amount of exercise, TV viewing, junk food eating, fruits, juice, vegetables, carbohydrates, computer games, and sleep participants have each week. In addition, we collect what we call empowerment metrics about support and trying new things. We get at support by asking, "How many people do you live with?", "How many people like you the way you are?", "Is anyone in your household overweight?" We specifically ask about trying new things and making new friends to get at the empowerment level and those aspects of a participant's life.

The physician may review the information collected by the medical assistant to prepare for the individual visit. This information should not be the basis of the interview, but could be used to help in guidance later. The sharing of this information with the child is not productive; rather it is your job to elicit things they need to change. Remember, the goal of the interview is to identify what may be contributing to obesity and discuss specific behaviors. The encouragement of relationships and trying new things is the job of the group visit in the group space.

The child is then called into the office that is connected to the group space. The office door is closed to help with a child's concentration and provide confidentiality. It is okay for the physician to build a relationship with a child, especially in the first visits. Questions like, "What would you like to be when you grow up?" or "Who do you live with?" would be an appropriate starting point. Typically the main question I ask is, "How do you think you are doing?" This question is usually met with "about what?" I usually say "about your health." Usually a child will say they are doing well. So a good follow up question is "Do you think there is anything that you need to do better?" This is a favorite question of mine and I try to pin down specifics. If they answer "I could exercise more," then I try to nail down the exact exercise, how they will do it, and then I specifically ask them "Will you make that change?" I then have them watch me write their idea into the computer "PATIENT WILL EXERCISE MORE BY JUMPING ROPE FOR 15 MINUTES EVERY DAY AFTER SCHOOL WITH HER FRIENDS." At the next individual visit I will specifically check-in and see if this change was made. If we can encourage one small change in our patients each visit, it opens up the possibility for bigger changes in the future.

Maintaining a Group/ Group Projects

Groups fall into a natural rhythm after several months or so. Always remember our two objectives: introducing participants to new things, and helping build relationships. Each visit is broken into: Sign-in, Group Check-in, Activity, Individual Medical Visit, and Project. The project helps give the group meaning, and so it is a vital aspect of the group. Once a program settles into a format and participants are comfortable being part of a group, there is a bigger sense of self. The project can help create a real experience that is memorable and can be a roadmap to following through on individual goals. Determining a project can be difficult for a group because it is often a long term commitment and participants may not be used to this sort of endeavor. Unlike the activity which is solely to help the participants within the group, the project should be designed to help a larger cause or learn a greater skill outside of the group. Helping others is not always possible for a child by themselves, as they are often in a position of requiring help. Helping others, however, is the most rewarding experience and contributes greatly to a feeling of empowerment. Using facilitation skills during check-in, watching successful activities, and developing a coup d'esprite are all helpful in discovering the direction of a group.

Projects which helped develop skills over the course of our program include: learning to swim, planning a trip to the ocean, making a book, learning to boat and fish, camping, making a dance video, opening a restaurant, learning meals to cook at home or healthy snacks, and so on.
Projects which helped our participants' immediate community include: making a cook book, creating a video against drugs and violence, writing and performing a rap song to encourage eating breakfast, or creating new games and sports.
Projects which helped those outside our participants' immediate community include: performing at a nursing home, building a community garden, or cleaning local parks.

Please refer to your organization's policies and procedures for conducting field trips or off-site visits. Again, work with legal counsel to ensure consent forms are appropriate.

Logistics of Initiating a GMV Program

Human Resources

Staff Assignments

In our program, there is a medical provider, an exercise instructor (EI), and a group coordinator (GC) assigned to every group. Although the provider may not be at every meeting, the GC will always be there to lead the group in the provider's absence. A specific patient service representatives (PSR) and medical assistant (MA) is assigned to each groups to maintain continuity and to allow better relationship building for the patients. In other words, each staff member is special and invested and may be important to the children in the group. Some children identify with the physician who leads a group, but more relate to the group coordinators, exercise instructors, MA, or PSR. You cannot have a random rotation of staff people or these relationships cannot develop or grow.

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.

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 work position for which they have 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 new, we tell them that we hired him or her for their relational qualities.

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. This does not mean that we only hire extroverts as that would be harmful to the empowerment of the patients and staff, but rather we hire people who are comfortable around others. 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 GC's 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 the provider and the group coordinator.

Ideal Qualities of the Provider

The provider for a pediatric obesity group does not need to be an obesity expert – he or she 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. Surprisingly, the best groups I have seen are run by introverts. It has been my experience that extroverted people are the ones who tend to think about starting group visits, but they have difficulty in allowing the group to create its own curriculum. They have to be mindful about listening to the group's intentions. Introverts are natural at allowing a group to 'speak' and develop, so they do not need an internal register. There are other characteristics that seem important. 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.
- Can take charge for safety reasons if needed.

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.
Confident 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 individual medical visit.

Confident 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 too many unhealthy or harmful 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 patient trust in the medical system.
Inspirational	The provider should be able to inspire the group. 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	The provider should promote each participant's positive self-image. Sometimes, lonely children 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. Or refer to the other members of the group as 'your friends'.
"Atypically" Dis-inhibited	The provider should be happy and dis-inhibited as an example of the goals for the patient. Use the metaphor that you are a "transparent eyeball" and as such this person is often introverted. It is recommended that the provider wear more casual clothing (e.g. khakis instead of suit-separate pants, short-sleeve shirts in the summer, no ties, no white coats), which makes a contribution to the environment you are establishing, too. Just as a GMV is not a typical doctor's appointment, the provider should not be a "typical" doctor.
Willing to let go	The provider should be comfortable interacting with and being part of the group. At the same time, the provider has 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.

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.
Able 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 a concussion, that require proper medical attention.
Empowered Lifestyle	We look for people with a history of trying new things (people 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 *because* 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.

Organizational Considerations

Administrative Buy-In

You will need to get administrative buy-in in order to establish a GMV program – support from many levels of an organization will be necessary to make your program run smoothly. There are some useful resources which can be found at IM4US.org.

Recruiting Patients for a New Group

Recruitment has not been a problem for our programs. We actually tend to have waiting lists for many who would like to participate and are looking for ways to expand our program. The majority of participants are referred to our program by primary care providers from our community health center after weight screening at their annual physical. We also have a healthy weight clinic that has a more traditional approach to treating obesity with a nutritionist and case manager. We try to have all participants go through this healthy weight clinic, as it seems to have added benefit to our programs.

Group Size

We have found that you need at least six participants in order to successfully establish and maintain a group. The upper end of the group size is determined based on the size of the space and the activity. We find that our pediatric obesity groups usually start small and grow to no more than 25 or 30 active participants. I believe that 12 participants would be an ideal number, but we maintain a greater number of participants so that we can provide experiences to as many children in our community as possible. We also have a transportation van that can accommodate 16 children and so we take full advantage of this in addition to those who walk or have their own transport.

Meeting Time

We have found that early afternoon is the best time for pediatric groups during the school year. We have never held programs on weekends but this is also a possibility. Most groups are one hour and fifteen minutes, which allows 15-minutes for check-in, 30 minutes for exercise or activity, and 30-minutes for an extended activity or project. Due to the high number of holidays on Mondays, we prefer Tuesday through Friday group times for our 8-17 year old children's groups. For family groups, the time is better after 6 pm in the evening to allow parents or caregivers to return from work and participate. Our toddler groups do best in the mornings at around 10 am to allow older siblings to get off to school so that they may comfortably come to the programs.

Additionally, we have noticed over the years that participation levels of our registered participants declined during the summer months. Thus, we have created a summer program that meets once or twice a week for longer periods of time, and had more field trips and adventures to the park neighboring our clinic. This program is enhanced by funding from New Balance.

Electronic Medical Records

The provider's use of the EMR during the individual medical visit makes a contribution to what we do at the GLFHC. 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, the EMR allows the provider to transcribe the patient's own words – particularly those about their social situation and behavioral changes that they plan to make – directly into the note for that week or month. The patient's observation of this note taking reinforces to the patient 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 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. We also have the participant's whole history available should medications need to be administered or prescribed.

New Patient Enrollment

In order to join one of our groups, patients must be referred from their PCP or our healthy weight clinic. The referral may come from the actual GMV provider, another GLFHC 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 GLFHC – must start on a day when the GMV provider is available. This allows the provider to do a medical assessment of patient's ability to participate. This is most important in an exercise group with patients who may have a cognitive, social, or physical disability. Thus, with these patients, we try hard to make sure they first come when the GMV provider is available.

We ensure that the appropriate forms are signed for the activities, and you should seek the advice of legal counsel to ensure your forms are correct and provide coverage properly.

Conclusion

We hope this manual has been helpful in creating sustainable, enjoyable, effective group medical visits. There are now many organizations doing group medical visits and shared medical appointments which have posted process and curriculum on-line. Please let us know ways to improve this manual, the empowerment model, or of any of your successes!

Resources for group medical visits

www.IM4US.org This website has an easy to navigate website and the organization has many examples of group medical visits that work in underserved communities. Group medical visit trainings are offered at the annual conference.

www.aafp.org This has useful information about billing for physicians with an emphasis on community health centers.

www.communityatworks.com This organization has a long history of training group facilitation skills. They offer a useful textbook, *Facilitator's guide to participatory decision making* by Sam Kaner which I strongly recommend serious group facilitators use. They also offer trainings that focus on facilitative skills.

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