Social Health and Group Medical Visits

A Clinical Conversation with Shilpa P. Saxena, MD, IFMCP, and Robert Rountree, MD

Shilpa P. Saxena, MD, IFMCP, is a board-certified family physician and internationally recognized educator, speaker, and author known for her “keep it simple” solutions and approachable style. In addition to over 15 years of progressive patient care in her successful medical practice, Dr. Saxena passionately serves as faculty with the Institute for Functional Medicine, CM Vitals Clinical Expert with the Lifestyle Matrix Resource Center, and Chief Medical Officer of Forum Health. Her experiences being fellow and guest faculty of the Andrew Weil Center for Integrative Medicine, contributing faculty of Integrative and Metabolic Medicine at George Washington University and Osher Center for Integrative Medicine at the University of Miami Miller School of Medicine highlight her mission to get simple, actionable, and lifestyle-based solutions to patients interested in helping themselves heal. She is internationally known for her contributions on the development and institution of the lifestyle-based group medical appointment model and as creator of Group Visit Toolkits and has been awarded for her work with her online patient university, SaxMD University. Her extraordinary patient outcomes have attracted the attention of local, national, and international patient and physician communities. She is honored to be a member of the Advisory Committee of the Human Medicine Career at Universidad San Ignacio de Loyola in Lima, Peru, where the first ever medical school with functional medicine curriculum has been created.

Robert Rountree: Where did you grow up, and what were your early influences? What made you decide to become a doctor?

Shilpa P. Saxena: I was born in Queens, New York. I was the firstborn daughter of two immigrant parents from India, and I grew up rather isolated. For the first five years of my life, I did not speak English. My major influences were traditional Indian culture, the people I spoke to, the food I ate, and the social interactions I had, which were all very similar to the motherland of India, but located in Queens, New York.

My father is from west India, from a state called Gujarat. My mother is from there as well originally, but she was raised in Uganda, Africa. So my upbringing is a mixture of African India and partly mainland India. What is interesting is these influences were all happening in Queens, New York. So my mother

would teach me words in Swahili, but I did not know they were Swahili. I just thought they were my other language, Gujarati. Later in life, when I met other Gujaratis, I would throw in an occasional Swahili word, and they would look at me confused, and I would think, “What is so confusing?” Slowly I came to understand I came from this very unique east Indian, African type of upbringing.

Dr. Rountree: It sounds like your first five years you were on your own a lot. Were you also surrounded by family?

Dr. Saxena: Oh, yes. I lived in an apartment upstairs, and there was another Indian family not even related to me downstairs. Indian culture has an open-door policy. So I would go down there for breakfast every morning, and that family would have me as their child. My father was very generous, and our apartment was almost like a little hostel for Indian professionals coming over and getting situated before they went out on their own in the United States. We were kind of like a clearinghouse to some degree. My mother cooked for them and my father supported them all the time, as our culture is to treat guests as God.

Dr. Rountree: That was actually the opposite of isolation. You grew up in community!

Dr. Saxena: I grew up in community, but a very specific community isolated from maybe what the norm community would be in America, although that was very common in Queens at the time. I grew up seeing people who looked very different from me and had completely different social and cultural customs, and I thought it was completely normal. I thought, “Oh, on your planet, you must do this, and on my planet...” When I moved to Florida at age 10, the diversity reduced drastically, and that is when I started realizing, “Oh, it is not like this everywhere.”

I was in a beach town on the East Coast, and there was a very clear difference between where blacks and whites lived. I remember we were some of the first Indians in town and we did not know where we fit in.

In 1991, when I graduated high school and went to the voter registration desk, two ladies helping high school seniors register to vote asked, “So which are you, black or white?” And I explained to them, “Well, I am neither.” And they said, “Well, which one are you more like, because those are the two options.” I asked, “Where is the ‘other’ category?” In national

tests, I was used to having an “other” box that I could mark off. And they said, “There is no ‘other.’ You will have to pick which one you are more like.”

I do not remember what I picked, because I was in such shock of the whole experience and was trying to feel cool at the same time in front of my friend who was with me. When I went to college, “other” was there, but now they also had “Asian and Pacific Islander.” So I marked that off until I found out in med school I am not considered Asian. I remember thinking, “Well, India is a pretty massive country in Asia. Why am I not Asian?” Friends explained to me, “You are not Asian. That means you are from Japan or China or Korea.” So I said, “Oh, okay, I guess I am ‘other’ again.”

It was not until residency, when I was taking my final certification examinations, the USMLEs, that I saw an option for “Indo-Pakistani.” And I thought, “That is me!”

I finally found the very specific box that people thought I was. I could have also marked off African as well, being that my mother was born and raised in Africa, however, many people would assert that I am not African. Interestingly, East African Indians are unique and follow quite a bit of African–Indian culture in their homes. Our food is different and the Swahili language is kind of intermixed in. Furthermore, not growing up in India in her formative years, my mother’s interpretation of the religion and the culture is different because she was not surrounded by the main people who practiced the culture. It was like a derivative form of Indian culture being practiced, almost like a satellite India.

Dr. Rountree: The awareness that there is a mixture of cultures in the world seems like something that you tuned into at a very early age. There are people who grow up thinking that their culture is the only culture.

Dr. Saxena: That is right. Until you realize that there are other ways of belonging, you think that the way you belong is the way it is. So, yes, that sense of “Who do I belong to? What am I?” was a very common question in my upbringing; because I also was simultaneously being raised in America, there were a lot of things that I did that were also “All-American.” I was a cheerleader, I was on the dance drill team, I took part in different clubs as leaders—very similar to what many typical American teenagers might do.

Dr. Rountree: And being pre-med is kind of an American thing—“the American dream” in a way. At least many people think of it that way.

Dr. Saxena: Oh, yes. In our culture, many of us did not think we had a choice of what to do career-wise. It was thought that your parents knew what was best for you, so your parents should advise you on the profession that made sense for you. With most of our parents coming to America and sacrificing everything to be able to take a risk here, their big goal was financial security and stability. This is why many Indian Americans of my generation are in medicine, law, or engineering.

Dr. Rountree: Was there a gender influence, as well? Did people say you should or should not go into medicine as a female?

Dr. Saxena: Well, my mother was a very special woman. She came from a very athletic family, and because of some of the cultural influences in Africa, being a survivor and being tough was in her mindset and was essential. I would jokingly say she raised me as an “it,” as in she did not create gender norms for me until I was old enough as a teenager to understand that other Indian families had gender norms. My parents were very forward thinking, because they knew I was ambitious as a female.

Dr. Rountree: When did you know that you wanted to go into medicine? How did that come about? What was it about medicine that you found intriguing?

Dr. Saxena: It was acculturated in me that I should become a doctor. I found the human body and the interconnectedness of it all to be quite amazing. I thought the human brain was really fascinating, so I wanted to be a neurologist in high school and in college. And then when I went to medical school, I did a rotation with neurologists. It is said that certain fields have certain personalities. I realized that I did not feel I fit in with neurologists, but I loved family medicine docs because we did an elective in rural family medicine, and I just loved how they could do everything.

Dr. Rountree: Was there something about the personalities of the family doctors that you found appealing?

Dr. Saxena: Absolutely. The family doctors that I met seemed to be friends with their patients. That reminded me a lot of relationships in my culture—it was very networked, and you help people out because you are part of the tribe. I interned with a rural doctor and lived there for a month; this doctor knew everybody’s children, their dogs, etc. She knew if somebody passed away. She knew their entire medical history. She really knew them, and achieved great patient outcomes because of it.

When I did my academic neurology elective at the hospital, patients looked more to me like cases as opposed to people. I realized at that point the science is interesting, but without the interpersonal aspects of medicine, the connections, it was not as interesting to me. No matter how intriguing the science was, I wanted to feel connections.

Dr. Rountree: May I ask where your rural rotation was? Was it in Florida?

Dr. Saxena: Both were in Florida. To be a vegetarian in the Panhandle at the time was a very unique thing. The people were super, super kind, but you could tell that I was obviously different. I spent a good portion of growing up as a teenager always analyzing how different tribes of people worked, and understanding how I could help them see that I could connect with them as well. Almost to say, “Hey, we are not that

different.” I would always understand people from a socio-cultural context.

They were just a different tribe with new ways of doing things that I was open to learning, but I had to always make it past any potential biases or ignorance that they had toward me. Growing up in Queens, the biases for me did not exist because everyone was naturally different. It was not until I moved to the South that I realized there is a hierarchy.

Dr. Rountree: I remember when you came on board with the functional medicine crew, one thing that really struck me about you is that you never apologized for who you were. By that, I mean, “Okay, I am a Functional Medicine doc in a conservative part of the country, and this is what I do.” Many of us had come into functional medicine from the integrative medicine model, where we had seen ourselves as being on the fringe—we were a different culture from mainstream docs, and we had an attitude about that. Then I remember meeting you, and quickly realized you did not offer an ounce of apology. You were really bold in your thinking, saying that, “This is just another approach, another valid perspective to bring to the medical community.”

Dr. Saxena: Maybe because I had already gone through something similar with multiple other aspects of my identity—being a female, being an Indian, being an African Indian among my Indian community, being Indian American with my Indian family in India. I was used to establishing by that point that “Yes, this is who I am, and what I do. I have no apologies about it. I think it is cool, do you want to learn?”

Dr. Rountree: I think that led to you becoming a really confident leader. I have seen that in your current career. You are assuming a leadership role that has morphed into a national position with the Forum Health organization.

Dr. Saxena: Yes. I am very much interested in making functional medicine available to the masses. There was a group of pioneers that includes you that forged the way, like that first machete work through the jungle. That environment probably required bravery by those who had to take on the initial backlash.

I got to come following with the path partly paved. It is so apparent that this type of medicine is what is going to change the clinical and economic trends of health care right now, and now I have a platform on which to help make it available to the masses.

Dr. Rountree: How did you get involved in this kind of medicine? Were you always thinking a little outside of the mainstream? Or did you have an epiphany or transformative experience? You started out in a rural family practice and loved it. It does not sound like you had major issues with the mainstream. So your professional evolution was more of a positive expansion rather than a path of disenchantment?

Dr. Saxena: Yes, I actually graduated from residency and worked for another individual for a few years, which turned out to be a great experience in retrospect because he was a very good businessman. I learned a lot about the business of medicine, because we do not learn about that in medical school in residency and as far as I knew from my upbringing, if you did not have a profitable business then you cannot continue to serve. My parents served many people coming in from India, but if they did not make money, they could not have food for them moving forward. They had to look at profitability and I came to know that as common sense.

I learned a lot of business information from this physician, but it inspired me to want to have a different type of practice. We moved to Tampa, opened my practice in a very underserved rural part of this area, and I was committed to bringing good family medicine there. Because I was from a different background and was always open to learning new ways of doing things, when I started with my new patient paperwork I asked them to list what they were taking as far as medications. At some point someone said, “Well, do you want me to list my supplements?” And I said, “Sure. If it goes in your mouth, I want to know.”

I noticed that when I gave permission to do that, people were writing down 5 and 10 vitamins and minerals and herbs and botanicals. I was shocked. My nature is not to criticize people for what they do, because I grew up learning that that is not right. “Do not criticize anything that you do not understand,” because I saw how that happened with racial issues. So I started asking my patients, “Why do you take fish oil, and why do you take probiotics, and why do you not choose to vaccinate your children?” And I soon came to be known as the open-minded doctor.

One day, a baby was born at a home birthing center, and pediatricians in this particular area would not accept the baby because of the way the baby was born with all the medical-legal risks. I am an FP/OB by training, so I was very comfortable with newborns and obstetrics. I said, “Please bring the baby. This baby needs to be examined.” That is when I met this population of patients including one mother telling me, “I do not want to do this vaccine, and I do not want to do that vaccine, and I took this kind of probiotic when I was pregnant.” I said, “Okay, well, let me understand that.” Once I was kind to her, there was this whole other community that came in and started seeing me.

Dr. Rountree: New doors opened up.

Dr. Saxena: Big doors of awareness about what is actually going on in people’s homes opened when I realized that supplements were a billion-dollar industry. I thought we are like ostriches with our head in the sand not knowing what our patients are doing on their own, because they cannot talk to us about it.

That is when I started researching what coursework I could take in order to learn more. I found out about functional medicine, because at that point I was a conventional doctor. I thought it should be CME level because otherwise I did not know whether I could trust it, as if that was the only standard that mattered.

Within a year, I found out about the Institute for Functional Medicine, did the coursework, and I was hooked. From then on I was learning as much as I could, I would implement what I learned and my practice would grow, and people were getting better. It was as if I was really connected to why I went into medicine. I really helping people to heal, which I did not feel in the previous three to four years. I used to call myself a legalized drug dealer, which I did not realize is what I had signed up for.

Dr. Rountree: I have a really important question to ask you. One of the criticisms of functional medicine is that it is only for wealthy people who have lots of time on their hands, and yet you said that you were working with an underserved population, and were looking for more tools that you could offer that population. It does not sound like you saw a disconnect between functional medicine and what you could offer.

Dr. Saxena: No, not at all. I just thought it was another option, and my patients were already exploring it. They were already spending their well-earned money on supplements. What I thought I could do is through my training give them more strategic options and also use lifestyle medicine, so that they did not need as much green medicine (an herb for every ill, versus the prescription for every ill).

My practice was 100% insurance based in rural Florida, where I had 15- to 20-minute appointments. When people came in I assigned them homework. I made little videos, and they would have to do their homework and watch the videos to understand their physiology and biochemistry. You elevate and educate; education was a huge theme in my upbringing. That is how you transform a life, you give them knowledge. As I was giving them knowledge on the safe or the correct ways to treat things naturally, they were seeing results. It was small little interventions that made big impacts over time.

I took care of people who were from one area of the rural South, but where I was in Lutz was on the outskirts of Tampa, so there was a young professional population there as well. I took care of this highly educated career-oriented population, and then farming families would come and say things like, “Well, of course food is medicine, my grandmother was so healthy and all she did was eat food from the farm.” Whether they came from the academic approach or they came from the cultural approach they both knew that healthy food and lifestyle are medicinal and necessary.

Dr. Rountree: So everything kind of fit into place.

Dr. Saxena: Yes, it really did. That was going really well for me, and then one of the physician assistants who worked with me became pregnant and she and I had around 4,000 patients that we managed. At the time I also had a three- and a five-year-old who I was taking care of. So I was thinking, “My goodness, she is going to go on three months of maternity leave. I have young children and 4,000 patients.” I was not going to work overtime, because family was way too important to me. That is where I dabbled with the group medical appointment idea; that is how that idea was born.

Dr. Rountree: When you first started talking about formal group visits, was that a new concept in medicine, or had there been some people, forerunners, who had inspired you?

Dr. Saxena: There were people who inspired and motivated me. Edward Noffsinger was considered the father of group medical appointments. But the way that he conducted them was appropriate for the conventional medical model or mindset, which was gathering people in a room and treating them one by one. These group medical appointments were very reactive to the disease or symptom, as each person’s condition was different. That did not work for my model, with integrative functional lifestyle medicine.

I decided I would rather gather people based on their condition or what they need to learn. So I might have a group visit on the elimination diet, with 16 people in the room. They would be there for different conditions such as autoimmunity, inflammatory bowel disease, allergies, etc. but they all needed to learn the elimination diet. I had 90-minute appointments with these 10 to 20 patients, and I started realizing that in a group setting they were actually doing much better than if I had seen them individually.

Dr. Rountree: Why was that? Was it because they were sharing information, was it the social support, or something else entirely?

Dr. Saxena: This harkens back to my upbringing; when a community comes together and shares their successes and struggles and they have a sense of belonging, they start to have more self-efficacy (meaning increased ability to do something new such as taking on an elimination diet, taking a supplement, or exercising). You have a sense of empowerment to be able to do a new behavior when surrounded by support from a group.

You also learn more as well because in a group setting, one person could ask a question about the elimination diet that you might not have thought to ask if you were in an individual visit; you also get the benefit of the answers that are accumulated from other people’s questions. And if you happen to be a shy person, you surely would get something extra out of it by being in a supportive group setting.

The people who are talkers would get something out of it because they would get a chance to share and also to learn from others. Everyone benefits from having more knowledge, support, and self-efficacy, and the data showed this as well.

I started researching this and talking about this model, which is really built upon ancient principles. You bring people together, and they do better. We are social beings.

Dr. Rountree: I remember the push toward use of the medical home, where you would get all the diabetic patients together, and manage them as a group. But that is different than what you are talking about.

Dr. Saxena: Yes, a medical home surely has benefits, but they still look at people as their disease or they look at people

as a population. In our group visits, each patient came in with a different set of preferences or different history, and we tailored to that uniqueness.

So we still personalize in our group visit whereas with a typical diabetic group visit everybody gets the same information; it is more of a lecture and Q&A. Then also, our information was always about addressing the root cause, not just the conventional approach of using a pill for an ill.

Dr. Rountree: What were the logistics of doing that? Were you doing these group visits as part of your day-to-day schedule, or did you have night classes?

Dr. Saxena: I would schedule our group visit as a two-hour block on my schedule, the last two hours of my day, and we had one long day where we worked until 6 PM. So from 4 to 6 PM was the group visit. At 4 o'clock, the patients would file in and get their vitals done. I would have bottled water or hummus and crudités there, because as I am from an Indian background, I wanted them to feel at home. In India, you would never have someone come to your home and not offer food or drink.

I would have that set up, and then they would sit in my lobby. I would rearrange my lobby so that it would be like a gathering place for us to all sit and talk. Then I would educate for 30 minutes, and then the last 60 minutes is where we would just have the discussion and sharing. A lot of it would be, "Oh, elimination diet, yes I am following that." And then some other person would say, "Oh, well, you should try Indian cuisine. There are a lot of gluten-free options there." Or, "Try using this brand of tortilla, it is gluten-free."

A lot of the time, I did not have to do the work. I just had to educate, and then I would facilitate these conversations in the groups. Many times people would have a much better understanding of what supplements do and incidentally, my supplement sales went up, because now patients understood why they needed them. Compliance went up. Results improved.

Dr. Rountree: Were you doing this within the third party/insurance system, or is this something people paid for on their own?

Dr. Saxena: This was covered by insurance. In fact, it was highly encouraged. Medicare promoted group medical appointments for chronic disease care. I followed all the rules in family practice management and did all the requirements. I had face-to-face time with each one of them, and I started creating visit templates. What is interesting is that I only did this maximum once a week, and that was enough for me to manage 4000 patients for three months on my own. That is what the data show.

Dr. Rountree: Did people adapt quickly to this system, or did it take some convincing?

Dr. Saxena: Well, there were two types of patients. There were people who needed more information because privacy

was important to them. Then there were other people who were like, "Oh, my gosh, I get to spend an hour and a half with you and ask you whatever I want to? I am in. And you are going to serve me hummus? It is like I am at your home." It is a social gathering for those people.

Those people I used to lovingly call my group visit groupies, because any time I had a group visit, they wanted to attend. And I had to explain to them that in order for insurance to cover the visit they had to have a medical reason to attend. So if I was doing it on acid reflux, I would say, "Sue, you cannot come because you do not have acid reflux." She would say, "But I would like to learn." I said, "You can come. I just cannot bill insurance and you cannot ask me questions, because legally anything I say I have to document, and you are not officially a patient right now. You are a friend."

Dr. Rountree: You need to establish a diagnosis—an ICD-10 code and a CPT code. So everything is just like a regular medical visit, except it is happening in a group, and you are focusing on lifestyle medicine?

Dr. Saxena: I created visit templates that had a lot of the HPI filled out by the patient including medical history, so I met all the criteria. All the documentation was embedded in the visit template. The only thing I had to do was do a targeted physical examination while I was answering questions. While I was moving around answering questions, I would listen to the heart or lungs if it was a cardiometabolic talk, for instance. Each patient had a clipboard and I would mark it there.

Soon I had a health coach on my team, so the health coach could answer some of the questions while I went around and did the face-to-face requirement. People really loved the whole concept. You have to imagine, in rural Florida, this was something that felt right culturally as well.

Dr. Rountree: When I spent time in West Africa years ago doing volunteer medical work, we did something kind of like group visits in that there would be a whole room full of people, where you would go from patient to patient, openly ask them what their health problems were, and then examine them in public. This was a big contrast from the conventional model of going into a small room and having a private experience with the patient. Maybe people's willingness to be exposed is somewhat culturally driven—to not be completely private about their issues.

Dr. Saxena: Yes, being vulnerable is kind of what Brené Brown talks about—being vulnerable and sharing what was hard or what you think will be hard is healing and transformative. If you share what you think will be difficult about the elimination diet, and then all of a sudden your community says, "Yeah, how is that going to work? How will I eat pizza?" Then I offer a suggestion and somebody else in the group who has already done that suggestion, says, "No, listen, this is what you do." All of a sudden, they feel that they are not alone, and that this change is doable because they are around others who have

done it and who are encouraging them. It is not just an academic doctor handing out advice on something that she has no connection to—it is coming from real experience.

When I would do, for instance, a group visit on rheumatoid arthritis and pain, I did not have those issues that my patients had. But my patients in the group visit would say, “This is my second time attending this. When I first did it, my pain went down 50% when I stopped my food triggers.” So it gives a level of authenticity that I cannot give, because I do not have the issue.

Dr. Rountree: For these reasons, do you see an increased interest in incorporating group visits into integrative practice, or functional medicine practice specifically? Is this something you see scaling up around the country, if not the world? With the pandemic going on, does that make it more difficult?

Dr. Saxena: I think there is not a more important time in the history of this planet that we bring in the social aspect to health care, because our physical isolation is increasingly triggering more physical and mental illness. Yes, we are not able to do it in the kind of ancient way of gathering right now, which is close and less than six feet apart. I am doing group visits through Zoom. I have 25 people on my screen, and people share openly; the sense of connection and support is still there, which is so needed right now. I think there is a cultural shift where people are getting used to Zoom meetings, Zoom conferences, Zoom gatherings, Zoom family reunions, and Zoom birthday parties, which I feel is absolutely necessary. I think group doctor visits are the future. How else are we going to get ahead of chronic disease epidemics? You cannot see all the sick people one person at a time. It is just mathematically not going to work.

Dr. Rountree: Are you doing any kind of trainings for docs who are interested and want to know how to do this? Are you offering any kind of template?

Dr. Saxena: Yes. Can I tell you a funny story? So as you know, I was invited to be part of the Institute for Functional Medicine’s faculty in 2012, and that year we were launching the cardiometabolic advanced practice module. Laurie Hoffman, the CEO at that time, called me; I was relatively unknown in rural Florida then. Dr. Kristi Hughes had noticed how well I was incorporating lifestyle medicine and functional medicine, so she said, “You know, it would be great to have representation of someone in the insurance model teach docs how to do Functional Medicine this way.” So she invited me to be a part of the faculty, and Laurie reached out to me and she said, “The other two people who are in this group are Dr. Mimi Guarneri and Dr. Mark Houston. They both have books. Do you have a book?” And in my head, I thought, “I do not have a book. I am just here in the trenches seeing patients.” But being from my resourceful immigrant background, I said, “I do not have books, but I have group visits that I have created,” because I had created a series of templates and PowerPoints that I used to

conduct my group visits. And I said, “Could I offer that to people as a resource?” And she said, “Sure.”

So my husband and I compiled toolkits for six minigroup visits about the topics that we talked about at that annual international conference, where we launched this advanced practice module. I remember we had a table and my two daughters and my husband came with me. It was 2012, they were 11 and 9 years at the time. They ran the credit card machine, and I remember thinking, “Okay, I guess this is official. I deserve to be on that stage.” It was a proud moment.

The Lifestyle Matrix Resource Center saw what we were doing and said they wanted to partner with us. Now we have sold hundreds of these toolkits for practitioners to teach the value of using groups to leverage time and team resources. That is how it started. It was born of the thought, “I do not have a book. I guess I will create a toolkit.”

Dr. Rountree: It sounds like this has been very successful. It has really taken off!

Dr. Saxena: Yes, it is wonderful for the people who are willing to take the risk of doing a different type of office visit. There is definitely a group that still feels comfortable with individual visits and there is nothing wrong with that. But if you are practicing in a high-volume practice, then the group model should be really considered to leverage your time. If you have knowledge and expertise, you need to get it out to more people and group medical appointments are the best way to do that.

Dr. Rountree: It is the way to go. I noticed on your website that new clients have the option of signing up for the group before they have ever seen you as a doctor, so it is not like they are already your patient, and you are steering them into the group.

Dr. Saxena: Absolutely, and no one is forced to attend the group. For instance, if I say, “Come to the elimination diet group visit,” and the patient says no, then I will explain that they may need more individual sessions with me, which can be more expensive than attending groups.

Soon they realize in one group visit, they only have to pay one copay and one visit for us. When they decide to see me individually for two and three separate visits, they have to pay three times as much.

Dr. Rountree: I hear you saying that this is really the way forward for health care providers who believe in educating their patients, as a way to build the educational part directly into their practice. I am pointing this out because—as I have said—one of the complaints about functional medicine models is it is very time intensive. It takes a long time to get people to understand this way of thinking.

Dr. Saxena: Yes. In an individual visit we are educating. For instance, in an individual visit, when I say, “Oh, you have an

autoimmune condition. We need to start with repairing your gut,” I would go into an educational portion to a certain extent before I would ask them to follow a therapy and diet.

In the group model, we mirror what is happening in the individual visit, but we expand it. It is not a lecture, because it is just as much a conversation as it would be in the individual room. It is just that you have all these other people to contribute.

It is very interactive and educational, just like an individual visit. But it is exponentially more informative and empowering. Sometimes the dynamic between doctor and patient can be disempowering if the patient does not feel confident with the doctor, or if they feel a huge hierarchical gap. This is very common with patients, especially if we put on the laboratory coat and stethoscope and put a big crease between our eyebrows. But if you put them in a room with others, and serve some hummus, it is a different person who shows up.

Dr. Rountree: There is no room for hierarchy?

Dr. Saxena: No. In fact, that is when the model starts to devolve, when the doctor makes it a lecture. That is not the gold of the group visit. The gold is when the doctor just gives the initial information, and then opens it up for the group to ask questions and team think.

The other thing this addresses, which is huge, is physician burnout. Clinicians are very much feeling the burden of having to know the right answer or solution. It is as though they feel like they have to fix and protect the patient. In the group medical appointment, the burden is not on the provider to create the power. The provider gives the information, but the power is generated from the peers. You see? That takes away a tremendous amount of perceived burden for the provider.

Dr. Rountree: I love your assertion that “the power is from the peers.” It could be your new catchphrase, your new tagline! Can we talk about your current endeavor with Forum Health? I understand you are expanding this model across the country. Is that an attempt to scale up this idea of group visits?

Dr. Saxena: Yes, Forum Health is built upon this concept of belonging and sharing, but now it is for the provider community, the practitioners themselves. So, for instance, I am in my little zone of Florida figuring out things in functional medicine. I am learning and figuring things out. But then there is another practice in Utah that is learning functional medicine, and they have a different population, and they have a different niche. So let us say that population in Utah has done really well with functional medicine and mental health, but I have decided to focus on autoimmunity. At Forum Health, within our practices we share best practices and strategies.

So instead of me having to figure out the way to clinically, operationally, and financially make mental health work, I could learn from my colleagues in Utah and then I can share with him how I have made it work with autoimmunity.

We are sharing not only best practices clinically, but also operationally. We are bringing in the group medical appointment model across the network because it is one of the practice management techniques that has worked in my practice. But they have other ideas and procedures that have worked for the issues they are handling. Instead of me taking five years to figure it out, we have Forum Health monthly roundtables between our providers where we share on a topic, and then each provider decides from the discussion what might work in their practice.

What we are doing is we are sharing information and creating community among functional medicine and integrative medicine providers, because we sometimes find ourselves feeling isolated in our areas. When we get together at conferences, we feel connected. Day to day I think many of us feel isolated and are taking it all on ourselves.

Dr. Rountree: Yes, absolutely. So this is something that you are rolling out all the way across the country, or is it just in certain areas?

Dr. Saxena: All across the country we are opening practices, meaning we are acquiring practices that fit our model of functional and integrative medicine. We are partnering with all different types of practices. As you know, there are different interpretations of functional medicine. I have found that I have one very strong version of it, but there are other educational organizations that also have expertise in other facets of functional medicine. So we have this diverse group of providers who are making a difference in their communities or cities, sharing best practices.

What we are also doing is sharing operational resources. We have a business team and a lawyer. Each one of us does not have to have a lawyer, an accountant, an HR person, and a marketing person. That is all centralized, because for many of us, we do not want to figure all of that out on our off time.

Dr. Rountree: What is involved if a person was in private practice and wanted to join Forum Health?

Dr. Saxena: They would reach out to us. They could just go to our website (www.forumhealth.com) and at the bottom there is a link to fill out your information if you are a practitioner. Our staff member who is in charge of acquisitions would reach out, get to know you, and get to know a little bit about your practice. Then there would be a due diligence process wherein we can see whether the practice would be a good fit.

Then there is an acquisition process, wherein their practice is actually purchased. This may also create an exit strategy for providers, because some people have been in the field 20 years or more. It is not easy to find someone who is going to take over a practice that is a very niche practice like many of us have.

By creating some centralized admin and bringing in another provider, it allows another provider to have an exit strategy if they wish. But they could stay if they want to be an employed physician, too. Obviously we want the practitioner to work for a certain amount of time while we transition the

practice, but it is a great exit strategy for some. It is a great growth strategy for some. It depends on what their goals are at that stage in their career, but regardless, Forum Health can help.

Dr. Rountree: Would you work with somebody who had just gotten out of residency and is looking to start a practice?

Dr. Saxena: We would not start a practice with someone as the first option, but if that person is interested in being a part of a network, they could join an existing practice that was ready to increase their providership. In general, we are acquiring established practices. Then we plan to, of course, through all these systems and processes, expand these practices where we would need new providers to join.

Dr. Rountree: Is it a fee-for-service model, then? Or is it like a primary care service wherein people pay a monthly fee?

Dr. Saxena: What we are doing at Forum Health, what we as the leadership has decided, is that we are not going to say what is the right way to practice functional medicine operationally and financially. We have some practices that are 100% cash. I am a hybrid membership and insurance model. We have another practice that is 100% insurance.

What we are looking to do is garner what is working in all of these practices, and see what we can do to optimize all of them. Maybe we will narrow in on a model that could work across the network in the next 5 years or so.

Right now we do not have a standard one-size-fits-all model because if something is working, and it works in your community, then we want to just be able to make it easier and expand it for you through the resources that we have. The clientele in Colorado is different than in a small suburban town in Texas. Some may need insurance, some may be comfortable paying with cash.

Dr. Rountree: How do practitioners find out about Forum Health?

Dr. Saxena: What is interesting is that there are not conferences in the classic sense right now. Word of mouth, just like it works with patients, has been amazing for Forum Health. We have more than enough people who are interested in being acquired. And what is interesting is that once we do a due diligence process with one provider, they usually know 5 to 10 others who would maybe be interested, because we are all very close in some ways. Once providers experience the benefits, they are interested in telling their peers.

Dr. Rountree: Word of mouth is big! I cannot say I have ever advertised in 30-some years of practice.

Dr. Saxena: Yes, just like with our patients many times, right? You have something that people want, and what we have learned is that functional medicine physicians are social people

in general. They really love the science and the healing aspect of what they do, but many are burdened by all the other things they are not interested in whether it is insurance or legal or marketing. They will do it because they know they have to, but it is not what they would love to spend their time in. This is one of the main reasons people join Forum Health. They want to reduce nonclinical administrative burden, and they want to increase participation in a network or community of like-minded peers.

Dr. Rountree: I have had colleagues who went to work for Kaiser for all those reasons, and ended up getting fired by Kaiser because Kaiser told them they spent too much time with patients or that they were too popular with patients. So if a practitioner said, "Well, I like that idea of a network like Kaiser, but Kaiser has too much control over how an individual practice is conducted," this would be the ideal segue?

Dr. Saxena: Yes, we are not interested in telling a practice, "You need to now start working this franchise model. Every patient you will see with this issue you will handle this way." We believe too much in the beauty and diversity of functional and integrative medicine and personalized medicine to say that.

Having said that, there are some systems that can streamline a lot of what all of us do. So, for example, if we have a system to be able to teach someone the elimination diet, we would have a program set up with all of our health coaches and then we have a centralized system to be able to take that on.

Dr. Rountree: That sounds pretty great to me. It is an ideal way to expand this model of medicine.

Dr. Saxena: Yes, right? What is beautiful is that the people who would join us at this stage would get that this is the next pioneering level of functional medicine. Just like doing functional medicine as an individual practitioner was a pioneering effort by itself, now for us to work together in large networks, that is the next evolution of fixing health care this way. So we have to figure out how are we going to be personalized and systematized at the same time?

Dr. Rountree: How do we scale up and keep it human?

Dr. Saxena: That is right. I realize that there is a difference between systematizing and standardizing. So I consciously use the word systematize. You can personalize and systematize. It would be harder to personalize and standardize. Those seem to conflict. That is the difference.

Dr. Rountree: I like that a lot.

Dr. Saxena: We are systems biology experts, right?

Dr. Rountree: Yes, we are systems biology people. So how do we get systematic about the system? How do we use systems systematically?

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Dr. Saxena: Exactly—to systematize, but personalize for each provider.

Dr. Rountree: Yes, yes. Well, I am really mindful of your time. I do want to ask how people can get in touch with you if they want to. What is the best way to follow you and what you are doing?

Dr. Saxena: That is a great question. I have a LinkedIn profile that people can find me at through my name. Forum Health is on Instagram, Facebook, and LinkedIn. Forum Health's website is www.forumhealth.com and you can contact us there. People can also e-mail me at Tampa@ForumHealth.com, and my staff will forward to me.

Dr. Rountree: Great. I think this work you are doing is amazing! You offer some really viable practical solutions for how we can move forward out of this kind of mess that we are in—and really, the mess the whole world is in. People are not sure how we move forward with health care. We have got great knowledge, great scientific knowledge, but how do we really implement that and help people achieve change? This seems like a really viable model to do that.

Dr. Saxena: Yes. I am excited. The answer is community; as a group, as a tribe, that is how change will happen. ■

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