

# Accessing behavioral health care during COVID: rapid transition from in-person to teleconferencing medical group visits

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## Abstract

**Background and aim:** Effective and safe behavioral health interventions in primary care are critical during pandemic and other disaster situations. California shelter-in-place orders necessitated rapid transition of an effective mindfulness-based medical group visit (MGV) program from in-person to videoconferenced sessions (VCSs). Aim: to Describe procedures, acceptability, and feasibility of converting from in-person to VCS.

**Patients and methods:** Methods: qualitative. Dataset: primary care. Intervention: a six-session 2-h MGV program with educational and mindfulness components was converted. Four in-person sessions and two VCSs were held. General Anxiety Disorder and Patient Health Questionnaire-9 were administered at first and last sessions. A semi-structured focus group was conducted after session six. Population studied: six primary care patients ( $42 \pm 11$  years) with stress, anxiety, or depression participated.

**Results:** Procedural changes included remote material distribution, scheduling, hosting, and facilitation functions using the Zoom platform. The focus group revealed that patients preferred in-person sessions during initial visits, but appreciated transitioning to VCS, which provided continued support during a challenging time. Instruction on technical (e.g. logging on) and social (e.g. signaling next speaker) aspects of VCS was suggested. Building relationships through conversations was an important part before and after in-person sessions missing from VCS. Patients suggested combining in-person and VCS to allow relationship building while also improving access.

**Conclusion:** While many procedural changes were needed to facilitate conversion to VCS, primary care patients seeking stress, anxiety, and depression interventions found VCS acceptable during COVID-19. Future iterations of this program are proposed which incorporate procedural changes and facilitate relationship building between patients in VCS.

**Keywords:** stress, anxiety, depression, mindfulness, medical group visits, teleconference visits, behavioral health

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## Introduction

The COVID-19 pandemic has sharply increased anxiety and depression levels in the general population. Initial reports found a 16.5% rate of moderate to severe depression and 28.8% of moderate to severe anxiety in a sample of the Chinese general public<sup>1,2</sup> compared with 2013–2015 12-month prevalence rates of 4.0% for any mood disorder and 4.1% for any anxiety disorder.<sup>3</sup> Similarly, elevated rates of both depression and anxiety in a US general

population sample collected April and May of 2020 reported moderate depression (Patient Health Questionnaire-8 >10) in 43.3% of the sample, and moderate anxiety (General Anxiety Disorder-7 >10) in 45.4% of the sample.<sup>4</sup> Those with preexisting mental health conditions were also identified as populations particularly vulnerable to increased risk of depression or anxiety during the pandemic.<sup>1</sup> Prior to the pandemic, 19.5% of patients with anxiety disorders were seen in urban primary care

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settings, and the increase in prevalence of anxiety due to the pandemic has already increased the need for mental health services across medical and mental health clinics. To maintain access for existing primary care patients, as well as increasing access to new patients with depression and anxiety, medical systems need to plan and develop new models for behavioral health care delivery.<sup>5</sup>

One model of behavioral health care is mindfulness-based interventions. Various evidence-based forms of mindfulness-based interventions are used for effective management of stress, anxiety, and depression.<sup>6</sup> One of the most well-known interventions, Mindfulness-based stress reduction (MBSR), is an 8-week standardized program focusing on moment to moment awareness encouraging daily meditation practice.<sup>7,8</sup> Mindfulness-based cognitive therapy (MBCT) integrates MBSR with cognitive behavioral therapy.<sup>9</sup> When MBCT was compared with individual therapy, both methods were found to be equally effective for reducing stress, depression, and anxiety in primary care patients.<sup>10</sup> Various forms of structured mindfulness programs for anxiety have also been reported including shorter 2–3 day retreats, 2–3 week sessions, and even smartphone applications.<sup>6,11,12</sup> The common elements to these interventions include a structured curriculum with regular meetings in a group format, facilitation by experienced meditators, focus on instruction of meditation, and encouragement of home practice between sessions.<sup>11</sup> Overall, mindfulness-based group interventions, using these elements, have shown a moderate to significant positive effect on anxiety and depression, with similar effect sizes to pharmaceutical treatments in depression.<sup>11,13</sup>

Medical group visits (MGVs) are effective models to expand the reach of mindfulness-based interventions while simultaneously increasing access to medical and behavioral health services.<sup>14</sup> MGVs are visits where a provider sees several patients simultaneously in a 1.5–2-h session.<sup>15</sup> These visits have increased access to traditional clinic appointments, reduced emergency room visits for non-urgent conditions, and been associated with high provider and patient satisfaction.<sup>15</sup> Moreover, mindfulness-based MGVs have been used to successfully manage pain,<sup>16</sup> anxiety, and depression.<sup>17</sup> These integrated MGVs may be particularly important in low income and diverse

populations where access to traditional models of integrative services, such as individual acupuncture or mindfulness training, are not as available.<sup>14</sup> Social determinants of health such as diet, nutrition, and even trauma have been successfully incorporated into the curriculum of integrated MGVs.<sup>14</sup> Finally, addressing social determinants of health along with providing integrated services to underserved populations provides a means for improving health equity.<sup>18</sup>

Videoconference visits are a form of telehealth that uses technology to support health care at a distance. Video visits have been particularly useful during stay-at-home orders and social distancing recommended/mandated to combat infection and spread of COVID-19.<sup>19</sup> Previous evaluations of group mindfulness-based videoconference visits have shown reduction in anxiety and depression in medical cancer patients<sup>20</sup> with good feasibility and acceptability.<sup>20,21</sup> Additionally, MBSR videoconference program with adolescent patients conferred added benefits of learning techniques, strategies, and skills to apply in real-life situations when compared with video online support groups, though both programs were effective in reducing distress.<sup>22</sup> Similar to one-on-one and in-person visits, videoconference MGVs providing education and/or social support, similar to in-person visits, demonstrate reduced depression and improved health quality of life, with high acceptability and feasibility.<sup>23</sup>

While positive results have independently been associated with mindfulness approaches, MGVs, and video visits, to our knowledge there is little evidence of the impact of an approach that incorporates the full package: physician-facilitated, mindfulness-based, group-visit, conducted *via* video. A videoconference mindfulness-based MGV addressing stress, anxiety, and depression in primary care is promising as it combines aspects of clinical care, health education, and peer support in an online format. In this context, our aim was to describe the conversion of an in-person mindfulness-based MGV in primary care to a videoconference format, and provide initial insights into the acceptability and feasibility among a single patient group. This conversion was necessary to continue providing care during a local COVID-19 stay-at-home order to patients who had started an in-person session.

## Methods

### *Intervention*

The intervention with six weekly 2-h MGVs was developed to expand on individual 1:1 primary care visits for patients who self- or provider-identified as struggling with stress. These MGVs included topics previously and unsuccessfully attempted to cover in one 20-min office visit, specifically education on stressors, symptoms/reactions to stress, mind-body connection, benefits of meditation, barriers to meditation, and how to continue meditation practice. The MGVs started in January 2016 and were conducted 3–4 times yearly until 2020, when the frequency of the sessions increased to eight sessions per year to accommodate increased demand during the COVID-19 pandemic. Past sessions were conducted by either one or two providers (physician and/or nurse practitioner) with at least 5 years of meditation experience. In addition to prior experience with meditation, providers also received training which included 1-h review of each session curriculum, attending a full 6-week session and then cofacilitating sessions with an experienced facilitator. A program coordinator manages scheduling, distribution of informational material and appointment reminders to patients but does not participate in the intervention.

For this 6-week intervention, one physician facilitated each of the MGVs. Patients verbally consented to participate at session #1, as had been our standard of care with prior sessions. Consent was documented in the electronic medical record. Prior to the pandemic, all sessions were in-person, but for this cohort four sessions were in-person and then moved to teleconferencing when local stay-at-home orders were initiated. The session format varied slightly between the delivery modes. The in-person sessions began with a short 3–5 min 1:1 check-in between the provider and each patient individually in a separate consultation room. The patients were asked to discuss their prior week's stress management and meditative practice. The remaining patients were encouraged to talk amongst themselves during this time. This check in period lasted 30 min. After conducting these check-ins, the group meeting followed. The group meeting format included: (1) short breathing meditation, (2) review of previous week's meditation practice, (3) educational topic, (4) longer meditation, (5) review of the

meditation practice experience, and (6) development of individual action plans. Weekly educational topics included stressors, stress symptoms, physical response to stress, and meditation types and benefits. Weekly practices included mindful breathing, body scan, guided imagery, and gratitude meditations. The present cohort completed four of the six sessions with this format.

The remaining two sessions were adapted to a videoconferencing format in response to the local COVID-19 stay-at-home order. The Health Insurance Portability and Accountability Act (HIPAA)-compliant software Zoom (Zoom Video Communications, Inc., San Jose, CA, USA) was used for these sessions. The primary change from the in-person to the teleconferencing format was elimination of the individual 1:1 check-in component. Instead, this component was conducted in the group setting where patients were encouraged to share within their comfort level about their previous week's stress management and meditative practice. As this was our first MGV experience conducted on Zoom, we did not use the breakout room feature due to concerns about time and efficiently moving participants from the group to the 1:1 sessions. The remaining components of the group format were unchanged from the in-person sessions. Educational topics covered in these teleconferenced sessions were barriers to meditation and expanding meditative practice. The mindfulness practice of the first teleconferenced session (session 5 of six) was changed from in-person yoga to a compassion meditation, and the final session included a gratitude meditation.

### *Videoconference conversion*

Major procedural changes from in-person to videoconferencing sessions involved three areas: instruction on accessing and logging into the remote platform (Zoom), group video hosting and facilitation, and distribution and collection of patient assessments.

Prior to the first videoconferencing session, Zoom platform downloading and logging in instructions were created with screenshots of the various steps in addition to written instructions. The instructions were then distributed to patients through the electronic medical record. Patients were then called by the coordinator to ensure

receipt of the information and ability to launch and log in to the remote platform.

Video hosting functions included ensuring confidentiality. A “waiting room” function was activated in the videoconference platform, enabling the provider to verify identities of participants prior to allowing them to join the main group. As each patient logged in, the provider verified their identity in the waiting room, and then admitted them to the main group meeting. The provider also maintained “host” functions including instruction on muting and unmuting, maintaining cameras on during session, and discouraging use of chat function. Patients were asked to mute themselves upon entry to the meeting, but were also able to unmute if they had questions or comments. The provider was also able to mute if there was distracting noise from a participant’s screen. Cameras were encouraged to be left on, except if needing to step away for a few minutes. Finally chat function use was discouraged. Patients were asked to follow these instruction to encourage group discussion and participation in the video while trying to reduce distractions such as surrounding noise or separate conversations. As facilitator, the provider was now responsible for scanning the screen to make sure all participants were engaged, had the opportunity to speak, and encourage quieter patients to comment.

Patient assessments, specifically the seven-item General Anxiety Disorder-7 (GAD7)<sup>24</sup> and nine-item Patient Health Questionnaire-9 (PHQ9),<sup>25</sup> were distributed in person at session 1 but electronically through secure electronic medical record (Epic Systems®, Verona, WI, USA) at session 6. Patients could complete the questionnaire from their own device at home and their responses were automatically and immediately integrated in the patient’s electronic medical record. The provider was able to immediately review scores upon completion. Additionally, a patient satisfaction survey was sent with the other assessments as an online questionnaire developed and administered *via* Stanford REDCap platform at the end of session 6.

### Patients

Patients from a university-based primary care clinic were either self- or provider-referred because of stress. No formal diagnosis of anxiety disorder or depression was required. Patients needed to be 18 years of age or older, English

speaking, and able to attend at least four of six sessions. Exclusion criteria included non-English speaking, inability to participate in a group setting, known psychotic disorder, or by the discretion of the provider.

### Questionnaires

*Clinical outcomes.* The two primary clinical outcomes are anxiety and depression, measured by the GAD7 and PHQ9, respectively. These were completed at the first and last sessions of the MGVP program. A total GAD7 score of 0–4 represents minimal anxiety, 5–9 represents mild anxiety, 10–14 represents moderately severe anxiety, and 15–21 represents severe anxiety.<sup>24</sup> A total PHQ9 score of 0–5 represents mild depression, 6–10 represents moderate depression, 11–15 represents moderately severe depression, and 16–20 represents severe depression.<sup>25</sup> PHQ9 and GAD7 were completed electronically, integrated into the patient’s electronic health record, and then manually extracted.

*Patient satisfaction.* At the last session, patients were also asked to complete an 11-item patient satisfaction questionnaire. Nine of the five-point Likert rated questions covered weekly topics, format, and mindfulness exercises with two remaining questions on optimal number of sessions and additional comments or feedback.

All quantitative data were processed in Microsoft Excel 2019 (Version 1808). Due to the small sample size, the results of this evaluation are descriptive and statistical analyses were not conducted.

### Focus group methods

A focus group was conducted at the end of week 6 after participants had been in two video sessions and a total of six sessions. Interview participant consent was obtained verbally. The focus group was facilitated by a qualitative expert (CBJ) on the same platform as the video session and audio-recorded for reference. The audio was listened to by a second researcher (HM), first for overall content and themes, then a second and third time for direct quotes, after major themes were agreed upon by both qualitative researchers. Consensus on themes was reached with the research team through an iterative process of presenting, reevaluating, and reshaping interim results.



This quality improvement project was given a non-research determination by the Stanford University Institutional Review Board (#55836). Supporting data is available on request.

## Results

### *Participants*

At the first session, 11 patients enrolled in the program and completed the measures of interest at session 1. Two participants dropped out of the program before the final session. The originally enrolled 11 patients were  $41 \pm 10$  years (range: 26–61 years) and nine (82%) were female. All participants had private insurance. The 11 enrolled patients had an average GAD7 score of 10.6 (standard deviation = 5.5) and average PHQ9 score of 10 (6.2). At session 1, five of the 11 (45%) enrolled patients scored within the moderately severe or severe anxiety range and four (36%) were within the moderately severe or severe depression range. After session 6, of the eight patients who attended four or more sessions and completed the measures at both timepoints, none indicated moderately severe or severe anxiety or depression. Additionally, for the six focus group participants, two (33%) patients indicated moderately severe or severe anxiety and three (50%) patients indicated moderately severe or severe depression at the first visit, but none of the focus group participants scored within these ranges after the final session. For patients in the focus group, >80% of the respondents provided the highest possible level of satisfaction in the survey.

### *Focus group: initial insights into videoconference sessions*

These patients had the unique experience of both videoconference and in-person sessions, as they were transitioned to video sessions due to shelter-in-place orders. Participant preferences varied; some appreciated the convenience and comfort of video sessions, while others would opt for in-person sessions given the choice, and still others were open to either format. Four major themes/insights emerged: (1) gratitude for continued mental health support; (2) convenience and comfort of video sessions (i.e. acceptability); (3) interpersonal group connections – video benefits and limitations; (4) varied preferences for in-person *versus* video (see Table 1, themes, insights, and exemplar quotes).

*Theme 1. Gratitude for continued mental health support.* Regardless of preference for in-person or video sessions, participants expressed gratitude to be part of the group program and reported being pleased that the group had the opportunity to continue to meet for the final two sessions.

- “I’m so happy that we started this before this all [COVID-19], before this whole thing started. Otherwise, I think we all would have been falling apart. I know for sure I would have been falling apart if I wasn’t on all of this [laughs].”
- “I found it very helpful. We talked about it early in the sessions. Because of the sessions going on, I feel like we have access to a toolkit that we can always go back on and learn new ways to deal with anxiety and stress, and the like. So, I’m really happy that it didn’t stop.”
- “I was grateful to have that continuity.”

*Theme 2. Convenience and comfort of video sessions (acceptability).* When asked about what they liked and did not like about the videoconference format, all participants reported understanding and being accepting of the need to transition. Some even preferred the video format over meeting in-person because of the convenience, particularly eliminating travel time and also reducing some stresses that come with attending in-person sessions:

- “It’s nice not to have to worry about rush hour commute and stuff. And also, considering the alternative of just stopping the sessions, I think I was really happy we were able to pivot so quickly and try it out.”
- “At the end of the day, there’s a lot going on, so the timing of it was a little bit stressful. . . So not having to drive makes a big difference for me. . . that makes it a lot easier.”
- “I find the in-person meetings causing more stress than the video because I would have to make sure that I can finish all my work by like 5 and then drive there. It was a 10–15-minute drive, but still, just the thought of having a deadline that I have to finish everything by 5 is more stressful than just being able to just log in from wherever I am. So, definitely find the online sessions less stressful [laughs]. Then again, it’s not a lot of stress, but if I compare the two, I find the online one less stressful to prepare for compared to the in-person one.”

**Table 1.** Themes, insights, and exemplar quotes.

| Themes/insights  | Exemplar quotes   |
|--|---|
| Gratitude for continued mental health support                    | <p>"I'm so happy that we started this before [COVID-19] started. . . I know for sure I would have been falling apart [without this group]."</p> <p>"I feel like we have access to a toolkit. . . I'm really happy that [the sessions] didn't stop."</p> <p>"I was grateful to have that continuity."</p>  |
| Convenience and comfort of video sessions (i.e. acceptability)   | <p>"It's nice not to have to worry about rush hour commute."</p> <p>"I find the online one less stressful to prepare for compared to the in-person one."</p> <p>"It's actually more comfortable."</p>   |
| Interpersonal group connections – video benefits and limitations | <p>"It's nice that we had met in person so I feel like I know these people."</p> <p>"Meeting people in person at first was helpful. That way, I felt more comfortable sharing. . . but maybe I would have felt comfortable over Zoom, too."</p> <p>"I think no matter what, the first couple of sessions, everyone was really on the quiet side. So, I think that should be expected, either way [in-person or online]."</p> <p>"It's harder to read body language. . . but I know Zoom has a feature called hand raise."</p> <p>"On video, [when] I wanted to speak, I unmuted myself. . . it happens in person, too – when a couple of people speak at the same time, and you know, just pick someone and they start speaking."</p> |
| Varied preferences for in-person <i>versus</i> video             | <p>"Given a choice, I would always choose the in-person one."</p> <p>"For me, I think Zoom was great and it was very convenient."</p> <p>"Maybe meet the first time only, so we can get to know each other in person and then continue at home."</p> <p>"One way of doing it is maybe alternating sessions or giving people options, if they want to do the online sessions or in-person sessions."</p> <p>"As far as the technical part of just using Zoom, I think all it would need is 10 or 15 min in maybe the first session."</p>   |

Another aspect of videoconferencing that participants reported enjoying was the comfort of being in their own home. Patients were comfortable with video, indicating initial acceptability of the modality. One participant noted the ability to be more comfortable and possibly more relaxed during the meditation portion of their group time together, and another shared their personal experience of feeling embarrassed to move around during the in-person sessions, but having the freedom to do so when at home, during the videoconference sessions.

- "One of the things is for this kind of meditation class, it's actually more comfortable, at least I'm sitting on a bed, so it's more comfortable for me to meditate. Because sometimes in the office, I was cold and the specific room and chairs we had, just weren't really conducive – the comfort wasn't there."

- "I noticed myself – I am very fidgety – to stand for 2h. And I think I like the home, too, because I was able to go from the living room to another room. And sometimes, so I don't bug everybody, I just put the camera to, like close the camera or close the screen and just move to another room. But I can't sit still for like the total 2h, but at the office, I was, I felt embarrassed to try to move."

*Theme 3. Interpersonal group connections – video benefits and limitations.* However, part of feeling comfortable and willing to share during these subsequent videoconference group visits was attributed to having met other group members in person beforehand and building trust. Many members voiced that they enjoyed and liked the video sessions, but were glad to have had the initial meetings be in-person, while others thought perhaps they would have been just as comfortable with videoconferencing the whole time, given that even

with the in-person sessions, people were initially quiet because relationships and openness take time.

- “For me, it’s really nice to have the in-person sessions. I enjoyed that. And I probably would not have participated as much if it was 100% on Zoom.”
- “It’s nice that we had met in person so that I feel like I know these people and so that, that made it really comfortable, so I really enjoyed this [video] format.”
- “Meeting people in person at first was helpful. That way, I felt more comfortable sharing things with the group, but maybe I would have felt comfortable over Zoom, too.”
- “I think no matter what, the first couple of sessions, everyone was really on the quiet side. So, I think that should be expected, either way [in-person or online].”

Although there were concerns about the use and reading of body language and turn taking for videoconferencing, participants also provided potential solutions.

- “It’s harder to read body language, and [decide] when you’re going to participate or not, but I know Zoom has a feature called hand raise, so maybe that’s something we can use.”
- “On video, [when] I wanted to speak, I unmuted myself, so it’s sort of self-selection. And other people, especially [name], I’ve noticed with you, you just look like you’re going to say something [laughs]. So, you know, you can sort of take turns talking that way. I like the hand idea that [name] said, of raising to speak. And, I mean it happens in person, too – when a couple of people speak at the same time, and, you know, just pick someone and they start speaking. So, I think it’s fine.”

*Theme 4. Varied preferences for in-person versus video.* For some, their personal preference was in-person meetings rather than online due to the ability to more readily build a human connection with others through conversations before or after the group. Yet others were more open to a combination of in-person and video sessions:

- “For me, it was an opportunity to go outside and make a connection. I really enjoyed

the in-person sessions a lot. It’s not that I’m not enjoying the online, but given a choice, I would always choose the in-person one.”

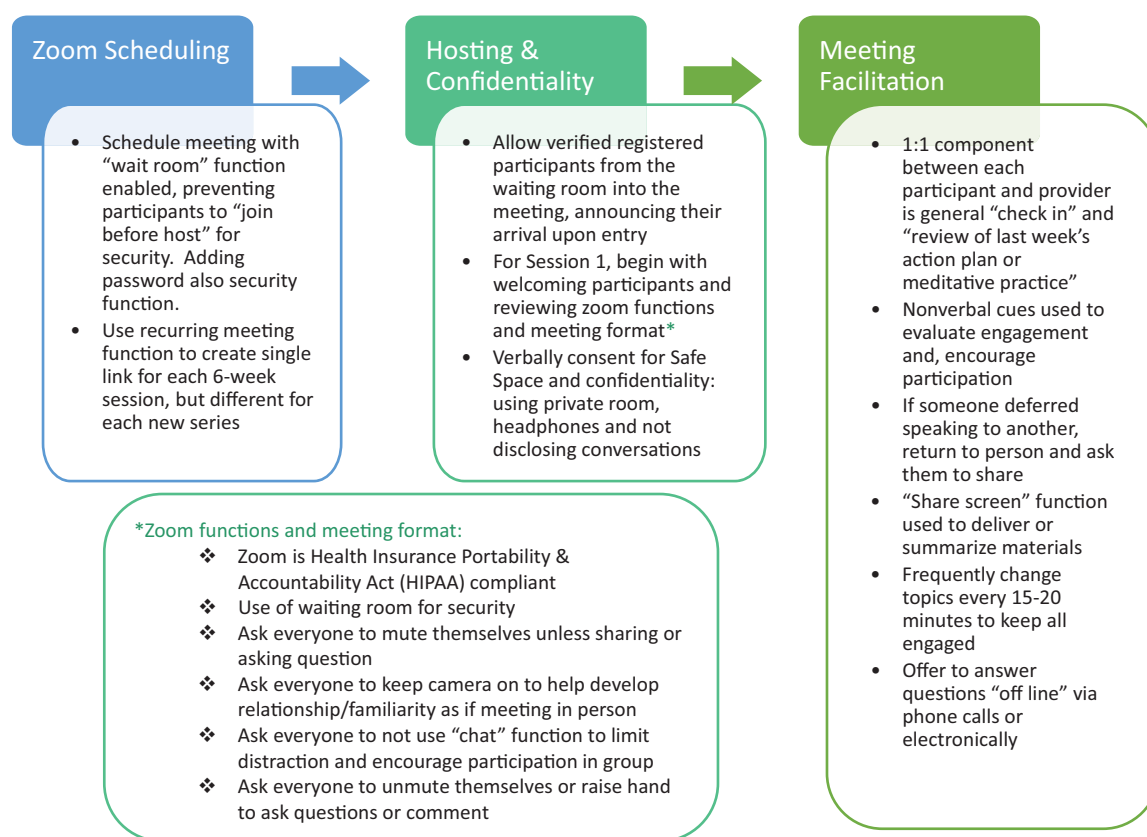
- “Just even waiting for the class to start while people are having their individual sessions, just having kind of casual conversations. Just what was going on, what they were working in, and it was just stuff that didn’t relate to meditation at all, just who we are as people and what we do and things like that.”
- “For me, I think Zoom was great and it was very convenient. And given I had met all of them already, I felt good about sharing how things went, so it was very comfortable in all aspects.”
- “Maybe meet the first time only, for the first time, so we can get to know each other in person and then continue at home.”
- “One way of doing it is to have maybe alternating sessions or giving people options, if they want to do the online sessions or in-person sessions. Like for some people, it resonates to stay at home and be in their own place, but for some, it’s good to have a connection, you know, at the office.”

Future preferences and suggestions for onboarding patients onto the video sessions included a guide on accessing the Zoom platform on multiple devices, the available features, and practice time for logging on and using the various capabilities to help reduce distractions and increase familiarity with using the videoconferencing platform.

- “As far as the technical part of just using Zoom, I think all it would need is 10 or 15 min in maybe the first session. I had another group that did that, just went through some of the features. I think that’ll be enough. You don’t need a whole session on it.”
- “Just a couple of minutes in the beginning to practice muting and unmuting, or whatever. Just some basic things, just so you feel comfortable once the class starts.”

## Discussion

Transitioning patients enrolled in an in-person mindfulness MGW to a videoconferencing format provided continuous behavioral health care safely during the COVID-19 stay-at-home order.



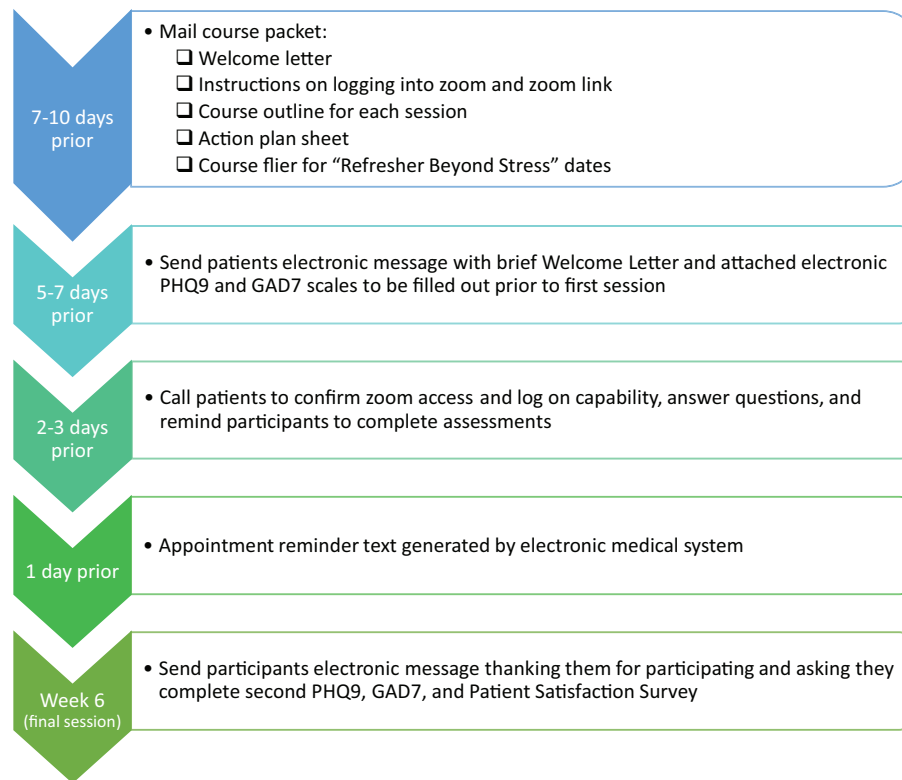
**Figure 1.** Video-conferenced mindfulness medical group visit scheduling, hosting, and facilitation.

Consistent with previous telehealth studies,<sup>26,27</sup> the focus group indicated overall participant acceptability of the videoconference sessions. Participants not only acknowledged that they had the tools to manage the stress of both pandemic and stay-at-home orders due to the group visits, they were also grateful that transition to videoconferencing meant they would be able to complete and participate in the remaining group sessions. The videoconference format resulted in less stress of physically travelling to in-person groups and greater comfort when meditating at home. Although a few participants voiced their preference for in-person sessions, most were open to the possibilities of the videoconferencing approach. Overall, these patients were satisfied with the mindfulness-based MGVs and the included educational topics and mindfulness training. Moreover, these patients reported decreases in anxiety and depression symptomology that were similar to those previously reported.<sup>17</sup>

For future iterations, we have developed a Procedure chart (see Figure 1) and Timeline (see Figure 2). Compared with in-person MGVs, additional staff

effort and time is needed to send (1) information packets (which include log-on instructions), (2) separate messages with pre-visit assessments, (3) calls to confirm log-on capability, (4) appointment reminders, and (5) post-visit assessments (see Figure 2). Our experience was that patients often needed assistance with downloading the application, identifying the secure email that contained the link for the session, and logging on to the videoconferencing session with the link, but this was early in COVID and may have changed as we have adjusted as a society to video-mediated communication. To further enhance patient comfort with the process of videoconferencing, informational material was essential to reiterate the process of logging on. In future programs, this information could be sent as hard copies in the mail or electronically prior to sessions, but either will require additional staff time as compared with in-person visits (see Figure 2). Procedural enhancements including many suggested in the focus group were formalized for future iterations (see Figure 1). Zoom scheduling using appropriate functions for security, hosting functions ensuring confidentiality and familiarity with basic platform functions, and meeting facilitation to





**Figure 2.** Video-conferenced mindfulness medical group visit timeline. PHQ9, Patient Health Questionnaire-9; GAD7, General Anxiety Disorder-7.

ensure inclusiveness and participation (see Figure 1) will be essential to a successful future MGV. Dedicated IT support for participants would additionally increase feasibility.<sup>23</sup>

Format changes were also required in the conversion from in-person to videoconferencing. Typically, the intervention includes a short 1:1 check-in with the provider to evaluate levels of stress/anxiety/depression and discuss mindfulness practice over the last week. In the videoconferencing format, this part of the intervention transitioned to a group conversation. This change kept everyone engaged, allowed for greater sharing of successes and difficulties amongst patients, and reduced the session length compared with the in-person sessions. Another solution could be the use of breakout rooms in Zoom to hold the 1:1 portion, remotely mimicking the in-person 1:1 sessions, while potentially encouraging small group conversations in the main group, as was happening in in-person sessions.

Potential enhancement of the videoconferencing format may be the mindfulness practice component

of the intervention. Patients commented in the focus group that they were in a private space and often sitting on a more comfortable piece of furniture than was available in the clinic setting. They felt more comfortable meditating in their own space, which may result in greater reductions in measured outcomes such as anxiety and depression. Future studies will be needed to evaluate this potential benefit of remote mindfulness MGVs.

Since the focus group patients participated in both in-person and videoconferencing versions of the mindfulness-based MGVs, their experience will be different from patients participating in either a complete in-person or videoconferencing format, thus limiting the generalizability of these findings. However, this converted format experience also offered some advantages and insights. Some patients preferred meeting first in person, making them more comfortable with each other than they would have been if all the sessions were on video. The time prior to and after in-person sessions was essential for socializing and becoming comfortable with their co-participants. Patients, however, appreciated that the stressors

of travel and parking were eliminated with videoconferencing. A potential solution suggested by patients was to conduct the first couple of sessions in-person and then transition to remote sessions for the rest of the intervention.

Overall, patients reported that they appreciated having continuity in the mindfulness-based MGW during COVID-19 and videoconferencing was an acceptable format. Lessons and insights from this evaluation, including the Timeline and Procedure functions described above, are being applied in a solely videoconferencing mindfulness MGW, maintaining essential behavioral healthcare during the global pandemic. The implementation of this exclusive videoconferencing format will be evaluated and reported along with its impact on anxiety and depression. As we move into a post-pandemic world that has adopted telehealth, however, balancing the convenience of teleconferencing with the benefits of developing rapport and relationships with patients face-to-face should be considered. Overall, the findings reported here suggest that videoconferencing is an acceptable and feasible format for mindfulness-based MGWs.

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