INTEGRATIVE HEALTH CARE

A Catholic System Develops a New Approach to the Art of Healing

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U.S. health care has entered an era of rapid change with brief transition periods. One force for change has been the health care consumer; becoming better informed, consumers have demanded higher quality, better service, and more choice.[1] In 1999 consumer demand was reinforced by *Crossing the Quality Chasm: A New Health System for the 21st Century,* a report from the Institute of Medicine's Committee on Quality Health Care in America. The report recommended a sweeping redesign of the health care system to produce care that would be safe, effective, patient-centered, timely, efficient, and equitable.[2]

In the same year, the Joint Commission for the Accreditation of Health Organizations issued standards requiring care to be patient-centered, comprehensive, and multidisciplinary in order to effectively address the issue of pain management for patients. Calls for health care to become more patient-centered and holistic have also come from the American Medical Association (AMA), American Holistic Medical Association, American Holistic Nurses Association, and the AMA Medical Ethics Guidelines.

This article is intended to share the continuing journey of Catholic Health Initiatives (CHI), Denver, toward the redesign and renewal of health care delivery. Our journey of organizational learning, which began five years ago, has consisted of three phases:

- Phase I focused on complementary and alternative modalities (CAM) of therapy.
- Phase II focused on the patient.
- Phase III focused on the design and implementation of patient-centered care.

We refer to our patient-centered approach as "integrative health care." It is important to note at the outset that integrative health care is not synonymous with CAM, although it does include complementary therapies when those are appropriate. Integrative health care is grounded in relationships and strives to unite the best of the world's therapeutic traditions and evolving practices.

PHASE I: FOCUS ON COMPLEMENTARY THERAPIES

By 1997, CHI's leaders had noted growing patient dissatisfaction with conventional medicine, which tended to be curative and symptom-focused. According to one study, an estimated 60 million Americans (33.8 percent of the adult population) were using at least one of 16 alternative therapies in 1990.[3] By 1997, alternative therapy use had increased to an estimated 42.1 percent of the adult population, or 83 million people.[4]

Of significant concern were the statistics for visits to primary care practitioners. Between 1990 and 1997, visits to all such physicians remained flat at around 386 million, whereas visits to CAM practitioners increased 47.3 percent, from 427 million to 629 million.

Consumers most frequently sought CAM for chronic conditions, including back problems, anxiety, depression, and headaches.[5] Out-of-pocket expenditures for CAM increased 45 percent between 1990 and 1997 and were conservatively estimated at $27 billion.[6] The increasing number of persons seeking CAM, especially among the chronically ill, indicated that such therapies were meeting the needs of consumers in ways that conventional medicine did not. These statistics were most sobering.

Wayne Jonas, MD, formerly of the Office of Alternative Medicine at the National Institutes of Health, Washington, DC, has written that in turning to complementary therapies, the American public is basically seeking five essential

elements in the practice of medicine:

- Attention to the illness and to the suffering that accompanies all disease
- Personal attention and expanded time from practitioners (patients particularly like the fact that most CAM practitioners spend at least an hour with each person)
- Patient empowerment and participation in the healing process
- A focus on patients' inherent capacity for self-healing and health promotion
- The use of a variety of appropriate healing modalities[7]

As consumer dissatisfaction with conventional health care increases, the gap between the public and the health care profession serving it will widen.

CHI responded to these significant lessons by conducting research and making site visits to leading practices. In 1998 a steering committee was formed; this group later became the system's Integrative Health Care Advisory Council. Intending to combine the best of traditional allopathic (Western) medicine with complementary therapies, we who served on the council continued exploring the feasibility of CAM programs and services and examined the possible obstacles to offering them to CHI patients. We also awarded a grant to the TriHealth Integrative Health and Medicine Center, Cincinnati, to develop an integrative health program that could serve as a model within CHI. The council was supported in these actions by CHI's National Clinical Leadership Group, Mission Group, and Business Development and Strategic Planning Group. The council's membership included representatives of CHI facilities that were already providing some complementary therapies as part of their services, as well as senior leaders and others from the three supporting national groups.

In response to requests from CHI facilities, the council developed a white paper to assist those seeking assistance with the credentialing process for CAM. Two council members, Jeff Sollins, MD, and Milt Hammerly, MD, wrote an extensive glossary on complementary and alternative modalities for the council's use in researching integrative care.

In August 1999 the council engaged 54 CHI facilities in conversations to determine the status of CAM programs and services in the system. The major items covered in these conversations were terminology, programs and services, supportive structures, and educational needs. Those conversations revealed, first, that there was great diversity in the system, and, second, that the success of the integrative health services offered would depend on their acceptance by the facilities' medical staffs and their local communities. Terminology was found to be a significant problem (see **Box** at left).

After its conversations with CHI facilities, the council conducted a retreat and reflected further on integrative care. We concluded that what was needed was a vision and goal to provide a more holistic (mind/body/spirit) approach to health care, an approach that would include a clinical and philosophical rationale for combining differing therapeutic modalities into a seamless, unified approach.

WHY "INTEGRATIVE" HEALTH CARE?

When CHI's Integrative Health Care Advisory Council began its work, it saw early on that it would have a problem with terminology. The terms "complementary medicine" and "alternative medicine" had severe limitations, including the fact that they were perceived as negative by many physicians. The council therefore began to use the term "integrative health care." The word "integrate" comes from the Latin *integratus* and means "to form or blend into a whole; unite, to unite with something else, to end the segregation of and bring into common and equal membership in society or an organization."

We found that the term "integrative health care" had at least three meanings in active use:

- The integration of Native American practices and Eastern healing modalities with conventional medicine
- The integration of complementary and alternative medicine (CAM) with conventional medicine
- The integration of mind/body medicine, or holism, with conventional medicine

The second definition seemed to be the most common. The problem with this definition is that it is therapy-focused rather than patient-focused, and carries with it no obvious rationale for combining these therapies and no directions for doing so. The council came to realize that a more meaningful and useful definition would be "patient-centered" care, care that included both theological and philosophical rationales for combining differing therapeutic approaches into a seamless, unified approach.

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Phase II: Focus on the Patient

As we learned more about integrative health care, we came to the realization that a more comprehensive approach to medicine—one that would involve assessing, understanding, and caring for the bio-psycho-social-spiritual dimensions of a person—was needed.[8] The council believed it was important for this patient-centered approach to be rooted in the tradition of Catholic health care and the healing ministry of Jesus.

CHI's framework for health care is grounded in the heritage of its founding congregations, which entered the world of medicine to serve as living witnesses to Jesus' ministry of healing of

the whole person: mind, body, and spirit. This same purpose is reflected in the system's mission statement: "Fidelity to the Gospel urges us to emphasize human dignity and social justice as we move toward the creation of healthier communities." The council found it helpful at this point to focus on *healing*, rather than *curing* (see **Box** below). The term "healing" pertains to restoration, bringing wholeness and attention to all dimensions of a human person.

With this important insight, we realized that "integrative medicine" or "integrative health care" should *not* just be a synonym for CAM. Instead, we decided, CHI's definition of integrative health care should reflect the spirit of its healing ministry and provide a comprehensive, collaborative, and compassionate approach to care. This personalized response to persons who are sick and in pain should be the hallmark of every CHI facility. Integrative health care is integral to the system's healing ministry and requires the uniting of medicine, health, education, and pastoral and social services.

Integrative Care's Essential Components

As a result of the council's work, CHI has chosen to use the word *integrate* (or *integrative*) because it implies the combining of the best of different models of medicine. Integrative medicine attempts to blend or unite the holistic mind/body approach with the modern scientific approach of conventional medicine. The council arrived at the following definition: "Integrative health care is a personalized, comprehensive and collaborative approach to assess and respond to a person's body, mind and spirit needs for healing." Integrative care includes conventional medicine, spiritual/pastoral care, behavioral health, and complementary modalities. Our initial working definition of integrative health care eventually became: "A holistic approach to health care delivery that unites providers, modalities and systems of healing in order to address and respond to body-mind-spirit connections in every patient, resident or community encounter."[9]

Integrative Medicine's Characteristics

CHI's definition of integrative health care emphasizes three principal characteristics: It is personalized, comprehensive, and collaborative.

Personalized Care Integrative care recognizes that each person is unique and precious and that similar patients may experience the same disease process differently and react to the same medications and treatments in different ways. Integrative health care practitioners assess and respond to patients' holistic needs by using a vast array of available treatments, therapies, and modalities, tailoring them to fit each patient's response to his or her particular illness. For example, in the area of pain management, 200 mg of a particular medication may be enough to control one person's pain, but not another's. Patients should act as partners with their practitioners, providing the feedback that enables practitioners to individualize care. In this way, patients assume responsibility for their own healing, wellness, and coming to wholeness. Personalized or relationship-centered care is accomplished through effective use of clinical narratives, the patient's description of his or her illness.

Comprehensive Care Integrative care is based on a multidimensional view of the patient. The mind, body, and spirit are three interrelated dimensions of a whole human person. Factors affecting one of these dimensions will simultaneously affect the other two as well. This holistic view considers the bio/psycho/social dimensions of each unique and precious person. "Bio" refers to the biological or physical dimension, "psycho" to the psychological dimension, and "social" to the relational dimension. These, along with the spiritual and energy needs of a person, constitute five interrelated dimensions of a unified reality.

In integrative care, the focus of all encounters between practitioners and patients is the healing relationship or "patient/resident/client–centered" approach to care. Concern for a particular person and for the impact of illness or disease on that person is central to the healing relationship. Although the outcome of an encounter may include the cure of disease, the goal is to help the patient come to healing or wholeness. As Fr. Gerard T. Broccolo, STD, CHI's vice president of spirituality, has put it, "Coming to wholeness is the ultimate treatment or care goal—in coping with illness, in facing death, or in living life."[10]

Mind/body/spirit connections can be addressed by uniting the various approaches or systems that provide healing. A comprehensive approach to care both employs the expertise and practice of conventional medicine and promotes its integration with holistic and other forms or modalities of healing. Comprehensive care also

"HEALING" AND "CURING"

The word "healing" comes from the Greek *holos*, which means to make sound or whole, and is thus different from "curing." The word "cure" comes from the Latin *cura* and refers to care, particularly care of souls. Currently "cure" is used to mean something that corrects, heals, or alleviates a harmful or troublesome situation and restores health or soundness, whereas "healing" pertains to restoration, bringing to wholeness, and attention to all dimensions of a human person.

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motivates patients to take responsibility for their health and results in their ability to experience wholeness in illness and in health. Comprehensive care is achieved through assessing and responding to mind/body/spirit needs in a caring and compassionate manner.

Collaborative Care Because integrative medicine takes a multidimensional view of patients and their treatments, it stands to reason that no single provider alone is capable of being genuinely comprehensive. Comprehensive care thus requires collaboration by an interdisciplinary team of practitioners.

The word "collaboration" comes from the Latin *com-laborare* and the French *collaborare*, which mean "to labor together." As Fr. Broccolo says, "The objective (of collaboration) is not to provide a system of experts but rather an expert system for healing the whole person."[11] Integrative health care uses teams of dedicated practitioners who communicate with, educate, and counsel patients to help them on their journeys toward healing. A team combines its individual members' insights and expertise to craft a unified care plan that will facilitate a patient's healing. Continuity of care is provided through a network of community resources and referral services.

Tools and Resources

After clarifying our vision, crafting a definition of integrative care and identifying the compelling reasons for it, we council members turned our attention to the tools and resources that would make this vision a reality. These resources, we decided, are the clinical narrative, the comprehensive evaluation process, and the educational resource manual.

Clinical Narrative In patient-centered care, patients and their families are the focus and basic units of care. Health care practitioners enter these relationships to facilitate the patient's self-healing process. For such a relationship to occur, effective communication—a rapport—must develop between the practitioner and the patient. The practitioner has, in the clinical narrative, a major means of connecting with the patient and establishing a healing relationship.

The clinical narrative, the patient's story, enables the practitioner to understand the patient's experience of illness, thereby minimizing the differences in perspective and providing a framework for empathy and insight.[12] Gaining insight into a patient's lived experience is imperative for four reasons:

- It is a primary way of treating patients as persons.
- It assists practitioners in making more individualized diagnoses and personalized therapeutic interventions.
- It provides more information for decisions on scientific therapeutic interventions.
- It provides a foundation for healing relationships.[13]

The main way practitioners gain insight into patients' lived experience is by having them tell the stories of their illnesses, the clinical narratives. Such narratives are not to be confused with medical histories, which include information about inoculations, past injuries, allergies, hospitalizations, chronic conditions, and past and present diagnoses. Clinical narratives contain the facts and events of the current illness, as well as the patient's explanation and interpretation of the illness, including his or her pains, concerns, fears, and apprehensions.[14] The narrative is considered "clinical" because the information gained from the story assists practitioners in making a clinical (medical) analysis. A clinical narrative should be as important to the practitioner as physical symptoms.[15]

A clinical narrative's content should also include the patient's own ideas concerning the causes of his or her symptoms; his or her perception of the seriousness of the illness; and his or her description of any major emotional or spiritual crises before the onset of symptoms, such as the loss of a job, death of a spouse, or divorce. In addition, practitioners should ask questions that elicit information about how the illness has affected the patient's life and what he or she fears most as a result of being ill.[16] Clinical narratives provide invaluable insights into patients' perceptions of their illnesses. What patients seek from practitioners is not only scientific explanations of the cause of illness but also understanding of and empathy for their suffering.

By using the clinical narrative effectively, a practitioner can both enhance his or her own ability and show the patient that the practitioner is a partner and friend on the healing journey.

Comprehensive Care Evaluation Integrative health care focuses on optimal holistic (mind/body/spirit) well-being. For comprehensive patient assessments, CHI has developed the Comprehensive Care Evaluation (CCE). This three-part process is designed to incorporate both the medical assessment model SOAP (subjective, objective, assessment, and plan) and the nursing assessment model APIE (assessment, plan, implementation, and evaluation). The evaluation tool incorporates subjective and objective data, assessment, plan of care, implementation, and evaluation of the overall plan of care.

Part I of the CCE is the "Intake Self-Evaluation Tool," which patients complete before they are seen by a health care professional. This tool gathers general information about the patient's well-being by using a six-category taxonomy: bio-

chemical, structural/anatomical, functional/movement, mind/body, environment (see **Box** below). During the patient's first visit, health care professionals review his or her self-evaluation regarding wellness and document any findings or comments, as well as the patient's responses.

This taxonomy and stratified stepped-care model for integrative medicine was developed by Hammerly, CHI's director of Integrative Medicine. His model allows for the inclusion of CAM and enables practitioners to rationally and judiciously select the most appropriate therapies, given the risk/benefit ratio in the clinical situation.[17]

Part II of the CCE is the "Practitioner Clinical Evaluation," which incorporates findings from the patient's physical examination. This evaluation includes a review of the patient's systems and the practitioner's assessment and clinical summary. The primary physician and other practitioners to whom the patient may have been referred document their findings on an interdisciplinary care team coordination form. These forms can be used on the patient's first visit and updated as needed.

Part III, called the "Wheel of Well-Being," is designed for practitioners and patients to use in reviewing the findings. It identifies areas of a patient's health and well-being that need improvement and educates the patient about them. The review incorporates the taxonomy used in the Intake Self-Evaluation. Practitioners can address patients' needs, but the patients themselves determine what is most important to them and take responsibility for improvement. Patients create personal "contracts," writing down what they intend to do to correct imbalances in their health and well-being.

A thorough patient evaluation requires teamwork involving a wide range of disciplines. The CCE enables the health care team to focus on both the patient's perceived needs and needs that the patient may not yet recognize. The team may include a primary physician, nurse, physician's assistant, advanced registered nurse practitioner, chaplain, nutritionist, and pharmacist, as well as representatives of other disciplines if a need for them arises. A nurse or physician's assistant may initially be responsible for reviewing and clarifying patient data. The team should refer the patient to appropriate resources, depending on the needs identified; spiritual care needs, for example, may indicate referral to a chaplain for a detailed assessment.

Integrative Health Care Manual To educate others regarding integrative health care, the council decided to compile and publish a manual, *Integrative Health Care: An Emerging Approach to the Art of Healing*. The manual provides a comprehensive resource for system leaders and members of facility steering committees, so that they can learn about integrative and patient-centered care and teach others about it. The manual is intended to provide background, ideas, strategies, processes, and tools for the implementation of this emerging approach to care.*

Phase III: Implementation of Patient-Centered Care

After completion of phases I and II, the council convened a cross-section of CHI's leaders in a national "summit." The meeting was intended to solicit input and guidance regarding the implementation of integrative health care. The participants basically affirmed the council's definition and rationale.

Participants did recommend that, in implementing integrative care, CHI should—rather than making the initiative systemwide and mandatory—allow each facility to customize it according to the facility's own strengths, resources, needs, and opportunities, as well as the readiness for it in the surrounding community. Participants also urged CHI to make the implementation process multidisciplinary and to

INTAKE SELF-EXAMINATION TAXONOMY

The Intake Self-Evaluation uses the following taxonomy:

- *Biochemical* refers to metabolic processes and incorporates nutrition, medications, hormones, and other substances that interact within the body.
- *Structural or anatomical* focuses on the human body, including past and current medical history and signs/symptoms related to disease processes. Listening to patients' concerns may help practitioners identify underlying health problems.
- *Functional/Movement* examines patients' ability to perform activities of daily living. Use of the SF-8 General Health Evaluation allows the evaluator to consider disease outcomes and compare the patient's functions with those who have related health conditions.
- *Mind/Body* incorporates mental health; sleep; financial concerns; and emotional, social, and spiritual concerns as they relate to patients' well-being. Part of the SF-8 is also built into this category.
- *Environmental* examines the impact of external factors on patients. It incorporates safety issues and awareness of communicable diseases and can serve as an opportunity for practitioners to educate patients regarding personal responsibility.

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*The manual costs $15. For a copy, contact the author's administrative assistant, Carolyn Burmont, at Catholic Health Initiatives, 1999 Broadway, Denver, CO 80202; phone: 303-383-2625; e-mail: carlmiddleton@chi-national.org.

include in it a practical template that each facility could adapt to its local market and culture, concrete measures of success, and pilot projects with which the facility could demonstrate the value of integrative health care.

The council, putting to use the insights gained from this feedback, has developed an IHC Implementation Action Plan that includes both education and pilot projects.

Implementation Education Integral to the council's action plan is education regarding the integrative care philosophy. It is important that practitioners understand that CHI's approach to integrative health care primarily consists of compassionate and attentive listening to the whole person as a way of:

- Delivering clinical care
- Engaging staff loyalty
- Ensuring organizational alignment of interdisciplinary resources, initiatives, competencies, and infrastructure

Education that addresses the conceptual framework, skills, and competencies of person-centered care is an essential component of the pilot projects.

Pilot Projects Given the summit participants' affirming response, CHI launched the pilot projects in 2001; these are now under way. We hope to demonstrate through them the difference that the integrative care approach can make clinically, organizationally, and financially. The projects' specific purpose is to implement and assess the impact of:

- A comprehensive patient/resident care evaluation process that will facilitate development of a single patient/resident care plan
- Retreats for the facility staffs, both clinical and administrative, that are involved in integrative health care implementation
- Modifications made by a facility interdisciplinary team to address infrastructure barriers and resolve alignment issues
- The development of pre- and postpilot measures regarding patient satisfaction, management-by-objective performance improvement, and staff performance management competencies and behavior

Moving into the Future

CHI's multiphased integrative health care journey began with the recognition of the contributions and limitations of the conventional medical model, especially the limitations of any single method of healing used in isolation from others. We have now evolved in our focus from complementary and alternative therapies to an integrative approach to care that is personalized, comprehensive, collaborative, and based on a multidimensional view of the patient.

At present, we are assisting the implementation of integrative health care pilot projects at our pilot sites. This requires cooperation with community resources to ensure continuity across all health care settings. Holistic assessments and the development of care plans by multidisciplinary teams and their patients drive the process. Care plans use conventional medicine, behavioral health, and spiritual care, as well as complementary therapies, to respond to an individual's mind/body/spirit needs. CHI is developing pre- and posttest measures, conducting educational retreats, and addressing infrastructure issues through national staff support.

We hope to mainstream integrative health care, thereby shaping and redesigning clinical care delivery. By taking a leadership role, CHI advocates a health care ministry that is "safe, effective, patient-centered, timely, efficient and equitable"[18] and sponsors a healing ministry of reverence and compassion. □

NOTES

1. See *Health Care Environmental Assessment 1999-2001: The Forces Driving Change*, Catholic Health Initiatives, Denver, 2001, p. 12.
2. Committee on the Quality of Health Care in America, *Crossing the Quality Chasm: A New Health System for the 21st Century*, National Academy Press, Washington, DC, 2001, p. 6.
3. David Eisenberg, et al., "Trends in Alternative Medicine Use in the United States, 1990-1997: Results of a National Follow-Up Survey," *JAMA*, November 11, 1998, pp. 1,569-1,575.
4. Eisenberg, p. 1,572.
5. Eisenberg, p. 1,573.
6. Eisenberg, p. 1,574.
7. Wayne Jonas, "Alternative Medicine: Learning from the Past, Examining the Present, Advancing to the Future," *JAMA*, November 11, 1998, p. 1,616.
8. See, for example, Barbara Dossey, *Holistic Nursing: A Handbook for Practice*, Aspen Publishers, Gaithersburg, MD, 1995, p. 7.
9. Gerard Broccolo, *Integrative Health Notes*, May 2001, p. 1.
10. Broccolo.
11. Broccolo.
12. Moira A. Stewart, "Effective Physician-Patient Communication and Health Outcomes: A Review," Canadian Medical Association, May 1, 1995, pp. 1,432-1,433.
13. Stewart, p. 1,424.
14. Stewart, pp. 1,425, 1,428.
15. Stewart, p. 1,428.
16. David Burns, *The Feeling Good Handbook*, Penguin Books, New York City, 1990, p. 364.
17. For a more detailed discussion of Hammerly's model, see "Integration of Complementary Therapies," *Integrative Health Care: An Emerging Approach to the Art of Healing*, Catholic Health Initiatives, Denver, 2001, pp. 1-9.
18. Committee on the Quality of Health Care in America, p. 6.