INTEGRATIVE HEALTHCARE: FACILITATORS TO SUCCESSFUL INTEGRATION OF COMPLEMENTARY HEALTH APPROACHES AND CONVENTIONAL HEALTHCARE

by

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A thesis submitted in partial fulfillment
of the requirements for the degree

of

Master

of

Nursing

MONTANA STATE UNIVERSITY
Bozeman, Montana

May 2015

ACKNOWLEDGEMENTS

With Gratitude:

Jean Shreffler-Grant my incredibly wise and patient thesis advisor. The words on these pages would not have happened without her guidance.

Elizabeth Nichols, committee member, your keen eye for detail and your humor were much needed and appreciated.

Laura Marx, committee member, for your simple approach to my thesis. You are an inspiration to me as a provider/owner of the only Integrative Healthcare clinic in Montana.

Michele Maisey, sister and friend, for your help transcribing interviews, editing, wordsmithing, and bringing me lots of coffee and hugs.

My family, Ted, Teddy, and Eleanna, for your support and patience these past four years. It has been an arduous journey and would have been much more difficult without your love and support. Thank you.

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ABSTRACT

Integrative healthcare (IH) is a relatively new area of specialization in the U.S. healthcare system. The existence of IH is widely attributed to popular demand for the range of therapies known collectively as Complementary Health Approaches (CHA) or Complementary and Alternative Medicine (CAM). In the U.S., alternative, complementary, and integrative healing movements have become a significant part of popular and healthcare cultures, yet there has not been a focus on what is driving integration of CHA and conventional healthcare. The purpose of this thesis was to identify factors that facilitate successful integration of CHA and conventional healthcare practices. To address this purpose, an answer to the following research question was sought: What are the principal driving forces that support the development and maintenance of Integrative Healthcare? Interviews with a convenience sample of eight allopathic providers were conducted to gain knowledge about their use of CHA, IH, or referral for these healthcare therapies. Participants were selected based on their current or potential involvement with CHA and/or IH. Roger's theory of the progressive stages used in adopting change was employed to guide the study. Qualitative analysis was conducted to identify major concepts and subconcepts. Based on the participants' responses, four key concepts and 4 subconcepts emerged. The major concept of perceived benefits was further narrowed to include clinical outcomes and financial outcomes. Other key concepts included growth of CHA and IH, and facilitators to utilization of CHA and IH. The fourth key concept was satisfaction which included the subconcepts of provider and patient satisfaction. All participants reported improved clinical outcomes, positive impact on the financial health of clinics/facilities, and enhanced provider and patient satisfaction through utilizing or referring for IH or CHA. Given the growth of IH, it is paramount that providers meet the demand for IH in a competent manner by educating themselves and developing alliances with reputable and knowledgeable CHA practitioners. Models of care delivery for IH need to be developed and tested. Finally, additional large scale studies are needed to validate the findings of this study and identify other facilitators that impact integration of CHA and allopathic healthcare.

CHAPTER ONE

INTRODUCTION

In the past few decades there has been enormous growth in the use of complementary health approaches (CHA) (formerly called complementary and alternative medicine or CAM). The CHA movement began in the United States (U.S.) in the early 1970's on the West Coast and quickly spread to other areas of the country. In 1990 a study published by the Journal of the American Medical Association revealed that 33.8% of the US population utilized CHA (Eisenberg et al., 1998). More recent data demonstrate a gradual but steady increase in the use of CHA in the U.S. In 2007, the National Center for Complementary and Alternative Medicine (NCCAM) released results of a study that identified that 38% of the United States population included CHA in their healthcare practices (NCCAM, 2009).

This interest in alternative approaches to addressing healthcare needs has led to the development of Integrative Healthcare (IH), an approach that seeks to bridge allopathic and CHA healthcare systems. As defined by NCCAM (2009), Integrative Healthcare "combines mainstream medical therapies and CHA therapies in a coordinated way." Integrative Healthcare is a relatively new term that emphasizes the combination of CHA and conventional healthcare to address the biological, psychological, social, and spiritual aspects of health and illness. The World Health Organization (WHO) identifies these practices as "integrated health services" and defines them as "The management and delivery of health services so that clients receive a continuum of preventive and curative

services, according to their needs over time and across different levels of the health system” (WHO, 2008).

The healthcare system in the United States has traditionally focused on disease management with a limited focus on disease prevention and wellness promotion. There is mounting evidence that conventional healthcare alone cannot address the growing epidemic of chronic disease which costs consumers 1.5 trillion dollars a year, or 75% of all medical expenses in the U.S. annually (Center for Disease Control and Prevention [CDC], 2008). Concomitantly, there is increasing awareness of the limitations of conventional healthcare and there should be an increased focus on the prevention of illness, health promotion, and healthful living (Maizes, Rakel, & Niemiec, 2009). "Integrative healthcare comes from a growing recognition that high-tech medicine...cannot address the growing epidemics of chronic disease that are bankrupting the US domestic economy" (Maizes, et al., 2009, p 3). This recognition is reflected by the inclusion of 63 services for the prevention of illness and the promotion of wellness deemed to be “essential benefits” in the Affordable Care Act (U.S. Health and Human Services, 2010).

Integrative healthcare is seen by some as a potential solution to the rising healthcare costs and disease burden in this country (Maizes, et al., 2009). By focusing on the whole person and lifestyle, and not just the physical body, a renewed attention to healing using all appropriate therapeutic approaches, whether they originate in conventional or alternative medicine, may be one answer to decreasing healthcare costs and increasing patient-centered care.

Background and Significance

Integrative Healthcare focuses on treating the person as a whole with a proactive approach that emphasizes health and wellness versus a reactive approach that focuses on treating disease. There is growing evidence that a healthcare focus on health and wellness of the “whole” person improves patient outcomes and patient satisfaction (Baer, 2004; Maizes et al., 2009). One of the key concepts of IH is a patient-centered approach which has been associated with improved adherence to treatment regimens and health outcomes (Bann, Sirois, & Walsh, 2010). These authors stated that the patient-centered approach is considered essential to care delivery and is widely viewed as playing an important role in patient outcomes by providing the context for healing.

Driven by consumer demand, IH is increasingly being accepted by healthcare providers, hospitals, and academic institutions. By the mid 1990’s U.S. hospitals began to open Integrative Healthcare clinics and in 1999 the Consortium of Academic Health Centers for Integrative Medicine was founded (Benda, 2009). In 2014 the consortium changed its name to the Academic Consortium for Integrative Medicine & Health (n.d.) and has 56 members including John Hopkins, University of Arizona, Duke University, and the Mayo Clinic. The goal of the Consortium is to advance the practice of Integrative Healthcare by bringing together medical colleges to include this healthcare model in their curricula. Another indication of the forward evolution of IH is the board certification of physicians in Integrative Medicine by the American Board of Physician Specialties (ABPS). The announcement of the new certification generated an "overwhelmingly positive" response, so much so that the first certification exam had to be delayed from

May 2014 to November 2014 to accommodate the "tremendous demand" (ABPS, pg 1, 2014).

Nursing as a profession has a long standing history of treating individuals from a holistic perspective (Mittelman et al., 2010). The focus and intention of Integrative Healthcare fits well with the holistic perspective of the nursing profession. Nurse practitioners too are making strides towards education in IH. The University of Minnesota offers a Doctor of Nursing Practice in Integrative Health and Healing. It is one of the first programs of its kind in the United States (University of Minnesota, n.d.).

The consumer driven rise in CHA utilization requires the support of healthcare professionals through development of evidence-based practices, open provider-patient communication, and an adequate knowledge level by practitioners and patients regarding CHA. To fully support and guide patients in healthcare, practitioners need to be educated and mindful of the changing tapestry of healthcare and the continued emergence of Integrative Healthcare. Education and knowledge are essential to successful interaction with other practitioners and with patients to provide safe and effective care. Nurse Practitioners must have a working knowledge of CHA, how they interact and work with traditional therapies, and confidence in communication with patients and practitioners regarding these practices.

Problem Statement

Integrative Healthcare is steadily growing; consumers like it and are demanding it. The research, however, needs to catch up to this reality. The factors which facilitate the successful integration of complementary health approaches with conventional

healthcare into an integrative model of healthcare have not been identified or studied. Still in its infancy, there is much to be learned about Integrative Healthcare and how to successfully develop, implement, and expand this healthcare delivery model. If the standard of healthcare is to be truly patient centered, patient/family inclusive, therapeutically effective, cost effective, and satisfying to the practitioner, and also if IH contributes to these outcomes, then identifying factors that support the development of Integrative Healthcare is necessary.

Purpose of the Study

The purpose of this study was to identify factors that facilitate successful integration of CHA and conventional healthcare practices. The research question that was pursued to achieve this purpose was:

What are the principal driving forces that support the development and maintenance of Integrative Healthcare?

To address this research question, a sample of Integrative and Conventional Healthcare practitioners in the state of Montana was interviewed.

Theoretical Framework

The theoretical framework used for this study was Roger's Theory of Diffusion and Innovation. This theory focused on the progressive stages used in the process of adopting change (Geraci, 2004). The integration of CHA with the mainstream of healthcare has prompted a progressive change in the delivery of healthcare. This change fits well within the constructs of Roger's theory.

Roger's theory encompasses five characteristics that influence the success and rate of adoption and change (Geraci, 2004):

Relative Advantage - there must be some advantage or improvement to the current system. The degree to which an innovation is perceived as being more valuable than the idea it replaces or supplements, is positively related to its rate of adoption. For example, the integration of CHA with conventional healthcare needs to offer some advantage, such as improved patient outcomes, patient satisfaction, or provider satisfaction, in order for the provider to adopt it.

Compatibility – the innovation or change must be compatible with existing values, norms, and needs of potential adopters. The more consistent an innovation or change is with values, past experiences, and needs, the more rapidly it is likely to be adopted.

Complexity – the degree to which an innovation is perceived as relatively difficult to understand and utilize is negatively related to its rate of adoption. The greater the complexity appears to potential users, the slower the rate of adoption.

Trialability - the extent to which the change can be experimented with and tried on a limited basis. Innovations which can be divided into smaller increments, and designed such that they can be tried more easily, are more rapidly adopted than those which are not divisible. Trying a new healthcare concept allows both clinicians and consumers to explore the potential value and the outcomes of utilizing the innovation. The greater the experience through trying the innovation, the better the understanding and adoption of the change. Trials serve to allay ambivalence about the new idea.

Communicability - Communicability is how well the intended change or innovation can be clearly expressed to others. Communication used to convey

information about clinical practice includes many avenues: for example, individual interaction, mass media, the world wide web, and workshops. Research suggests that the most effective communication strategy is face-to-face exchange (Bero, Grilla, & Grimshaw, 1998). This provides an opportunity to tailor information to recipients and allows the advocate of the change to discuss and explain why a shift in clinical approach should be considered.

According to Rogers (1983) innovations or changes that are perceived as having greater relative advantage, compatibility, trialability, communicability, and lesser complexity will be adopted more rapidly. It is possible that the rapid expansion of CHA and the development of Integrative Healthcare have been fueled by these factors.

Assumptions

A few assumptions were made prior to this study. It was assumed the respondents involved in this study would provide honest responses during the interview. It was also assumed that the data gathered had the potential to provide valuable information for the future development of IH.

Definitions

In the following section, definitions of various terms used in this study are provided:

Complementary Health Approaches (CHA) is defined as “a group of diverse medical and healthcare systems, practices, and products that are not presently considered to be part of conventional medicine. (National Center for Complementary and Integrative

Health [NCCIH], 2014). This term is synonymous with Complementary and Alternative Medicine (CAM).

Conventional Healthcare is defined by NCCIH as “medicine that is practiced by holders of M.D. (medical doctor), and D.O. (doctor of osteopathic medicine) degrees and by allied health professionals, such as physical therapists, psychologists, and registered nurses.” (NCCIH, 2014). This term is synonymous with Allopathic Medicine, Biomedicine, and Western Medicine.

Integrative Healthcare is defined by NCCIH as “combining treatments from conventional medicine and CHA for which there is some high-quality evidence of safety and effectiveness.”(NCCIH, 2014).

CHAPTER TWO

REVIEW OF LITERATURE

The purpose of this study was to identify factors that facilitate successful integration of CHA and conventional healthcare practices. The literature review includes central topics relevant to Integrative Healthcare, with a focus on studies addressing use of Complementary Health Approaches and IH, institutions of higher learning and IH, attitudes of Allopathic providers about CHA, and governmental influence on Integrative Healthcare. An historical perspective is also provided to clarify the background and development of modern day IH.

Historical Background of Integrative Healthcare

A review of the history of Integrative Healthcare can provide a contextual understanding and point of reference from which IH began its emergence in the late 1990s. The literature suggests that the relationship between CHA and conventional healthcare is best viewed as a sequence of historical movements. The presence of an array of medical systems is not new to the United States (Baer, 2001). A variety of healing therapies flourished in the early 19th century as homeopaths and purveyors of water cures competed successfully with medical doctors. Their 'natural' therapies were more popular with patients than the drastic and often ineffective practices, such as purges and bleedings, used by regular physicians (Baer, 2001). In the first quarter of the 20th century conventional healthcare began to gain a foothold as the dominant method of healthcare delivery and was fueled by the Flexner report which was published in 1910

(Beck, 2004). The report recommended that more than half of the medical schools across the United States and most non-allopathic schools be closed. The report indicated that it was imperative that medical education focus on 'science' and be free of 'dogma'. Flexner's recommendations were quickly endorsed by the American allopathic medical communities and over the next 25 years close to 60% of medical schools were closed (Beck, 2004; Maizes, 2009). What is now called Complementary Health Approaches (CHA) was pushed out of the mainstream with the majority of schools providing training in therapies such as naturopathy and homeopathy being forced into closure (Maizes, et al., 2009).

The 1960s-1980s saw an increase in interest in CHA fueled by the movements toward self-help and feminist health movements which began to challenge previously-held medical definitions of health and treatment options (Baer, 2004). The goal of the feminist movement was self-actualization with a primary importance placed upon the rights of women to determine the course of their own healthcare. The Boston Women's Health Book Collective's *Our bodies, ourselves* (2005) emphasizes the need for women to not only assume responsibility for their bodies, but to recognize the mind-body-spirit connections in addressing their health and healthcare. This book has gone through 4 editions since its release in 1984 and remains a relevant resource for women today. As Baer (2004) argued, these movements were also synonymous with the 'holistic health' and 'New Age' movements that foreshadowed the re-emergence of the CHA professions in the late twentieth century. This challenge led to the partial loss of medicine's control over clients in that patients were actively seeking health options outside of the traditional medical framework.

The reemergence and growth of CHA in the past decades has led to development of various organizations both in the private and public sectors that seek to guide and support CHA and Integrative Healthcare. In 1977 the American Holistic Medical Association was created by MDs and DOs who had begun to incorporate CHA therapies into their practices (Baer, 2004). In 2014 the association changed its name to the Academy of Integrative Health & Medicine (n.d.). It now encompasses many different types of practitioners other than MDs and DOs such as nurses, acupuncturists, and psychologists. Nursing was not far behind the medical profession and developed the American Holistic Nursing Association (n.d.) in 1980. Today this organization has 5,400 members in the U.S. Another organization that made an impact on the progression of CHA and Integrative Healthcare is the Office of Alternative Medicine. It was created in 1992 as a division of the National Institutes of Health (NIH), was mandated by Congress, and had a budget of two million dollars (Baer, 2004). Its mission is to fund and conduct research in the field of Integrative Health. Its name was changed in 1998 to the National Center for Complementary and Alternative Medicine (NCCAM). In 2014 it was renamed the National Center for Complementary and Integrative Health (NCCIH, n.d.) with an annual budget of 124.1 million dollars for the 2015 fiscal year.

Use and Growth of Complementary Health Approaches and Integrative Healthcare

According to King, Pettigrew, & Reed (1999) consumers are voicing their dissatisfaction with the high tech, low touch, cost driven, depersonalized care they are receiving and voting with their dollars. Population based studies such as the National

Health Interview Survey (NHIS), revealed that consumers are using CHA to lower their personal healthcare costs (Pagan & Pauly, 2005). The latest NHIS survey indicated that CHA use was considerably more common among respondents who indicated they had difficulty obtaining healthcare due to cost. These authors suggested that the increasing numbers of Americans without insurance would drive more CHA utilization.

Foster, Phillips, Hamel, & Eisenberg (2002) observed that CHA use varied by income, "43 % CHA use among those with annual incomes less than $20,000; 37 % among those earning $20,000 to $30,000 per year; 44 % among those earning $30,000 to $50,000 per year; and 48 % among those with annual incomes above $50,000 (p. 1562)." In addition, the average annual out-of-pocket expenditures on CHA rose with each income quartile corroborating that those with higher incomes utilized more CHA therapies. Although the data indicated that CHA use appeared to be highest among those with higher incomes, the data also showed that 43 percent of those in the lowest income group (those with incomes less than $20,000 per year) used CHA therapies routinely, confirming that CHA use is prevalent in all socio-demographic segments of our society.

The past decades have shown steady growth of CHA and IH as consumers seek care outside of the traditional medical establishment. The first nationally representative study of prevalence, costs, and patterns of use of Complementary Health Approaches (CHA) was conducted in 1990. The results indicated that 25% of Americans used Complementary Health Approaches (Eisenberg, et al., 1993). A follow up study done by Eisenberg et al. (1998) indicated an increase in CHA use in the U.S. with 33.8% of respondents indicating they used this type of healthcare. This study also revealed there was increasing integration of CHA and conventional medicine in numerous settings:

hospitals, private physician practice, integrative medicine centers, and cancer treatment centers. Also, increasingly health maintenance organizations and insurance companies are covering some CHA.

In 2007 about 38 % (83 million) of U.S. adults aged over 18 years and approximately 12 percent of children used some type of CHA (Nahin, Barnes, Stussman, & Bloom, 2009). In dollars this equals 33.9 billion spent out of pocket on visits to CHA practitioners and purchases of CHA products, classes, and materials. This represents 11.2 % of total out-of-pocket expenditures on healthcare. Total annual visits to CHA providers in 2007 were more than 300 million.

A report by Monmaney and Roan (1998) shows a different slant on the growth of CHA. The table below illustrates the tremendous growth of homeopathic practitioners, massage schools, drugstore shelf space, and herbal supplement sales from 1969-1998.

Table 1. Growth in CHA

Homeopathic Practitioners	1970: 200	1998: 3,000
Massage Schools	1969: 15	1998: 800
Drugstore Shelf Space*	1995: 8 feet	1998: 22 feet
Herbal Supplement Sales	1994: 2.09 billion	1997: 3.65 billion
*Space per store for vitamin, mineral, and herbal supplements at Rite Aid pharmacies.		

The 2002 NHIS queried respondents about their reasoning for using CHA modalities (Barnes, Powell-Griner, McFann, Nahin, 2004). More than 54 % believed that CHA therapy along with traditional medical treatment would help them, 50.1 % thought

that CHA would be interesting to try or test, and 25.8 % indicated CHA had been recommended by a traditional medical provider. In addition, 27.7 % thought traditional medical therapy would not be helpful and 13.2 % believed traditional medical modalities were too costly.

Kessler et al. (2000) asked participants how likely they were to continue using CHA once such therapy were initiated. The study revealed that 50 % of all CHA therapy use continued at the 5 year mark after initiating the modality. This suggests that persistent use of CHA may be geared towards prevention of illness and to maintain health. Other researchers such as Astin (1998) have also found that the majority of CHA therapy was utilized to maintain health and vitality and prevent illness.

Institutions of Higher Learning and Their Influence on Integrative Healthcare

Academic institutions have responded to the demand for CHA by including CHA in education in various ways. In 1995 a national conference on complementary and alternative medicine involving the NIH recommended CHA curriculum be included in medical and nursing education (Berman, 2001). Of 125 academic institutions queried in 1997, 91 have included CHA as a part of their curriculum (Wetzel, Eisenberg, & Kaptchuk, 1998). The curriculum varied greatly with the majority of content offered as electives and only a modicum of core curriculum lectures. Although medical students responded favorably and pushed for the inclusion of integrative medicine as a part of their curriculum, the responses of faculty varied from supportive to hostile.

Healthcare providers have demonstrated that they want and are supportive of CHA education. One study conducted by Krietzer, Mitten, Harris and Shandeling (2002) queried 627 students and faculty from medicine, nursing, and pharmacy. Ninety percent of the respondents favored integrating CHA into education and clinical care. Comparisons between the three professional groups revealed that nursing was more favorable towards CHA than medicine or pharmacy.

By 1998 at least a dozen major medical schools had created integrative medicine programs. These include: the University of Arizona, University of California Los Angeles, Columbia, Harvard, and the University of Maryland among others (Berman, 2001). The Consortium of Academic Health Centers for Integrative Medicine (CAHCIM) is tasked with developing new models of clinical care and innovative IH educational programs in addition to performing rigorous scientific studies related to Integrative Healthcare (Maizes et.al, 2009). The Consortium also holds a large IH research conference annually. It is supported by membership dues and grants from philanthropic partners such as the Bravewell Collaborative.

It is well recognized that nurses practice within a holistic framework which is consistent with Integrative Healthcare (Burman, 2003). The premise of holistic care is on health and wellness, not on diagnosis and cure. Burman (2003) found, however, that the curricula in nursing and nurse practitioner (NP) programs generally lacked training in CHA. The majority (98.5%) of respondents of a survey sent to all NP schools in the U.S. had incorporated CHA in some form in their courses. Eighteen percent of the programs had both integrated and stand-alone courses. Despite the curriculum changes, 70% of the faculty reported their CHA ‘expertise’ was self-taught and 16% had no CHA preparation.

This study found that a primary barrier to offering CHA in nursing curriculum was that many educators had little background or preparation in CHA. When they did it was often obtained through self-study. Additional studies have found similar results that support the desire by students and faculty to incorporate CHA into nursing undergraduate and graduate curriculum. It is well documented in the literature that a gap in the education of healthcare providers and academic faculty can lead to reluctance to discuss CHA therapies (Stevenson, Britten, Barry, Bradley & Barber, 2003; Hayes & Alexander, 2000).

In 2002, fifteen NCCAM grants were awarded to nursing and medical schools in the U.S. (Booth-LaForce, et.al, 2010). The University of Washington (UW) was one of the schools to receive a grant for the purpose of facilitating and evaluating the incorporation of CHA material into the nursing curriculum. Close to 50% of the nursing faculty at UW incorporated CHA content into their courses. After the pilot program, surveys of students and faculty indicated that 97% of students believed incorporation of CHA into course content was important and beneficial and faculty indicated the amount of CHA content was adequate or not enough. Since completion of the pilot program, UW has sustained the changes that were incorporated into the curriculum. In 2006 they added a graduate certificate program in CHA that is a direct result of the NCCAM grant.

Montana State University started its first stand-alone courses in CHA in the 2014-2015 academic year (personal communication, L. Marx, January 17, 2015). The University of Minnesota (n.d.) is one of the only institutions in the U.S. that offers a DNP in Integrative Health in addition to offering CHA courses for their undergraduate and graduate nursing students.

Attitudes of Conventional Healthcare Practitioners Regarding CHA

The literature on healthcare provider attitudes toward CHA is large and growing (Hirschkorna & Bourgeault, 2005). The available evidence suggests that patient demand has a significant influence on health provider behavior and that attitude, along with training, is the strongest predictor of providers utilizing CHA in their practice.

Astin, Marie, Pelletier, Hansen, & Haskell (1998b) conducted a literature review of 25 research studies that were published between 1982 and 1995 on incorporation of CHA into mainstream medicine. Reviews of research on the practices and attitudes of medical providers regarding CHA found that large numbers of providers were referring or practicing some form of CHA, yet there were methodological limitations in the publications under review, most notably, small sample sizes. In this review, physician attitudes toward specific CHA therapies, referral patterns, and reasoning behind advocating for specific CHA therapies were explored. Physicians had a range of responses to patients' desires to use CHA, both positive and negative. On the negative side, opponents were concerned that CHA providers did not possess adequate knowledge to diagnose, there was a lack of evidence on the efficacy of CHA, these modalities could be potentially harmful, and patients might not seek appropriate medical advice or care. Astin et al. (1998b), however, also acknowledged, "By contrast, clinicians have become strong proponents of particular types of CHA, regardless of whether or not there is scientific evidence of efficacy (p. 2308)."

A more recent study of medical students throughout the U.S. found that 49% had used CHA themselves (Abbott, et al., 2011). The authors also found that 74% believed IH

would be more effective than conventional or CHA provided independently. Eighty-four percent believed that CHA includes ideas and therapies that could benefit conventional medicine, yet many are unwilling to use CHA for their future patients due to lack of studies evaluating the efficacy of CHA.

The popular demand for CHA, as measured by Eisenberg et al. (1993,1998), coupled with the work of Astin et al. (1998b) and Abbott et al. (2011), provided converging evidence of social change during the period. The tension between the consumer-driven demand for CHA and the hesitation of providers to recommend CHA, due to the variety of factors discussed above, raises questions about the degree of constraint these factors have on providers' practice behaviors.

Literature regarding attitudes of nurse practitioners about CHA is elusive. An extensive literature search regarding this topic yielded virtually no results and revealed a significant gap in the literature compared with the growing body of literature on the topic with physicians.

There is a small body of literature regarding attitudes of nurses about CHA. A literature review from 2000-2009 conducted by Trail-Mahan et.al, (2013) on this topic yielded 80 results. The majority of these studies were related to nursing students and faculty regarding CHA in nursing education. Few studies focused on the attitudes or knowledge of hospital-based nurses and CHA and those studies were performed in countries other than the U.S. These same authors conducted a descriptive study on knowledge and attitudes about CHA among acute care registered nurses in California. They found that these participants had limited knowledge of very basic CHA terminology and practices. The nurses strongly believed that patients have the right to utilize CHA

therapies along with conventional medical modalities. They felt ill equipped, however, to counsel patients about CHA therapies and believed they should not be responsible for assessing patients' use of CHA. The authors surmised that these knowledge deficits would limit the nurses ability to accurately assess patients use of CHA, educate patients about CHA, or advocate for CHA opportunities.

Fearon (2003) conducted a descriptive study in the United Kingdom (U.K.) on the attitudes about CHA of different types of healthcare providers including nursES. The results showed that 64% of nurses had positive attitudes about CHA therapies and felt these modalities were effective for patients and themselves. The author reasoned that the positive attitudes may have been linked to use of CHA by the participants. The use of CHA by the study participants was much higher in this study than in other studies according to Fearon, 2003. This study also found that respondent knowledge about CHA was limited and 68 percent lacked confidence to discuss CHA with patients.

Based on the studies reviewed, what is lacking for nurses is a level of comfort with their CHA knowledge base, with assessing their patients for CHA use, and with discussing CHA with their patients. These themes were echoed in various studies (Fearon, (2003); Trail-Mahan, et.al (2013). For example, the nurses surveyed by Trail-Mahan strongly agreed that patients have the right to IH but they were ambivalent about their role in the integration of CHA and conventional medicine. The majority of the respondents did not think nurses should be accountable for educating patients about CHA, assessing patients for CHA use, or answering patients' questions about the subject.

Integrative Healthcare Outcome Studies

Outcome studies about the integration of conventional medical care and CHA are beginning to emerge in the literature. One study by Greeson, Rosenzweig, Halbert, Cantor, Keener, and Brainard (2009) evaluated changes in health-related quality of life (HRQoL) in patients utilizing IH in a large academic center. The investigators evaluated patient characteristics and HRQoL treatment outcomes and found that utilization of IH for these patients significantly improved their HRQoL.

In 2011, the Bravewell Collaborative (Horrigan, Lewis, Abrams, Pechura, 2012) commissioned a study to investigate how IH was being practiced across the U.S. The researchers did a mapping study that looked at patient populations, health conditions being treated, defined core practices, identified values and principles underlying care, reimbursement practices, and attempted to determine the factors driving successful implementation of IH. The two main themes regarding factors driving IH implementation were clinical success and long-term viability. Factors recognized as influencing clinical success included treating the patient with holism, utilizing an evidence-informed approach, encouraging collaboration among providers, and developing “Best Practices” (p. 52). Building connections between IH clinics and hospitals/healthcare systems, continual development of providers and faculty, and mindfulness of financial performance were considered keys to long-term viability of IH clinics.

The Arizona Integrative Health Center is currently conducting a three year study titled: Integrative Medicine PrimAry Care Trial (IMPACT). This study is currently underway and results are not yet available. The researchers are evaluating clinical

outcomes, patient quality of life, patient and provider satisfaction, utilization, and cost factors. The impetus for this study is to develop patient-centered models of care, decrease the burden of chronic disease, and lower healthcare costs (Herman, et al., 2014).

Cotton, Luberto, Bogenschutz, Pelley, and Dusek (2014) investigated the potential benefits of IH on pain in hospitalized children and adolescents at a large academic pediatric medical center. Referrals for CHA primarily came from nurses (41%) and the majority of interventions were body-based therapy (e.g., massage therapy-77%). Other modalities included healing touch, music therapy, and breathing techniques. Around 45% of patients received two therapies at the same visit. The researchers found that both pain and relaxation showed significant improvement with these patients after primarily massage therapy and healing touch interventions. This study demonstrated IH can improve pain management in this patient population.

Another study on IH and its effect on health outcomes and lifestyle adherence was conducted at an academic teaching hospital in the U.S. (Michalsen, et al., 2005). This was a larger study with 1825 participants. Each participant chose whether to follow a 7 day fast or a normocaloric vegetarian diet. In both groups quality of life indicators increased significantly at discharge. The main disease-related complaint, however, was significantly improved in fasters versus nonfasters. Additionally, fasting patients had better conformity with certain lifestyle practices, such as physical exercise and relaxation, than the group following the vegetarian diet.

Governmental Influence on CHA and Integrative Healthcare

Governmental influence has had an impact on the forward progression of IH at the state and federal level. Over the past few decades there have been governmental agencies and mandates which have affected the development of public policy, consumer and practitioner education, and utilization of CHA and IH.

Federal Government

The federal government's involvement in healthcare takes place through various avenues including administration of Medicare, the work of agencies such as the Food and Drug Administration (FDA), and by setting national research priorities through the allocation of research funds. Some examples of the direct implications of federal intervention for the CHA sector include creating the National Center for Complementary and Integrative Healthcare (previously known as NCCAM) within the National Institutes of Health (NIH) in 1992, and consequent funding of clinical research trials of CHA therapies. Other influences include Medicare coverage of CHA services (limited to chiropractors, to date); and FDA regulation of medical supplies such as acupuncture needles and biofeedback devices (Baer, 2004).

In 2000 President Clinton established the White House Commission on CAM to provide recommendations to ensure that public policy maximized the potential benefits of CHA to all citizens of the United States. The commission made recommendations that focused on research, development and dissemination of information about CHA, ensuring the safety of CHA products and services, and guidance about appropriate access and

delivery of CHA (White House Commission on Complementary and Alternative Medicine Policy, 2002). There are no documented results about the implementation of these recommendations or related outcomes.

The Veterans Administration (VA) covers a vast array of CHA therapies for its beneficiaries. The VA Field Advisory Committee conducted a study in 2011 and found that 89% of VA facilities utilized CHA therapies. The primary reasons cited for offering CHA was to promote wellness, respond to patient preferences, and provide an adjunct to chronic care (Kozak & Ananth, 2012).

State Government

In the U.S., much governmental regulation in healthcare emanates from state rather than federal agencies. One example of this is the regulation of the health professionals through licensing which is managed at the state level. Also state-based are healthcare providers' requirements for certification and training, and their legal scope of practice. Additionally, states can mandate coverage by health insurance companies for services delivered by both traditional and CHA providers and have control over the types of services and providers deemed eligible for reimbursement under Medicaid programs (Sturm & Unutzer, 2000). Several states have mandated that payors include reimbursement for CHA services which can lead to access and utilization of IH. The coverage varies in each of the states. The most well-known example of this is the state Washington which in 1995 was the first state in the U.S. to pass a law mandating health insurance coverage for CHA providers (Lafferty et al, 2006). Payers in Washington provide reimbursement for more CHA services than any other state in the U.S. This

mandate has served as a catalyst for other states to mandate coverage of some CHA services.

CHAPTER THREE

METHODS

The purpose of this study was to identify factors that facilitate successful integration of Complementary Health Approaches and conventional health care practices. This chapter includes a summary of the methods used for this investigation including the design, population and sample, setting, procedures for data collection, human subject considerations, and analysis methods.

Design

A qualitative descriptive design was utilized in this study. This method was chosen to allow the participants to describe their experience with IH and what factors they have found that lend to its success. An inductive approach to conducting qualitative research is suitable for this exploratory and descriptive research project in order to establish an understanding between the research purpose and the results derived from the interviews.

Population and Sample

A purposive convenience sample of eight licensed healthcare providers with prescriptive authority participated in the study. Potential participants were selected based on their current or potential involvement with CHA and/or IH. Qualified participants were identified through internet searches and professional networking. Participants were either a practitioner in an Integrative Healthcare clinic or in a conventional health care

setting. Other criteria in identifying participants were the participant's availability and willingness to take the time to participate within a timeframe that was conducive to study deadlines. Each potential participant was contacted by telephone, e-mail, or in person to determine his or her willingness to be involved with the study. Once the individual agreed to participate in the study, the participant was sent an interview guide and consent form by e-mail. The consent form was then returned to the researcher at the interview or by mail.

Procedures for Data Collection

An interview was conducted either in person (6 participants) or by telephone (2 participants). The investigator interviewed the participants during an 8 week period of time from mid-January-mid March, 2014. In person interviews took place in local public eateries in the community. Data were gathered by focused interviews using a prepared interview guide. The semi-structured interview format allowed participants to be asked questions that allowed for open-ended responses. Additional questions were asked based on the participant's responses.

Audio recording and field notes were utilized to document the responses of each participant. Permission was obtained from each respondent to tape record the interview.

Instrument and Data Collection Methods

The instrument for this study was an interview guide developed by the investigator (see Appendix A). The semi-structured questions were open-ended to allow the participants more flexibility and creativity to respond to the questions.

The interviews were tape recorded and later transcribed word for word. The transcripts were reviewed by the investigator while simultaneously listening to the tape recording to ensure their accuracy.

Each interview took approximately one hour. Basic demographic information was gathered from the participants at the beginning of the interview that included: location of residence, gender, years in practice, years practicing IH or referring to CHA practitioners, number of patients seen per week, training in CHA including specific modalities and length of training.

Human Subjects Consideration

The study was approved by the Montana State University Institutional Review Board (IRB) on December 16, 2014. To ensure that participants understood the study process, potential risks or benefits, the right to refuse participation, and the protection of each participant‘s confidentiality, a signed consent form was obtained from each person who participated in an individual interview (see Appendix B).

All data including the tapes, transcripts, and consent forms was maintained in a locked file cabinet. The investigator possessed the key at all times and was the only individual who had access to the data.

Data Analysis

The data generated from the interviews were analyzed for similarities and differences using inductive content analysis (Elo & Kyngas, 2008). The goal of this analysis technique is to describe the phenomenon by identifying concepts and

subconcepts which are derived from the data collected. Elo & Kyngas (2008, p 109) described this as “an approach based on inductive data moves from the specific to the general….this process includes creating categories and abstraction.” Grouping data limits the number of categories by sorting similar data into broader categories. Creating categories and subcategories provides a means of describing the phenomenon; increasing understanding, and providing knowledge. Once the categories and sub categories are generated, the researcher returns to the data to confirm the reliability of the categories. Transcribed interviews were read and reread and memos or notes were made in the margins with phrases, thoughts, and key concepts identified.

CHAPTER FOUR

RESULTS

In this study, factors that facilitate successful integration of Complementary Health Approaches and conventional healthcare practices were explored. The results of the study are reported in this chapter. An answer to the following research question was sought: What are the principal driving forces that support the development and maintenance of Integrative Healthcare?

The study participants were eight Allopathic providers who referred clients for CHA or practice IH in the state of Montana. Six were interviewed in person and two were interviewed by phone. Each interview was audio-recorded after informed consent (Appendix B) was obtained. Informed consent was obtained by e-mail correspondence for those interviews conducted by phone. Interviews were structured around an eighteen question Interview Guide (Appendix A) that the participant had an opportunity to review prior to starting the interview.

Demographics

All eight participants were female who worked in various outpatient clinics. Seven providers practiced in Allopathic settings and one practitioner practiced in an Integrative Healthcare setting, the only one identified as such in the state of Montana. All providers were either Physician Assistants or Nurse Practitioners. Their length of practice varied from 1.3 years to 16 years. All lived in the state of Montana and practiced in one

of two communities with populations of either 38,000 or 69,000. The number of patients seen per week ranged from 14-81.

Table 2. Demographics of Study Participants

Number of participants 8	
Gender	
Female	8
Male	0
Practitioner type	
Physician Assistant	3 (37.5%)
Nurse Practitioner	5 (62.5%)
Specialty	
Internal Medicine	2 (25.0%)
Family Practice	3 (37.5%)
Integrative Medicine	1 (12.5%)
Oncology	2 (25.0%)
Years in practice	
< 5 years	2 (25.0%)
5-10 years	1 (12.5%)
10-15 years	2 (25.0%)
>10-15 years	3 (37.5%)
Population of community served	
69,000	1
38,000	7
Number of patients per week	1
14-20	2
21-40	2
41-60	2
61-80	1
80+	

Seven of the participants referred for CHA therapies and one participant practiced IH. The frequency of referral ranged from 1-2 times per month to several times per week and the number of years participants had been referring for CHA was 1 to 16. Only 3 of the participants had training in CHA (see table 2).

Table 3. Integrative healthcare practitioner practice patterns

Number of years referring to CHA or practicing IH	
<5 years	2 (25.0%)
5-10 years	1 (12.5%)
10-15 years	3 (37.5%)
>15 years	2 (25.0%)
Practitioners with CHA training	3 (37.5%)
Frequency of referral to CHA or IH practice	
1-2 times per month	1 (12.5%)
1-2 times per week	2 (25.0%)
Almost every day	3 (37.5%)
Every day	2 (25.0%)

Study participants reported a variety of Complementary Health Approaches which they either referred for or practiced, ranging from acupuncture and chiropractic to essential oils and yoga. Table 3 lists these different modalities and the number of study participants who either practiced or referred for each.

Table 4. Types of CHA modalities participants refer for or practice

Modality	Number of participants
Naturopathic	3 (37.5%)
Acupuncture	5 (62.5%)
Massage	4 (50.0%)
Essential oils	2 (25.0%)
Meditation	1 (12.5%)
Yoga	2 (25.0%)
EMDR*	2 (25.0%)
Supplements (including probiotics)	8 (100%)
Chiropractic	2 (25.0%)
Ayurveda	1 (12.5%)

*Eye movement desensitization and reprocessing

Responses among the participants to the question of why there has been an increased focus of IH in our healthcare system included: consumer demand, a push towards wellness, distrust of pharmaceutical companies, fragmentation and depersonalization of conventional healthcare, and increased access to information about CHA and IH. Other reasons cited focused on patients looking for new options, patients becoming more active in their care, and patients' perception that CHA and IH providers take more time with their patients.

Unanimously, participants believe the field of IH will continue to grow in the coming years and decades. Responses to the question of what facilitates the utilization of IH included: positive experiences with these practices, provider support of IH, provider openness, improved outcomes, coverage by insurance, and on-going IH research. Participants also believed that utilization of IH improved patient outcomes, patient satisfaction, and provider satisfaction.

Concepts

Grouping the concepts identified from the interviews allowed for major and subconcepts to be identified. Each major concept was given a title. Four major concepts emerged from the interviews; perceived benefits, satisfaction, rationale for growth of IH, and facilitators to utilization of IH. Similar subconcepts were grouped under each major concept (See table 4). Numerous supporting excerpts from the participants are included to provide richness from the data.

Table 5. Key concepts and subconcepts

Concepts	**Subconcepts**	**Descriptions**
Perceived benefits	Impact on clinical outcomes Impact on financial health	Improved symptom management Holism of patient care Offers edge over competitors Enhanced revenue
Satisfaction	Patient satisfaction Provider satisfaction	Patients convey satisfaction with incorporation of CHA Participants affirm improved satisfaction with inclusion of CHA
Growth of CHA and IH		Informatics Consumer choice directed towards natural healing Consumerism focused on holism and personalized care
Facilitators to utilization of CHA and IH		Provider beliefs Provider openness and support Improved outcomes Increased availability of information Evidenced-based studies

Perceived Benefits

This concept, perceived benefits, was identified as a major theme. Statements from the participants provided insight into their perception that referral to CHA or practice of IH was beneficial to their patients and their facility. Two subcategories; clinical outcomes, and financial outcomes, were identified when responses were grouped.

Impact on Clinical Outcomes

Participants unanimously identified that inclusion of CHA and the concept of IH improved clinical outcomes. The following quotations from participants support this subconcept:

"I have seen acupuncture help with cancer-related neuropathy and chemo-related nausea. I have seen patients get rid of their walkers and canes and get back in to what they want to do in life."

"Less illness, decreased pain, improved mental health. I see them [in clinic] less. They have less of an impact on society. Clinically, whatever I'm sending them for is definitely improved when they go to any of the alternative approaches."

"People who are in motor vehicle accidents who do acupuncture and massage, and who incorporate that with their PT, they just get better faster. They feel better. Yes, I have seen some very good outcomes."

"Treating the patient in a holistic way has a positive outcome. Like their psychosocial, just other aspects of who they are. CHA as an adjunct to narcotics has proven really helpful for my patients."

Impact on Financial Outcomes

Some of the study participants reported a positive financial impact from either referring for CHA or practicing IH, and some indicated that failure to refer may result in patients seeking care elsewhere.

"We compete with Billings Clinic. If we can provide the same kinds of CHA that they do then that keeps patients in Bozeman. There is definitely a demand for CHA. If we can provide it here then I do think it helps our financial health."

"I think if healthcare facilities don't start to incorporate CHA then they are going to lose money because people are seeking out these services."

Satisfaction

Patient and provider satisfaction were identified as sub concepts under the major concept of satisfaction. Every participant indicated that incorporation of CHA and IH has had a positive effect on patient and provider satisfaction:

"I absolutely believe CHA and IH positively affect satisfaction. Our prescription pad is not going to solve people's problems all of the time. Why not utilize the entire picture as opposed to just a handful of things that you've been taught in school?"

"I feel like patients really want to feel like their provider is open to alternatives, to all options. This fuels satisfaction for me and for them."

"I think treating the patient holistically and not just with medical care is improving their patient satisfaction, and mine as a provider. For sure."

Growth of CHA and IH

Another major concept identified was the growth of CHA and IH over the past few decades. King, Pettigrew, & Reed (1999) & Barnes (2004) identified one of the primary driving forces for IH growth was consumer demand. This was echoed by the

findings from this study's participants. Their explanations of why consumer demand had increased include:

depersonalization of allopathic medicine; patient dissatisfaction with traditional medicine including lack of time with providers and the desire to a more natural approach instead of pharmaceuticals; increased access to information about IH; increased patient involvement in their healthcare decisions.

Participants shared their perspective on why they believe there has been growth in these fields of healthcare:

"I think provider openness and improved outcomes are factors. Also, increased information from friends, the internet, from the media. I think the stamp of approval from your allopathic provider also positively affect utilization."

"I think its society wanting to take responsibility for their bodies."

"I'm hoping it is a push towards wellness and prevention. People are looking for natural ways. I think people are more involved with their healthcare."

Facilitators to Utilization of CHA and IH

The fourth major concept encompasses the facilitators that participants identified which enhance the utilization of CHA and IH:

"I think one of them is provider support. I think patients want approval for using CHA. Also, educating patients and showing them that yes, therapy will improve your energy level and decrease your nausea. It is showing them studies and actually talking about the scientific part of it."

"I think the biggest factor is making sure that you are referring them to a reliable provider. Making sure that the people that you are sending them to are really good at what they do."

"Affordability is huge. Practitioners who want to help their community by using a sliding scale. Finding practitioners who can balance paying their bill while taking care of their community. It's a team approach to caring for those in need."

"I think provider openness and improved outcomes are factors. Also, increased information. I think the stamp of approval from your allopathic provider also positively affects utilization."

Barriers to Integrative Healthcare

Although none of the interview questions specifically addressed barriers to IH, participants expressed concerns about challenges they encountered in their practices. Resoundingly, participants stated that the cost of CHA and IH was a huge barrier for patients. The lack of insurance coverage for CHA therapies combined with the financial constraints of many patients simply put IH out of their reach.

One practitioner stated that resistance from other providers was a barrier for her. She had a supervising physician who did not believe in any aspect of CHA and she often received opposition from him about her use of IH. This did not deter her from practicing IH.

Another provider expressed the challenge of keeping up with all the data and not having time to learn more about what was evolving in the realm of IH. Having only a small database of evidenced based studies was also a concern for two of the providers.

Principle Driving Forces Supporting Development and Maintenance of IH

Since one of the inclusion criteria for this study was involvement or interest in CHA and IH, it was not surprising that this sample of allopathic providers utilized and supported the practice of Integrative Healthcare. All providers interviewed observed improved patient outcomes when they included CHA modalities with traditional healthcare methods. They had observed improved symptom management with pain and nausea, most notably, and improved mental health. They believed treating the patient holistically, mind, body, and soul had a positive outcome for patients not only for physical issues but also for emotional health and fostering well-being. It was universal among the participants that improved patient outcomes directly led to patient satisfaction which influenced provider satisfaction. Further, a few of the providers believed that offering or referring for CHA services had a positive impact on the financial health of a facility by offering an edge over their competitors. Referring for CHA also offered indirect revenue advantage through patient's seeking care from providers who offer or support referral to CHA providers.

There appeared to be a relationship between the years of practitioner experience and the frequency of CHA referral. Practitioners with the most experience referred or incorporated CHA modalities every day or almost every day. Those with the least experience referred only 1-2 times per week or 1-2 times per month. Only three of the eight providers had been trained in CHA modalities and there did not appear to be a relationship between their training and frequency of usage or referral.

Only one practitioner practiced IH on a daily basis. She practiced in the only identified IH clinic in the state of Montana. She verbalized that an IH model of care is advantageous for the following reasons:

1. Accessibility to various modalities under one roof benefits both the patient and the provider.
2. Direct provider collaboration allows for care that is less fragmented. It also offers a level of confidence in the other providers in the practice through collaboration and sharing of workspace. In addition, it fosters sharing of ideas and problem solving to best address a patient's needs.
3. Enhances collegiality among the providers.

The participants also identified that provider beliefs, provider openness and support, improved clinical outcomes, readily available information about CHA and IH practices, and a growing body of evidence-based studies about these healthcare fields also facilitate the forward growth of IH.

Summary

In summary, the results of this study provided evidence that integration of CHA with conventional healthcare offers various facility, provider, and patient benefits. Participants' responses indicated clear support for incorporating CHA and IH. Additionally, several facilitators to successful integration of CHA and conventional healthcare were identified in the results of this study.

CHAPTER FIVE

DISCUSSION

The goal of this study was to gain insight into the factors that facilitate integration of CHA and conventional healthcare. To achieve this purpose a sample of allopathic providers who refer patients for CHA or who practice IH were interviewed. The research was designed to answer the following question: What are the principle driving forces that support the development and maintenance of Integrative Healthcare? Several factors that positively influence IH practice and CHA referral behaviors were identified in the study. Major concepts and sub concepts were identified that illustrate the major factors participants shared as facilitating inclusion of CHA and IH in their practices. This chapter includes a summary of the results, study limitations, and implications for practice and future research.

Summary of Results

The findings of this study offered insight into the participants' thoughts and perspectives regarding what factors they believe promote integration of CHA and conventional medicine. Unanimously, the participants thought that one of the main catalysts for the growth of IH was consumer demand. This is echoed in the literature. King, et, al., (1999), found that consumers were voting with their dollars by increasing their utilization of CHA because there was "increased frustration with depersonalized, high-tech medicine; discontent with the many side effects of traditional medicine; an expanding volume of scientific data relating disease and numerous health problems to

nutritional and emotional factors (p. 250).” The growth of CHA and IH over the past decades is substantiated by results of various studies including those conducted by Eisenberg, et al., (1993,1998) which revealed growth of CHA utilization in the U.S. from 25% to 34% over a period of 5 years.

The participants in this study stated they saw improved patient outcomes by incorporating CHA modalities in their patient’s treatment plans. This is consistent with the emerging research on outcomes of IH. A study conducted by Greeson, et al., (2008) revealed significantly improved health related quality of life through utilization of IH. Another study conducted by Cotton, et al., (2014) found significant improvement in pediatric pain with utilization of IH as compared to conventional medicine alone. Michalsen, et al. (2005) also found improved health outcomes and lifestyle adherence with incorporation of CHA.

Provider openness, provider belief, and provider support were other factors identified by the participants in this study that enhanced integration of CHA and conventional medicine. These factors were discussed in the literature as provider attitudes. Abbott, et al., (2011) found that 74% of medical students believed IH was more effective than conventional medicine alone. These authors also found that 49% of the study respondents used CHA personally. Fearon (2003) found that 64% of nurses had a positive attitude about CHA modalities.

Increased availability of CHA and IH information for consumers and allopathic providers was another factor identified as a facilitator for IH. Academic institutions have incorporated CHA and IH into their curricula. Wetzel, et al. (1998) found that as of 1997, 91 of 125 medical schools included CHA in their curriculum. By 1998 over a dozen

major medical schools had created IH programs (Berman, 2001). Krietzer, et al. (2002) found that 90% of medical, nursing, and pharmacy students favored integrating CHA into education and clinical care.

Another unanimous response from the participants in the current study was the belief that the use of IH positively impacts patient and provider satisfaction. Additional thoughts in support of incorporation of CHA into provider practices included increased numbers of evidence based studies on CHA and the potential for improved financial outcomes.

Respondents also shared the barriers they faced utilizing CHA in their practices. All participants stated that patients' financial constraints and lack of insurance coverage for CHA was the primary reason they were unable to increase utilization of CHA modalities in their practices. This was noted to be a frustration for all the participants in this study.

Rogers' Theory of Innovation and Diffusion

Rogers' theory was the theoretical framework for this study. Correlating this study's findings to Rogers' framework illustrates how his theory is relevant to the study. Rogers' identified characteristics that are associated with successful implementation of change (Geraci, 2014). These characteristics related to the study results as follows:

Relative Advantage: Is the change one which represents an advantage or an improvement over the current system? The findings that were the most relevant to this characteristic were the impacts on clinical and financial outcomes. The participants unanimously believed that IH had a positive impact on clinical outcomes by treating the

patient holistically and improving symptoms such as nausea, pain, and anxiety. Another advantage of IH which participants mentioned was improved financial health: by offering an edge over competitors who did not offer or refer for CHA therapies, and by increased patient volume and therefore enhanced revenue by being willing to support and refer for CHA.

Complexity: Is the change too complex for people to understand? Patients' willingness to experiment with and incorporate CHA modalities into their healthcare treatment plans suggested that complexity was not a factor. While patients often relied on the practitioner's blessing or guidance with CHA, participants indicated that patients were educating themselves about healthcare, especially with regards to wellness and preventive care.

Trialability: Can the innovation be tried? A positive experience with trying CHA with patients led to the participants in this study to continue practicing IH or referring for CHA.

Communicability: Can the intended changes be clearly articulated to others? Many of the participants indicated that educating patients was essential to their understanding of CHA and IH; understanding fostered engagement, and ultimately facilitated improved outcomes. Additionally, participants stated that patients were educating themselves outside of the clinician's office, through internet searches, networking, and mass media. This augmented their knowledge base although not all of the information obtained through these avenues was accurate and could lead to misunderstandings based on inaccurate or misrepresented data or advice.

Limitations

A limitation of this study was related to the sample size. Eight participants constituted a small, purposive sample recruited from a specific region in two fairly liberal communities with respect to the availability and use of CHA and IH. This may limit the generalizability of the results. Another limitation is the lack of physicians in the sample of participants. Additional interviews with these providers may uncover differing results from those obtained in this study. The study sample included only women. A study with a gender mix may have offered differing viewpoints. Lastly, the interview guide had not been used previously and therefore, may need refinement.

Implications for Practice

Complementary Health Approaches and IH play an important role in healthcare delivery and are very prevalent in the U.S. as shown in the literature reviewed in this study. Given the growth of CHA and IH and the need for health promotion it is realistic to assume this type of healthcare will continue to grow. This was reflected in the responses by the participants in this study who all believe these fields of healthcare will continue to expand. Providers are in a position to influence their patients regarding the choices they make in their approach to health care, including both CHA and conventional medicine. To meet the demand for IH in a competent manner, providers need to be educated or have ready resources about CHA to instruct and guide patients. As academic institutions, professional journals, and government agencies continue to publish and

expand the available body of literature our knowledge as practitioners will be enhanced and broadened.

Providers need to evaluate their attitudes and beliefs about CHA and IH and determine how this may affect their interaction with patients about these topics. Guiding patients as they make healthcare decisions needs to be conducted in an unbiased manner. Nurse practitioners and other allopathic providers should also develop alliances with reputable, knowledgeable CHA practitioners. Having confidence in other members of the health care team will enhance comfort in referring patients for care and foster collaboration with those practitioners. Finally, Integrative Healthcare models of care delivery need to be developed and tested.

Implications for Future Research

Future research and large scale studies conducted over time are needed to investigate the experience providers and patients have with CHA and IH. A study similar to this study with a larger and a more diverse sample that includes physicians and male participants is needed. Studies involving allopathic providers who not integrate CHA in their practice may yield contrasting insights. There is little published research in the area of nursing education and knowledge regarding CHA and IH. More research is needed in this area. Further studies evaluating the outcomes of IH for patients and providers may foster confidence in this healthcare practice and future growth of IH.

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APPENDICES

APPENDIX A

INTERVIEW GUIDE

Thank you for meeting with me today. I am interested in finding out more about your experience with “Integrative Healthcare (IH)”. By Integrative Healthcare I mean, a combination of Complementary Health Approaches (or CAM) and traditional medicine in clinical settings.

I have several questions I would like to ask you about this topic. Please answer as accurately and with as much detail as you can. And please remember, as the consent form specified, all information you provide will be kept strictly confidential. Also, you may ask me to turn off the tape recorder, or withdraw from the interview at any time.

1. Can you give a brief description of your professional role in this facility? If you are a provider, how many and what types of patients do you see each week? How many other providers see patients at this facility? If a hospital, how many patient care beds are in your facility?

2 How many years have you been in practice in your current position?

3 How many years have you been involved with practicing Integrative Healthcare or referring for Complementary Health Approaches therapies?

4 What is your educational background?

5 Have you had any training in Complementary Health Approaches? If so, which modalities? What was the length of the training? Do you currently provide this modality to your patients?

6 Can you briefly describe the types of therapies your clinic offers to patients that are complementary health approaches?

7 If you refer for CHA, what services are you seeking for your patients? How often do you refer?

8 Why do you think Integrative Healthcare has become a recent focus in our healthcare system?

9 What has led you to participate in Integrative Healthcare?

10 In your opinion, what are the driving forces leading to integration of traditional medicine and complementary health approaches?

11 What do you think the future is for Integrative Healthcare?

12 What factors do you believe positively affect the utilization of Integrative Healthcare?

13 In what way has Integrative Healthcare had an impact on clinical outcomes in your facility or with those you have referred out for this type of care?

14 Does Integrative Healthcare have an impact on patient satisfaction? If so, in what way?

15 Does Integrative Healthcare have an impact on provider satisfaction? If so, in what way?

16 What effect do you believe Integrative Healthcare has on the financial health of a healthcare facility? Has it impacted this facility financially? If so, how?

17 What would you say is the most important reason that you practice or refer for Integrative Healthcare?

18 Is there anything more you think I should know about your practice or about your perspective on Integrative Healthcare in general?

Thank you very much for your time today. I know it is very valuable.

APPENDIX B

SUBJECT CONSENT FORM PARTICIPATION IN HUMAN RESEARCH MONTANA STATE UNIVERSITY

Project title: Facilitators to Successful Integration of Complementary Health Approaches and Conventional Healthcare.

You are being asked to participate in a research study about Integrative Healthcare. The purpose of the study is to determine facilitators that encourage utilization of Integrative Healthcare. You are being asked to participate because you are a healthcare provider. In order to participate, you must be willing to answer questions about Integrative Healthcare.

If you agree to participate, you will be interviewed once in the location of your choice. The interview should take no longer than one hour to complete but may take longer upon your request. The interview will consist of face-to-face semi structured open-ended questions with the researcher tape recording and taking notes during the interview. After the interview, no additional contact from the researcher will be required. Participation is voluntary and you can choose to not answer any question that you do not want to answer, and you can stop at any time. Declining participation will have no future impact. There will be no benefit to you for participating in the study and the only risk is the use of some of your valuable time. During the interview, you are encouraged to ask questions if you do not understand a question or if additional clarification is needed. You may also ask additional questions regarding the research study.

Your identity will only be known by the researcher and will otherwise be confidential. The information gathered will be used for completion of a Master's Thesis and may be published in a health related publication. No identifying information will be used in either of the above. The interviews will be coded to remove any identifying information.

Should you have questions about this research, you can contact Sheri Bagley at [redacted] or sheri.bagley@yahoo.com. If you have additional questions about the rights of human subjects you can contact the Chair of the Institutional Review Board, Mark Quinn at [redacted] or mquinn@montana.edu

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AUTHORIZATION: I have read the above and understand the discomforts, inconvenience and risk of this study.
I, _____ , agree to participate in this research. I understand that I may later refuse to participate, and that I may withdraw from the study at any time. I have received a copy of this consent form for my own records.

Signed: _____ Witness: (optional)_____

Investigator: _____ Date: _____