ORIGINAL RESEARCH

Implementing Whole Person Primary Care: Results from a Year-Long Learning Collaborative

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Purpose: **The National Academies of Medicine report on *Implementing High-Quality Primary Care* calls for a transformation of the primary care to a "whole person" model that is person-centered, relationship-based and takes into account the social, spiritual, emotional and behavioral aspects of health. However, our current delivery tools, such as the SOAP Note, do not sufficiently capture and organize the delivery of these elements in practice. To explore how to remedy this, an Integrative Health Learning Collaborative (IHLC) was established to implement and test new tools for changing primary care practices toward whole person care.**

Methods: **The IHLC comprised primary care practices committed to changing to a whole person care model of care along with a panel of experts in integrative health and change management. The IHLC met virtually monthly. Representatives from each practice and an assigned expert met to strategize and adapt the tools to their environment and practice. The practices used previously developed tools (the HOPE Note toolkit), change management tools, and quality improvement techniques to introduce, implement, and evaluate the changes.**

Results: **Sixteen clinics completed the process after 1 year. Overall, practices used the HOPE Note tools in 942 patients. Participants reported changes on the effectiveness of the collaborative (1) on clinical practice, (2) on the skills and attitudes of participants; and (3) the support in change management.**

Conclusions: **This online learning collaborative supported practices implementing a whole person care model in primary care and improved the understanding, skills, and delivery ability of whole person care in all clinics completing the program. (J Am Board Fam Med 2023;00:000–000.)**

Keywords: **Collaborative Learning, Inservice Training, Integrative Medicine, Organizational Innovation, Primary Health Care, Workforce**

Introduction

Current delivery of primary care in the United States does not meet the needs of assuring the health of the population. In 2021 the National Academies of Sciences, Engineering and Medicine (NASEM) compiled a report on *Implementing High-Quality Primary Care*.[1] The report recognizes that primary care needs to be – but is not – the backbone

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of a high-functioning health care system. The report defines high quality primary care as "integrated; whole-person health" and "comprehensive person-centered, relationship-based care that considers the needs and preferences of individuals, families, and communities."[1] Primary care needs to switch "from a reactive disease-oriented medical care system to one that promotes disease prevention, health, and well-being."[2] This is done by expanding the traditional focus of the biomedical model of health to include the individual/family behavioral, mental, social and spiritual health and wellness goals.[1] Subsequently, the Academies published a report, *Achieving Whole Health: A New Approach to Veterans and the Nation*, which makes further recommendations on scaling and spreading whole person care.[2]

The majority of family physicians (83%) are already aware that social and behavioral factors influence health, and that family and community context are critical.[3,4] Many have the desire to treat patients more holistically. Yet, the systems and structures that undergird most primary care in the United States do not provide them the time, skills, tools, and reimbursement to ask patients about and address the underlying personal determinants of health and healing and linking those to what matters in a patient's life.[4]

To make the shift to a whole person model, primary care practices need to learn and operationalize new approaches to address the social, behavioral, mental, and spiritual aspects of individuals. The SOAP note, with its focus on making the diagnosis and moving to standard treatment of identified disease, does not help us consider these other factors. In an effort to move from a disease-centered to a person-centered, whole person approach, The Samueli Foundation developed the Healing Oriented Practices and Environments (HOPE) Note approach to explore patients' values and goals in life, identify their personalized determinants of healing, and assist the patient in meeting those goals and in preventing and reversing chronic disease.[5] It asks the patient not, "what is the matter," but, instead, "what matters?" By knowing what matters to patients, clinicians can explore, with the patient, the underlying root causes or personal determinants of health so that they can begin to change or improve.[5]

The tools comprising the HOPE Note Toolkit include the Personal Health Inventory (PHI), a self-administered survey in which patients can identify and communicate their meaning and purpose in life, current health needs and readiness for change (Online Appendix A). Patients complete this before or during a primary care visit. Based on these answers, the clinician, instead of using the SOAP note format, uses a HOPE note format (Online Appendix B) to explore patients' social, behavioral, mental, and spiritual aspects of health, their values and goals in life and identify their personal needs for healing. The third part of the toolkit is the Personal Health Plan Template, a tool that helps clinicians and their teams partner with patients to develop a care plan comprising of conventional, nonpharmacologic (also called complementary, and alternative medicine) combined with self-care support and identified social needs.

In 2020, The Samueli Foundation and the Family Medicine Education Consortium partnered to establish a year-long "Integrative Health Learning Collaborative" (IHLC) to facilitate practice changes toward more routine whole person care. The integrative health model, which predates the whole person care model, includes the components of care outlined by the NASEM. Integrative health is a person-centered, relationship-based approach that combines self-care with evidence-based conventional medicine and nondrug approaches (complementary and alternative medicine).[6] Integrative practitioners take into account all the factors that influence healing including physical. mental health, behavioral and the social determinants of health. There are numerous reported outcomes of integrative health at the Veterans Administration and other practices,[6] making this a good model to spread and scale as recommended by the NASEM.

The IHLC was an educational approach to introduce new information, culture, and practice patterns into primary care practices through the use of supported teamwork and individual practice-level work. Since this strategy has previously been effective at spreading innovation and facilitating practice improvement, the American Board of Family Medicine (ABFM) has proposed including learning networks as part of the residency redesign.[7] We experimented with this approach using an action-research model helping practice-based team members develop new skills and identify the tools they need to implement Integrative Health visits using the HOPE Note Toolkit.[8]

The goal of this report is to summarize our findings regarding the success of the IHLC in

supporting and changing the participating practices. Specifically, our aims were to (1) evaluate the effect of the IHLC on clinical practice; (2) the effect of the IHLC on the knowledge, skills, practices, and attitudes of participants; and, (3) to determine whether the IHLC support was effective.

Methods

This project evaluated the effectiveness of the IHLC implementation strategy based on the use of 2 theoretical models of change and change management. Primary care practices from across the United States were invited to apply for participation in the IHLC. Eligible practices could include private practices, practices within accountable care or hospital systems, community clinics and FQHCs, and training programs (ie, residency-based practices). Seventeen practices joined the IHLC in September of 2020.

Representatives from the clinics were required to attend monthly 2-hour meetings, during which the tools and resources were introduced, as well as attend monthly faculty-led small group meetings where clinic representatives discussed implementation strategies and challenges. All clinics were asked to use the HOPE tools and standard practice improvement processes to implement and evaluate their delivery of integrative care.

The IHLC was directed by one of the authors (Wayne Jonas) who is also the creator of the HOPE Note approach.[5] Logistic support was provided by the Samueli Foundation and the Family Medicine Education Consortium. Four board certified family medicine physicians and a consultant on change management comprised the faculty. They presented the content during the large meetings, facilitated the small group sessions, and served as consultants to individual practices.

To support implementation efforts, participant practices had access to a database (shared drive) of resources. At each monthly large group meeting, one or more topics would be presented by a faculty member (see Table 1); these topics comprised both integrative medicine topics as well as change management strategies, community asset mapping, and ideas on how to develop a network of services to support whole person care. The curriculum and resources were largely drawn from existing resources created by the Samueli Foundation.[5]

Initially plans were to run the IHLC for 12 months. However, during this time, there were various peaks of COVID-19 throughout the country and a 6-month extension of the IHLC was offered as an option. Participation in this extension was not evaluated by this study.

Table 1. Clinical and Delivery Process Topics Presented to the Learning Collaborative Participants

Clinical Topics	Delivery Process Topics
Intro to Integrative Health-How healing works	Using HOPE/PHI
Social determinants of health (SDOH) approach-community asset mapping	Managing change
Mind-body practices	Quality Improvement (QI), outcomes measures and data
Nutritional Supplements	Using PDSA process
Sleep	Billing and Coding
Food and diet	EHR
Treatment of chronic pain	Health Coaching
Journaling	Behavioral Change
Movement	Group visits
External environment	
Evidence-Based Decision Making	

Abbreviations: HOPE/PHI, Healing oriented practices & environments/Personal health inventory; PDSA, Plan-do-study-act model; EHR, Electronic health record.

Change management and implementation was supported through the use of 2 conceptual models and several tools. The McKinsey 7S model[9] was used as a general conceptual model of change. The Kotter model[10] was used as a guide for change management of team members. Content was delivered in the large group sessions and via self-directed online modules. In addition, tools were provided, including the Institute for Health care Improvement (IHI) description of the plan-do-study-act (PDSA) model, gap analysis, strength-weaknesses-opportunities-threats (SWOT) analysis, and a Gantt Chart prepopulated for project management. At the small group sessions, teams were asked to report on the conduct of at least 1 PDSA cycle and to describe how they used other tools.

Clinics were asked to implement the HOPE Note Toolkit in their practices in a particular cohort of patients of their choosing. They were also asked to reflect on the internal and external integrative services that were currently available to them and what additional services they could add. They were encouraged to consider hiring or training health coaches to work with the teams and use group visits to enhance scalability of the services.

Small group meetings were led by a dedicated expert. At these meetings, representatives from the practices shared progress on implementation. Practices shared successes as well as challenges in practice change, supported each other and learned from each other's experiences. At the completion of the first year, practices presented the outcomes of their PDSA cycle in the small groups.

Analysis

Clinics were asked to track and evaluate the implementation and use of the PHI, HOPE Note and other resources. They counted the number of Integrative Health (IH) visits using these tools and other services, evaluating patient outcome changes using the Center for Disease Control's (CDC) "Healthy Days" index[11] and the PROMIS-10 (Patient-Reported Outcomes Measurement Information System)[12] scores, and doing at least 1 PDSA cycle and McKinsey 7S evaluation on their clinic changes. Descriptive evaluations of the clinics, the numbers of PHIs, HOPE Notes and Integrative Health visits completed, and changes implemented in the clinics with proposals for next steps were assessed. Information on the effectiveness of the IHLC operations were also collected and analyzed.

Evaluation of the program was completed by collecting data via surveys completed by a representative of each participating medical practice. The first survey collected basic descriptions and patient demographic information about the practices, current integrative health practices, and goals of the practice for joining the IHLC. The second survey, completed 9 months after the start of the project, collected reports regarding the expansion of integrative health services, use of the tools provided as part of the IHLC (the PHI and HOPE note), changes to the office structure and processes (ie, staffing, electronic medical record, and team structure), and effects on billing and revenue. A third survey, administered at the end of the project, surveyed individual participants regarding their experience with the learning collaborative, changes in comfort with providing integrative health, and achievement of their goals.

Results

Seventeen practices participated in the IHLC at inception with 16 completing the full 12-month process. One clinic was unable to complete the process because of changes within their organization limiting time and resources for participation. The 17 clinics represented more than 220 clinicians and serving approximately 39,000 patients annually drawn from most regional areas of the US Clinic types are summarized in Table 2 below. Six of the practices identified as more than one clinic type categories. Most of the practices were family medicine clinics. There was 1 pediatric practice and 2 practices providing adult care only.

The clinics served people who spoke many different languages. The top languages spoken were: English, Spanish, Arabic, French and Portuguese. Other languages spoken at the clinics included Vietnamese, Nepali, Japanese, Mandarin, Burmese, Tagalog, and other. Many of the patients received governmental insurance services with Medicaid covering the majority of their patients, followed by Medicare and then Commercial insurance, noninsurance or self-pay. Most of the practices were located in urban areas (13). Six serviced a suburban area and 3 were rural. Some of these practices served more than one location type.

IHLC participants included physicians, nurse practitioners, health coaches, naturopathic doctors, research associates, dietitians, psychologists, research coordinators, and practice administrators. The size of interdisciplinary teams participating in the IHLC varied. Three participating clinics (18.75%) were composed of 10 or more team members. Another 6 (37.5%) had teams of 5 to 9 participants.

Effect of the IHLC on Clinical Practice

Number and type of Visits

Fourteen of the 16 practices were able to institute integrative health (IH) visits using the PHI and the HOPE note. During the project, the participants provided 942 IH visits; 67 visits, on average, per practice. Practices reported less use of the Personalized Health Inventory with a total of 512 visits; 37 PHIs per practice.

Table 2. Types of Clinics Participating in IHLC

Type of clinic	Number of practices in IHLC
FQHC	7
Residency-based practices	10
VA	1
Health systems	4
Integrative centers	2

Abbreviations: IHLC, Integrative health lerning collaborative; FQHC, Federally qualified health centers; VA, Veterans affairs.

In total, more than 90 clinicians provided IH visits to their patients. IH visits were provided by a single provider in a majority (67%) of practices, though 4 practices reported 2 to 4 clinicians using the HOPE toolkit and 2 practices reported 5 or more clinicians using the tools.

Four practices (25%) reported using the HOPE Note for patients with specific diagnoses (eg, chronic pain or diabetes). Five practices (31.25%) adopted the HOPE Note for patients specifically chosen by various team members. Three practices (18.75%) used the HOPE Note for most, if not all, patient visits regardless of visit reason. Other unique uses of the HOPE Note included first-time IH visits or consults (n = 2; 12.5%) and annual wellness visits (n = 1; 6.25%).

Implementation of PHI and HOPE Note

Participants reported administering the PHI in the examination room before the visit (67%), and 3 practices provided the PHI to patients to be completed before the visit or in the reception area. The PHI was also administered via telephone (37.5%) or after the visit (31.25%). One practice administered the PHI via an online patient portal. Other methods for PHI use were in the room directly with the patient and a team member (eg, coach or nurse). Seventy-five percent of clinics conducted HOPE visits in person and 37% of clinics by telephone. One group reported using the tool during group visits. Most practices (68.8%) reported they needed more than one visit to address all aspects of the HOPE note.

A total of 91% of participants agreed or strongly agreed with the statement, "I like the PHI" and 83% agreed or strongly agreed with the statement, "The PHI is easy to use." Written comments, include, "excellent tool - warmly received by patients," and "I love the structure and the format," and, "useful, helps change the doctor- patient relationship and patient expectations." Several participants noted that part of the tool was confusing for patients. One participant mentioned that, "most patients do not fill out the second column correctly. I find it best to do it together or verbally." Another participant noted that, "the second part where patients rate willingness to change needs explanation."

For the HOPE note, 83% agreed or strongly agreed with the statement, "I like the HOPE note" though 52% agreed or strongly agreed with the statement, "The HOPE note is easy to implement." Survey responses regarding the HOPE Note were similarly varied. One participant mentioned "it is great organizationally," another that it is "good. Easy to implement into a visit overall especially if you are addressing one or two main areas." Several responses mentioned that the HOPE note "produces useful information but is long and time consuming" and "too long. I like it a lot though and will continue to use various components." One participant did not feel the tool could fit into their existing model as "it was too difficult to use. . .with 15 minutes visits and patients with so many other acute complaints and other needs to be addressed." Other comments were that "the HOPE note seems very specific to practitioners (mainly MDs) who are not used to taking a holistic view of health and perhaps new to concepts of integrative health." In addition, "Plugging it into an existing workflow was somewhat challenging because doctors are used to their methods, and they found that introducing the HOPE note added additional time and/or certain redundancies. . .."

Specific Integrative Services

Developing a network of integrative services helps practices provide whole person care. Through this process, practices were introduced to different topics including community asset mapping and were provided resources on topics such as mind-body practices and integrative modalities. Five participating groups (31%) reported they did not note any changes to the way they addressed social determinants of health during the IHLC. While 2 participants noted increased propensity to approach social determinants in patient visits. One of the participants, who performs group visits, noticed the development of a support system among group participants.

All but one practice (94%) reported the addition of one or more integrative health practices delivered in their practice. Food and nutrition services (6 practices), acupuncture (5 practices), guided imagery (4 practices), and health coaching were the most common added services. In addition, 60% of practices identified external integrative health services that they could provide to their patients. The most common external services were chiropractic (2 practices), food and nutrition services (2 practices), and massage therapy (2 practices). Manipulation (osteopathic or chiropractic), food and nutrition

services, and acupuncture were categorized by respondents as the most popular external services.

Incorporation into the Electronic Health Record

The Electronic Health Record (EHR) was identified by IHLC teams as a useful tool in systems implementation. For this reason, IHLC's goal was for 95% of Integrative Health visits to be documented in the EHR. The majority of participating practices (81%) reported using an EHR template or other EHR capabilities in their implementation of integrative health. Of those using the EHR as part of the implementation, more than half (54%) incorporated both the PHI and HOPE Note into the EHR. Additional EHR implementations included the PROMIS 10 template, CDC Healthy Days template, and other tracking of measures.

Costs

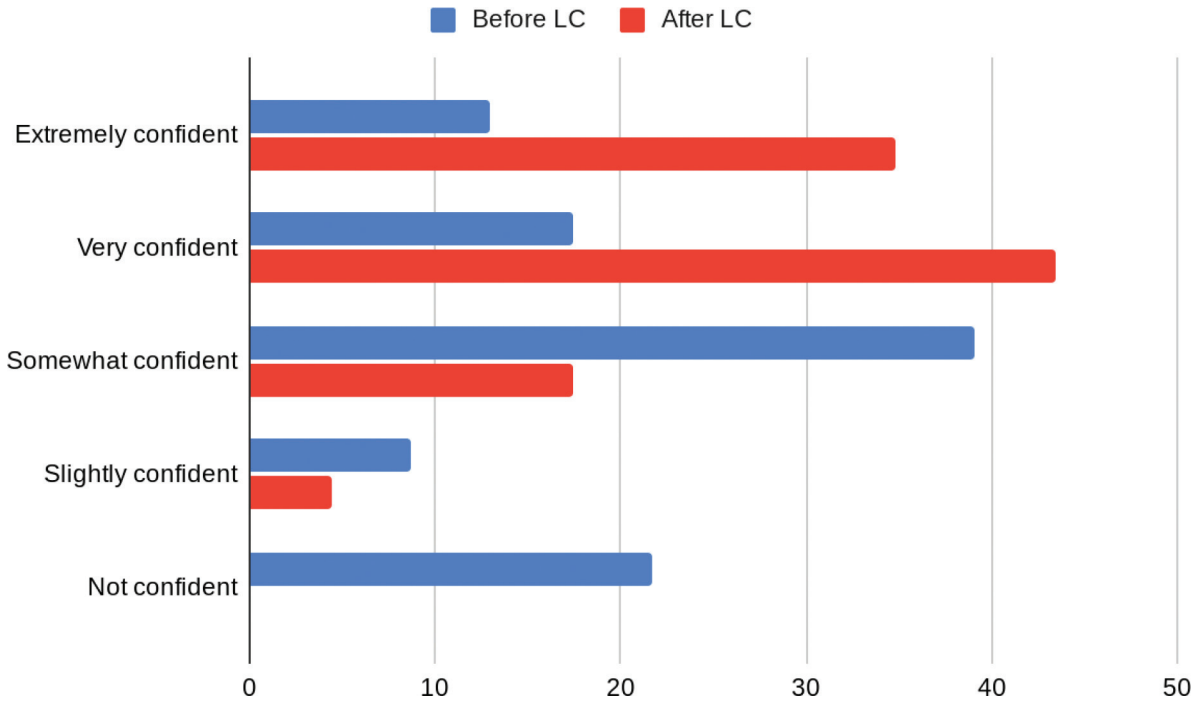
A formal cost analysis of this initiative was not performed but the IHLC goal was to capture changes in billing and coding because of IH use. The IHLC provided resources regarding collaborative billing codes, group visit billing practices and shared ideas on how to support internal IH services. The goal was that notation and coding would be accomplished in 95% of the visits. Most practice respondents (81%) reported that they were "unsure" or "did not adopt any changes in billing" as a result of implementing the HOPE Toolkit. Three practices reported changing their billing practices. Two of these 3 reported an increase in revenue because of these changes in billing practices. One practice reported that the increase in revenue due to billing for Integrative Health services offset the cost of the additional services.

Most practices (60%) reported not knowing the impact of IH visits on costs or revenue. Three practices reported costs associated with IH visits. These costs included staffing (2 practices) and clinic services & supplies (1 practice each). Three practices reported there were costs associated with the implementation of IH visits.

Effect of IHLC on Knowledge, Skills, Practices, and Attitudes of Participants

Specific aim 3 pertained to the effect of the IHLC on the knowledge, skills, practices, and attitudes of participants. The goal was for knowledge about and skills in integrative health to have increased by 50%. Each participant was sampled by the survey for these sets of questions on subjective confidence.

Figure 1. Self-assessed confidence level on integrative health knowledge skills before and after learning collaborative.



Based on a numerically graded conversion of these subjective confidence reports, the average participant's confidence in performing IH visits increased by 40% following the IHLC, with 78% "very" or "extremely" confident at the end of the year. Average scores on a 5-point Likert Scale went from 2.91 to 4.09 where 0 was "not confident" and 5 was "extremely confident." See Figure 1.

Ten practices were able to present findings at the FMEC annual meeting in 2021. Other meetings where practices presented findings included the Academic Consortium for Integrative Medicine and Health Conference (University of New Mexico) and local university research days.

IHLC's Support Effectiveness

The third aim was to evaluate the ILHC's support effectiveness and participants were asked whether the change management tools used by the groups were helpful in systems change. The results of this aim will be reported separately in another article.

Discussion

The expanded use of whole person care models is essential if the health of the nation is to be improved and costs brought under control. This implementation science project[13] evaluated the ability of a nationally coordinated implementation strategy to introduce simple tools to change approaches to health care across 17 practices. Practices successfully implemented the HOPE Note Toolkit in a cohort of patients in their practices and met the overall IHLC goal of 25 to 50 IH visits. Practices were also successful in expanding integrative health service networks by adding both internal and external services available to clinicians to refer patients. In terms of shifting from individual physicians providing care to teams, several IHLC practices added health coaches and other providers to the integrative health teams. Two used group visits to scale these services. Thus, the IHLC was effective in building confidence in integrative health knowledge and skills.

Limitations in the evaluation included that we did not provide a way to evaluate for integrative health knowledge and skills before and after the Collaborative. In addition, though the IHLC some practices were able to implement CDC Healthy Days and PROMIS-10 as part of the Integrative Health visits, we were unable to evaluate whether the patients participating in Integrative Health visits had improved healthy behavior engagement and improved self-perceived health and wellbeing because we did not have access to the individual clinic patient measure responses. Future studies to look at the impact of this approach on patient outcomes are necessary.

Major challenges for whole person care implementation were COVID, engaging leadership in organizational buy-in, the need for more time both with patients and in the practice, integrating the toolkit into EHR, data tracking and reimbursement issues. Simple tools such as operational software and enhanced leadership support were identified as key needs to address these challenges.

Participating practices also provided feedback on the ease of implementation of the HOPE Toolkit components and offered ideas on how to improve the tools. Through the small and large group discussions, practices were able to share lessons learned from their experiences, challenges as well as successful adaptation to the tools and processes. Feedback on the Toolkit will allow us to improve the PHI and HOPE note process. Several practices simplified the PHI, particularly, for patients who were non-English primary speakers and for practices that did the PHI over the phone. As mentioned in many survey comments, several practices felt that the whole person care approach can be time consuming if done all at one time and breaking it up into smaller sections was acceptable to clinicians and still beneficial for patients. In practices where clinicians are expected to see a high volume of patients, breaking the visit into smaller sections and doing as part of group visits were ways that they were able to adapt the approach/tools. In other practices, billing for team time was another way to offset the revenue and allow for more time for these visits. Group visits were a promising way to optimize these tools and topics. However, only 2 of the participants had experience in using group visits.

The IHLC had a variety of types of practitioners and levels of experience with whole person care. Some feedback from participants was that the IHLC small groups could have been divided differently to support the different levels of implementation and integrative health knowledge and skill.

Overall, many participants felt that the camaraderie of the IHLC was important to them. One

participant mentioned the importance of "support of like-minded professionals." Many others noted similar benefits and mentioned it in the surveys. Perhaps this is particularly true because the Collaborative was conducted virtually during the peak of COVID-19. Overall, the evaluation shows that a virtual Learning Collaborative was successful at sparking the whole person care process for 16 practices across the country during a difficult time for many.

Participants have plans to continue expanding on the whole person care work they had begun with the IHLC. Several practices plan on recruiting more patients for the visits and expanding the population offered integrative health services. Participants are hoping to train more practitioners within the practices to do more integrative health visits. Some mentioned trying to use group visits to implement the toolkit while several others will be trying out other processes for use of the tools in the practice. Most participants are planning to expand whole person care efforts within their practices after the IHLC. Many have also asked for continued opportunities to network. Overall, the learning collaborative was well received by participants.

Conclusion

In conclusion, if we are to implement high-quality primary care as recommended by the National Academies of Medicine 2021 report, practices will need to learn ways to operationalize whole person, team-based care. This evaluation suggests that the IHLC helped most practices implement whole person care tools, expand integrative health services available to their patients and was enjoyable for participants and they had gained from the experience. This is a strategy that could be used as we think about large scale primary care practice change to whole person and advanced primary care.

To see this article online, please go to: http://jabfm.org/content/00/00/000.full.

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Appendix

Appendix A: Personal Health Inventory (PHI)

This personal health inventory is adapted from and aligned with the VA's Whole Health model.

PATIENT'S NAME: _____ DATE: _____

Personal Health Inventory

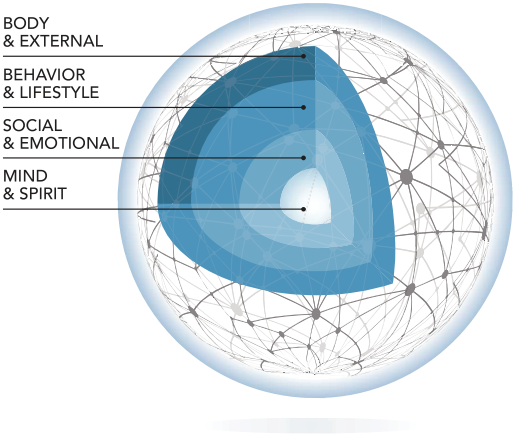
DrWayneJonas.com/HOPE

Complete your personal health inventory before your integrative health visit.

Use this circle to help you think about your whole health.

All areas are important and connected to your ability to heal and be healthy.

- The outer ring addresses what your home and work are like and how you feel physically.
- The next ring addresses everyday choices on self-care and lifestyle.
- The social and emotional ring looks at your relationships and social support.
- The inner ring addresses **what matters** to you rather than what's the matter with you.



Rate where you feel you are on the scales below from 1-5, with 1 being poor and 5 being excellent.

PHYSICAL WELL-BEING				
1	2	3	4	5
POOR	FAIR	GOOD	VERY GOOD	EXCELLENT
MENTAL/EMOTIONAL WELL-BEING				
1	2	3	4	5
POOR	FAIR	GOOD	VERY GOOD	EXCELLENT
LIFE: HOW IS IT TO LIVE YOUR DAY-TO-DAY LIFE?				
1	2	3	4	5
POOR	FAIR	GOOD	VERY GOOD	EXCELLENT

Thinking about your mental and physical health, which includes stress, depression, problems with emotions, physical illness and injury, for how many days during the past 30 days was your mental or physical health good?

☐
DAYS

What do you live for? What matters to you? Why do you want to be healthy?

Write a few words to capture your thoughts:

_____

_____

_____

Tell me when you were last well.

_____

_____

Where You are Now

Write in a number between 1 (poor) and 5 (excellent) that best represents where you are now. Then rank how ready you are to work on that area between 1 (not interested) to 5 (would start today).

Area of Whole Health	Where I am now (1–5)	Mark how ready you are to make changes (1-5)
BODY & EXTERNAL		
Feeling safe: Having comfortable, healthy spaces where you work and live. The quality of the lighting, color, air, and water. Decreasing unpleasant clutter, noises, and smells.		
BEHAVIOR & LIFESTYLE		
Moving: Moving and doing physical activities like walking, dancing, gardening, sports, lifting weights, yoga, cycling, swimming, and working out in a gym.		
Sleep: Getting enough rest, relaxation, and sleep.		
Food: Eating healthy, balanced meals with plenty of fruits and vegetables each day. Drinking enough water and limiting sodas, sweetened drinks, and alcohol.		
Stress Management: Tapping into the power of your mind to heal and cope. Using mind-body techniques like relaxation, breathing, or guided imagery.		
SOCIAL & EMOTIONAL		
Social Support: Feeling listened to and connected to people you love and care about. The quality of your relationships with family, friends and people you work with.		
Paying for Basics: Quality and availability of food, housing, utilities, and transportation.		
MIND & SPIRIT		
Purpose: Having a sense of purpose and meaning in your life. Feeling connected to something larger than yourself. Finding strength in difficult times.		
Learning and Growing: Developing abilities and talents. Balancing responsibilities where you live, volunteer, and work.		

PHI-V11

Appendix B: HOPE Note Template

The HOPE Note

A TOOL FOR ADDING INTEGRATIVE HEALTH CARE TO A ROUTINE OFFICE VISIT

What We Know

Physicians and other health care providers strive to keep patients healthy, help them heal when sick or hurt, and improve their quality of life at every stage. People with chronic conditions account for 81% of hospital admissions; 91% of all prescriptions filled; and 76% of all physician visits.[i] More than half of all adults in the United States have at least one chronic condition such as heart disease, diabetes, high blood pressure and arthritis. These conditions are among the most preventable and manageable with lifestyle changes and evidence-based self-care and complementary approaches to healing.[ii] If health care is to deliver health and well-being, it must address these underlying causes of ill-health and learn to better facilitate healing.

The Challenge

Our health care system is not set up to effectively deliver what patients want and need—health and well-being. Eighty percent of health comes from outside the doctor's office, including social and emotional factors, personal behaviors, mental and spiritual factors, and the physical environment. Most health care encounters deliver treatments that do not address these health determinants.

Chronic disease requires an approach in which all factors of a person's life are considered—where the focus is not just on countering illness, but also on promoting health; where healing is as important as curing.

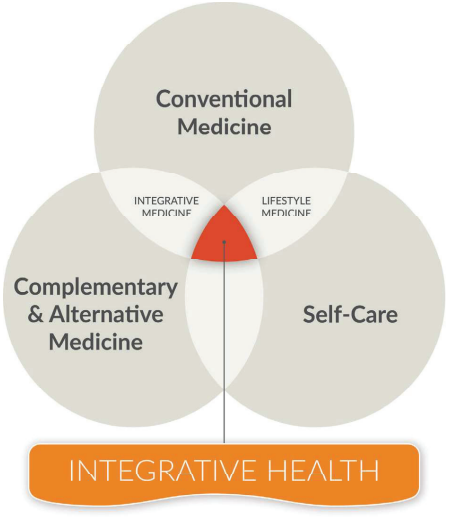
A Solution: Integrative Health

Integrative health is the pursuit of personal health and well-being foremost, while addressing disease as needed, with the support of a health team dedicated to all evidence-based approaches—conventional, complementary and self-care.

It is a partnership between the practitioner and patient that looks to a wider set of offerings with proven approaches—approaches that address the underlying causes of disease. A growing body of evidence shows that when patients are integrally involved in managing their own care, they will be healthier and happier.[iii]

While the constraints in our health care system prohibit rapid, wholesale change to an integrative health approach, physicians can still begin to transform their own practices and incorporate more healing factors into day-to-day practice. Many already include the elements of integrative health care.

MORE THAN HALF OF THE TOP 25 CONDITIONS **(hypertension, hyperlipidemia, diabetes, obesity, chronic back pain, anxiety and depression) can be mitigated and treated with health promotion and healing approaches—nutrition and movement, stress management, sleep and social support, and evidence-based complementary medicine such as therapeutic yoga, acupuncture and massage therapy.**



Sources:

[i] RWJF/JHU Bloomberg School of Public Health (2010) http://www.rwjf.org/content/dam/farm/reports/reports/2010/rwjf54583

[ii] https://www.cdc.gov/chronicdisease/overview/index.htm

[iii] http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=86

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The HOPE Note

HEALING ORIENTED PRACTICES AND ENVIRONMENTS

The HOPE note is a tool for physicians that can be used to improve a patient's health and well-being, particularly those with chronic conditions. The goal of the HOPE note is to reframe the patient experience from one of disease treatment to one that emphasizes self-healing and integrates evidence-based complementary approaches into conventional medical care.

The HOPE note complements what physicians have already learned in their medical training—the SOAP note—the **S**ubjective **O**bjective **A**ssessment and **P**lan. This is the way that every medical student learns how to organize their thinking around a patient visit. After a full medical diagnosis and treatment is completed, including a SOAP note, the physician would complete a HOPE note.

The physician begins the HOPE note by asking the patient a series of questions geared to evaluate the areas of life that impact health.

This discussion results in a patient action plan. The plan is mutually agreed upon and goals are set and tracked. Continuing support can come through a health coach, group visits, health apps, or ongoing informational resources.

> **"I developed the HOPE note because as a primary care provider, I've found that the SOAP note is too narrow to effectively grasp the causes of and approaches needed for many of the conditions I see – conditions like chronic pain, obesity, diabetes and hypertension."**
>
> ***— DR. WAYNE JONAS***

The HOPE Questions

Together, patient and provider can spark healing beyond the SOAP Note. Let's make asking these questions a routine part of medical care.

Mental and Spiritual Areas

1. ***What is your goal for your healing? What's meaningful for you?***

This addresses a person's the inner life — their desires, their beliefs, and their needs—why they get up in the morning, their purpose in life—what's meaningful for them. What matters rather than what is the matter.

Social and Emotional Areas

2. ***What are your connections and relationships?***

So often the reason and process for healing has to do with social relationships — with family, friends, communities and colleagues.

Lifestyle and Behavioral Areas

3. ***What do you do during the day? What is your lifestyle like?***

Lifestyle and behavior can impact up to 60-70 percent of chronic illnesses; therefore, these behaviors are essential for creating health. But behavior change must be connected to what is meaningful for the person, or it cannot be sustained.

Physical Environment

4. ***What is your home like? Your work environment? Do you get out in nature?***

The communities, the work sites, the schools and the environment in which patients live, often dictate what they're able to do; what happens to them; how long they live; and how well they flourish and function.

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