A Whole Person Approach to Behavioral Health: Improving Outcomes and Lowering Treatment Costs

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EXECUTIVE SUMMARY

Healthcare spending is a topic of heated discussion in the healthcare industry. Centers for Medicare & Medicaid Services (CMS) reports U.S. healthcare spending grew to $3.8 trillion in 2019 and is estimated to reach $6.2 trillion by 2028. The Centers for Disease Control and Prevention (CDC) estimates that nearly 90% of current spending is dedicated to chronic and mental health conditions. The relationship between physical and mental health is too great to ignore; while progress has been made in the shift to a more holistic and individualized approach to health, more work is needed. A new model of complementary and integrative health (CIH) care emphasizing prevention and early intervention has shown great promise, particularly in behavioral health treatment, by lowering costs, reducing hospital readmission rates, and improving patient outcomes.

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INTRODUCTION

Healthcare leaders will find no lack of discussion on the topic of healthcare spending. Centers for Medicare & Medicaid Services ([CMS], 2020) estimates national health spending to reach $6.2 trillion by the year 2028. Of particular interest are those conditions related to chronic and mental health disorders; 90% of the nation's $3.8 trillion current annual health care expenditures are for people with chronic and mental health conditions (Centers for Disease Control and Prevention [CDC], 2021). There is no shortage of data on how chronic conditions and mental health disorders are related, how they impact an individual's overall health, and the societal cost of treating both. The issue now lies in how organizations can implement a care model that can both lower treatment costs and improve patient outcomes.

The challenge of change is difficult, but the possibility of success exists if we are willing to accept change; it is time for the healthcare industry to see individuals as a whole being. There will be no improvement in health outcomes until a focus on Complementary and Integrative Health (CIH)[*] is adapted.

UNDERSTANDING THE SCIENCE

A vital first step in implementing a complementary and integrative care model is understanding the importance of a biopsychosocial approach to an individual's healthcare

[*] Due to the varying terms defining "whole health" – integrative medicine, complementary healthcare, alternative and comprehensive medicine – the term 'Complementary and Integrative Health' is used here to describe the care model that is designed to approach physical and psychological care with a biopsychosocial, transdisciplinary lens.

needs. The biopsychosocial model views health and illness behaviors as products of biological characteristics (such as genes), behavioral factors (such as lifestyle, stress, and health beliefs), and social conditions (such as cultural influences, family relationships, and social support). Researchers have found that while most psychiatric disorders are genetic, the activation and regulation of those genes is greatly dependent on environmental contributors and understanding their role is key to understanding the disorders themselves (Tripathi et al., 2019).

The role of epigenetics (the study of how your behaviors and environment can cause changes that affect the way your genes work) is well established. Psychiatric disorders are not the result of a simplistic "cause and effect" medical model but are the result of a complex model of multiple causes and effects (Tripathi et al., 2019).

Pain and Health

Advances in neuroimaging have suggested an overlap in the pathway of chronic pain and depression. Regions in the brain that are associated with the emotional and sensory features of pain are closely related to the regions of the brain affected by depression (Vadivelu, Kai, et al., 2017). Namely, experiencing one is likely to result in experiencing the other; depression is a positive predictor for the development of chronic pain, and chronic pain increases the risk of developing depression.

Because of this reciprocal relationship, research describes pain and disability as a "multidimensional, dynamic interaction among physiological, psychological, and social factors that reciprocally influence one another, resulting in chronic and complex pain syndrome" (Meints & Edwards, 2018).

Pain treatment often involves medication, therapeutic exercise, chiropractic care, and surgery, however, these approaches do not provide individuals with the skills to manage the cognitive, emotional, and physical challenges associated with living with chronic pain (Donahue et al., 2021).

Stress and Health

The amount of devastation that stress can inflict on our physical and mental health is astounding. Without considering the physiological harm that cortisol (the hormone released when an individual experiences stress) inflicts on our heart, lungs, digestive system, and brain, the effect of stress on our mental health is the most dangerous.

When an individual is experiencing stress, they are more likely to engage in risky and/or unhealthy behaviors to mitigate the stress they feel such as increased pharmacological use/abuse, increased alcohol consumption, cigarette smoking, decreased physical activity, or unhealthy eating habits; all are substantial risk factors for the four deadliest chronic conditions in the United States – cardiovascular disease, cancer, diabetes, and obesity (Centers for Disease Control and Prevention, 2021).

Additionally, it is highly likely that a diagnosis of one or more of these conditions will lead to an additional diagnosis of a psychiatric disorder such as depression or anxiety. Mental health disorders are likely to amplify one's experience of pain. And so, the cycle repeats itself.

A WORKFORCE AT RISK

The COVID-19 pandemic has left a lasting mark on all sectors of humanity, but particularly for healthcare workers. The toll of the pandemic stretches beyond physical

illness and into the realm of psychosocial stressors like prolonged social isolation, fear, uncertainty, and financial strain. Unfortunately, as the pandemic reaches its two-year mark, an increase in physical and psychological distress among the healthcare workforce is expected (Clauw et al., 2020).

As mentioned earlier, chronic pain conditions can be triggered by psychosocial stressors and may occur more heavily in individuals with underdeveloped stress response systems. In the healthcare industry, these stressors can manifest into compassion fatigue and burnout. Extensive research has revealed the dangerous effects of burnout, which include a reduction in quality of care, patient safety, professional productivity, and patient satisfaction. Additionally, burnout can also lead to decreased staff retention, increased healthcare costs, and substance abuse and suicide among healthcare professionals (Dyrbye, Shanafelt, Sinsky, et al., 2017; West, Dyrbye, & Shanafelt, 2018).

SHIFTING PRIORITIES

This does not suggest that treatment and/or prevention of these conditions is always simple and straightforward. There are a multitude of unique factors that can affect an individual's physical and mental health; some genetic disorders cannot be treated without a complex treatment plan, and for others, what started out as a treatable condition has evolved into multiple conditions of which treatment is elusive. Pharmacological and elaborate intervention is a reality for many; CIH approaches do not diminish this.

All of this is to say that current treatment modalities are not sufficient in treating those conditions that are both treatable and preventable when caught early enough. To see a real impact, providers cannot focus on one single form of treatment or intervention, but

rather, a spectrum of care and treatment options. It is time for a conscious and intentional approach to improving mental health and well-being.

The National Institutes of Health (NIH) developed the National Center for Complementary and Integrative Health (NCCIH) more than 20 years ago for the sole purpose of developing 'whole person' healthcare strategies and to evaluate their impact on outcomes, patient and provider experience, and costs (U.S. Department of Health and Human Services [DHHS], 2021).

A MODEL FOR IMPLEMENTATION

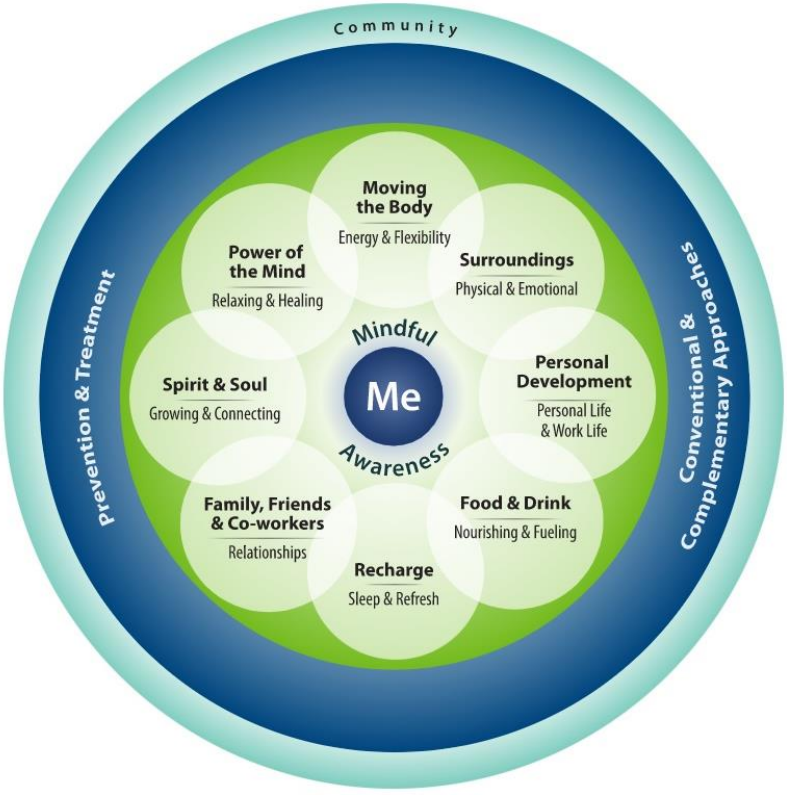
Healthcare organizations desiring to reduce the cost of treating behavioral health disorders and their comorbidities must consider alternative modalities via CIH. These interventions are patient-driven and allow patients to feel more in charge of their health. They are meant to assist patients in the intervention of harmful daily habits that could lead to further chronic conditions and/or mental health disorders and build resiliency.

The VA's Whole Health System (WHS) stands as a beacon of success in CIH implementation. While the initial goal of the WHS was to reduce rates of opioid addiction and improve chronic pain management using complementary and alternative approaches, a two-year study of over 130,000 Veterans found that Veterans experiencing chronic pain who participated in WHS activities reported engaging in healthier behaviors, becoming more involved in their care plan, and finding new purpose, well-being, and quality of life (Bokhour, Hyde, Zeliadt, & Mohr, 2020).

This WHS model introduces the Circle of Health, shown in Figure 1, which helps individuals explore the components of their lives that affect their health and well-being,

Figure 1

VA Whole Health System's Circle of Health



Note. The Circle of Health. From Department of Veterans Affairs, 2021, (https://www.va.gov/wholehealth/circle-of-health/index.asp)

with the patient ("Me") at the center. There is an emphasis on the idea that improving one area has a positive influence on other areas and one's overall physical, emotional, and mental health (Department of Veterans Affairs [VA], 2021). The inspiration from this model came from the Institute for Healthcare Improvement cofounder and former CMS administrator, Donald Berwick. Berwick's personal story about undergoing a risky surgery made him reflect on what really mattered to him – to have time with his

grandchild – and the fact that not one of his providers knew this about him. His motivation to not only undergo this surgery, but to fully recover from it, was his main driver. He knew this would need to become the foundation for a new healthcare model – whole health is about connecting what motivates a person to their health (Gaudet & Kligler, 2019).

In the WHS model, three major components work together to keep individuals at optimal health – 1) the pathway; 2) well-being programs; and 3) whole health clinical care. The pathway is the starting point for those entering WHS treatment and involves the development of a personal health plan and an introduction to the wide range of well-being programs and providers available to them. These programs involve a multitude of care approaches to support personal health, such as health coaching, acupuncture, chiropractic care, therapeutic massage, yoga, and tai chi (Haun, Paykel, & Melillo, 2021).

A care team is assigned to each Veteran and can include individuals from many specialties, like physical therapy, social work, massage therapy, nutrition, etc. The Veteran (the patient) determines what areas of their wellness they want to change first, and the care team guides the activities in which the Veteran chooses to engage.

The benefits of this model are seen in decreased hospital admissions and readmissions, a reduction in emergency behavioral health care, and a reduction in pharmacological use in the management of pain and certain mental health disorders.

POTENTIAL BARRIERS TO IMPLEMENTATION

Despite its great success, the WHS still experiences barriers and challenges, and these are important for any organization to understand and address. However, if

participation in CIH models increases, there is greater opportunity for resource and information sharing to help diminish these barriers to make lasting change.

When considering the barriers to implementing a new care model, many leaders get frustrated at the slow pace with which the change occurs. However, incremental change is key, as there are many factors to consider before implementation is considered complete and successful, including, but not limited to, culture of care, financial constraints, and health inequities.

Changing the Culture of Care

In an article by Hansen, McKernan, Carter, Allen, & Wolever, (2019), it is suggested that the first step in building a new care model is to build a new culture of care. Fragmentation seems to be a regular part of healthcare, especially as it refers to mental/behavioral care and primary care. Despite the mountain of evidence suggesting otherwise, the U.S. healthcare system continues to treat the mind and the body separately, with separate clinician training, making cross-specialty collaboration difficult.

A change in culture begins with the practitioners and champions of an organization's CIH program. These program leaders need to be visible and regularly collaborate with leadership and department heads to consistently and effectively champion the evidence behind integrative health.

Perseverance in the face of bureaucracy is also key. Leaders must find a way to either align CIH with the current strategic plan, mission, and/or vision, or redevelop the strategic plan, mission, and/or vision to align with the goals of CIH. Taylor et al. (2019) found that leadership was "more likely to support new approaches that are either: 1)

linked to their medical facility's priorities, national initiatives, or national pain guidelines; 2) cost-effective; 3) have evidence of effectiveness; or 4) lead to increased patient satisfaction". Here is the good news: CIH is all these things.

Educating healthcare staff on the benefits of CIH has never been easier. VA's Whole Health Library, available to anyone with an internet connection, offers many courses on several topics, including whole health for employees, whole health coaching, implementing whole health into clinical practice, whole health as it relates to pain and suffering, nutrition, mental health, social determinants of health, and so much more.

The University of Arizona Center for Integrative Medicine offers online courses for resident physicians to increase their knowledge on the topic of integrative medicine (Gannotta, Malik, Chan, et al., 2018). Medical schools should also consider implementing CIH courses into their core curriculum.

A culture shift among the patient population is also necessary if CIH models are going to be effective. Some patients may feel that these alternative approaches are "mystic" in nature and have no scientific backing. It is vital for the practitioner to be able to explain the evidence-based, positive impact these methods have on whole person health. Gaudet and Kligler (2019) suggest replacing the term "patient-driven" with "person-driven", to send the message that individuals are not merely passive recipients of treatment; success (health) requires that they be self-motivated and self-activated toward their personal goals in wellness.

A new culture of care is not only necessary for patient health and well-being, but also for employee health and well-being. Bodenheimer and Sinsky (2014) recommended

that the “Triple Aim”, coined by the Institute for Healthcare Improvement (IHI), be redesigned to include a fourth aim – care of the patient requires care of the provider – and to be renamed the “Quadruple Aim”. They found that the stressful work life of clinicians and staff impacted their ability to achieve the IHI’s three aims, and if any of the aims were going to be achieved, provider well-being needed to be the pre-requisite.

The flexibility and individualized approach offered by CIH allows these methods to be easily implemented into an organization’s Employee Assistance Program (EAP). The most important factor is having leadership who believes in and supports CIH. In a survey of 1,130 respondents of a large healthcare system in the southeastern United States, respondents experiencing lower distress levels at work stated that perceived organizational support was the biggest factor (Meese, Colón-López, Singh, Burkholder, & Rogers, 2021).

Financial Constraints

An enormous barrier exists with financing the implementation of a CIH model. Healthcare payment reform is necessary to eliminate the fragmentation that occurs when treating behavioral/mental health as a separate entity that requires separate payment. Health laws and insurance billing regulations have made it difficult to not only treat across specialties, but to also bill and reimburse across specialties. The job of a healthcare executive goes beyond their office; advocating for policy change is necessary to begin to bridge these care gaps.

Insufficient funding for hiring CIH practitioners and support staff is a large reason why integrative health programs fail. This is where creativity comes into play. Health

coaching is an evidence-based process that empowers patients to engage in their own health improvement through behavioral changes. In a study of high-risk health plan enrollees, Jonk et al. (2015) found that health coaching led to significant reductions in outpatient and total expenditures by reducing readmission rates and more complex treatment plans, with an average monthly outpatient and total cost savings of $286 and $412 per person, respectively. The advantage for healthcare organizations is that health coaching does not need to be facilitated by a state/nationally licensed practitioner.

VA has found great success in utilizing peer support specialists and health coaches in their WHS program. These are individuals with lived experience who receive on-the-job training in coaching and facilitating wellness appointments and are not as costly to hire and retain as licensed providers. Other organizations have found that physicians and other healthcare support personnel seek out additional training to add the role of ‘health coach’ to their current duties.

VA has also found success in partnering with community organizations, such as the YMCA, to facilitate classes in yoga, tai chi, and mindfulness to help alleviate constraints on insufficient staffing and space. Furthermore, the widespread use of telehealth due to the COVID-19 pandemic has made this coaching more widely available without utilizing the same space/time as a clinic appointment.

The electronic/virtual health services market is one that has exploded in the last two years. Many organizations have created their own branded applications for patients to access and offer various services such as nutritional advice and diet recommendations, exercise videos, meditation prompts, and other items related to general health. Other

organizations have invested in home health to mitigate patient wait times amid a shortage of staffing within their clinics.

Rogers Behavioral Health partners with the Wisconsin Initiative for Stigma Elimination (WISE) to offer an online Compassion Resilience Toolkit meant to assist in implementing compassion and resilience programs in schools, health and human service organizations, and even in the home. This toolkit focuses on the physical, emotional, and mental well-being of individuals (Compassion Resilience Toolkit, n.d.).

Advocate Aurora Health utilizes their Live Well application to offer resources to patients that go beyond traditional healthcare. The app offers guided meditation, information on general health topics, and healthy recipes and nutrition advice, among several other self-care resources that do not require insurance involvement.

It is important to consider the availability of these electronic resources for those who may not have smartphones or internet access. A partnership with a community center or local library may be essential.

Being open to innovative care modalities is an essential characteristic for healthcare leaders looking to alleviate the burden of behavioral health care treatment costs amid staffing shortages and increased patient loads.

Health Inequities

It is important to consider the community in which a practice operates and the population it serves – the payer mix, workforce, and socio-demographics of its patients – in order to provide the most effective integrative care. This approach relies on the strength of partnership building, community mobilizing, and developing shared goals and

initiatives with non-health sectors and policymakers to thoroughly address and eliminate social and systematic inequities across the life span (Trinh-Shevrin, Nadkarni, Park, Islam, & Kwon, 2015).

Reducing health inequities requires an examination of interventions at the individual, organizational, and community levels to ensure improved and sustainable behavioral change and access to care. Care teams should build partnerships with stakeholders from multiple sectors (education, transportation, criminal justice, etc.) to address determinants of health and underlying inequities. These partnerships should also include community health workers (CHWs); these workers have unique access and local knowledge that can inform care development and evaluation, improve care coordination, and expand access to care (Islam, Nadkarni, Zahn, Skillman, Kwon, Trinh-Shevrin, 2015).

Also essential for reducing health inequities and improving the health and well-being of the population is policy change. The problem lies with certain lobbyists who have the most to gain by healthcare processes remaining costly and inefficient. Again, community partnerships play an important role in advocating for policy change. Those sectors outside of public health, such as education and criminal justice, strongly influence the health and well-being of a population; addressing the needs of a community must be a multi-sectored approach.

Pollack Porter, Rutkow, and McGinty (2018) highlight four key principles one should consider when attempting to advocate for public health policy change: 1) use

evidence to inform policy; 2) consider health equity; 3) design policy with implementation in mind; and 4) use proactive research-policy translation strategies.

The healthcare system needs to be redesigned on all levels, but without input from those closest to the issues, change will continue to be nonexistent, or at the very least, ineffective.

RECOMMENDATIONS PRIOR TO IMPLEMENTATION

For those interested in making a CIH model a reality in their organization, the first step would be to develop a strategic plan that involves the creation of a CIH steering committee to evaluate current financial status and the ability to develop a CIH program in-house (hiring CIH practitioners, utilization of space, etc.), or contract out specific services (such as yoga, tai chi, massage therapy, etc.). This steering committee should focus on the creation of, or building on existing, partnerships with community organizations who can better address the needs of the surrounding population.

The steering committee should also ensure the CIH program runs as its own individual program instead of CIH approaches being used across departments (Taylor et al., 2019); patients referred for the CIH program should be evaluated by the CIH program lead where a care plan can be created.

Healthcare providers and support staff should be well-versed on the topic of CIH as well as the science behind it so they may act as champions. Organizations need to either invest in a consulting team to build an education program for them or consider certification for their current employee education team in CIH models. Once this

education requirement has been met, robust marketing of the CIH program and its efficacy is vital for both patient and provider participation.

As always, advocacy for population health, and staying informed on policy processes, remains an important factor. This involves a range of activities, from cultivating leadership support for the CIH program, to advancing population communication via community centers or community health workers, to advocating for health policy change at the local, state, or federal level. This step is important not only for the current state of healthcare but should be a focus for future health leaders, and sufficient training on policy development and competency is crucial.

CONCLUSION

These barriers should not prevent any healthcare leaders determined to make a real change in the way behavioral health is viewed and treated. Nothing worth it was ever easy. As more organizations implement CIH models and show success in improving outcomes and lowering treatment costs, payers may begin to realize the benefits of CIH and will adjust payment models to better allow for these treatments. Additionally, resource and information sharing across organizations will make implementation a much smoother process.

There are challenges ahead. The ever-changing and volatile political climate is impacting healthcare like never before and change often seems out of reach. But healthcare leaders and public service organizations must continue to challenge the system in order to create a more resilient and empowered society through a healthcare structure that promotes health and well-being.

References

Bodenheimer, T., & Sinsky, C. (2014). From triple to quadruple aim: care of the patient requires care of the provider. *Annals of Family Medicine*, *12*(6), 573–576. https://doi.org/10.1370/afm.1713

Bokhour, B. G., Hyde, J. K., Zeliadt, S., & Mohr, D. C. (2020). Whole Health System of Care Evaluation – A Progress Report on Outcomes of the WHS Pilot at 18 Flagship Sites. *Veterans Health Administration Center for Evaluating Patient-Centered Care in VA (EPCC-VA).* https://www.va.gov/WHOLEHEALTH/professional-resources/clinician-tools/Evidence-Based-Research.asp

Centers for Disease Control and Prevention. (2021, June 23). *Health and economic costs of chronic diseases*. National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP). Retrieved November 15, 2021, from https://www.cdc.gov/chronicdisease/about/costs/index.htm#ref1

Centers for Medicare & Medicaid Services. (2020, December 16). *NHE fact sheet*. CMS.gov. Retrieved November 15, 2021, from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet

Clauw, D. J., Hauser, W., Cohen, S. P., & Fitzcharles, M. A. (2020). Considering the potential for an increase in chronic pain after the COVID-19 pandemic. *Pain*, *161*(8), 1694–1697. https://doi.org/10.1097/j.pain.0000000000001950

Compassion Resilience Toolkit. (n.d.). https://compassionresiliencetoolkit.org/healthcare/compassion-resilience/

Department of Veterans Affairs (VA). (2021, April 1). *The Circle of Health.* Whole Health. https://www.va.gov/wholehealth/circle-of-health/index.asp

Department of Veterans Affairs (VA). (2021, November 8). *What is Whole Health?* Whole Health. https://www.va.gov/wholehealth/index.asp

Donahue, M. L., Dunne, E. M., Gathright, E. C., DeCosta, J., Balletto, B. L., Jamison, R. N., Carey, M. P., & Scott-Sheldon, L. A. J. (2021). Complementary and integrative health approaches to manage chronic pain in U.S. military populations: Results from a systematic review and meta-analysis, 1985–2019. *Psychological Services, 18*(3), 295–309. https://doi.org/10.1037/ser0000417

Dyrbye, L. N., Shanafelt, T. D., Sinsky, C. A., Cipriano, P. F., Bhatt, J., Ommaya, A., West, C. P., Meyers, D. (2017). Burnout among health care professionals: A call to explore and address this underrecognized threat to safe, high-quality care. *NAM Perspectives*. Discussion Paper, National Academy of Medicine, Washington, DC. https://nam.edu/burnout-among-health-careprofessionals-a-call-to-explore-and-address-this-underrecognized-threat-to-safe-high-quality-care.

Gannotta, R., Malik, S., Chan, A. Y., Urgun, K., Hsu, F., & Vadera, S. (2018). Integrative Medicine as a Vital Component of Patient Care. *Cureus*, *10*(8), e3098. https://doi.org/10.7759/cureus.3098

Gaudet, T., & Kligler, B. (2019). Whole Health in the Whole System of the Veterans Administration: How Will We Know We Have Reached This Future State?

Journal of Alternative and Complementary Medicine, 25(S1), S7-S11. https://doi.org/10.1089/acm.2018.29061.gau

Hansen, K. A., McKernan, L. C., Carter, S. D., Allen, C., & Wolever, R. Q. (2019). A Replicable and Sustainable Whole Person Care Model for Chronic Pain. *Journal of Alternative and Complementary Medicine, 25*(S1), S86-S94. https://doi.org/10.1089/acm.2018.0420

Haun, J. N., Paykel, J., & Melillo, C. (2021). Transforming Health and Resiliency Through Integration of Values-based Experiences: Implementation of an Electronic Evidence-based Whole Health Clinical Program. *JMIR Formative Research, 5*(6). https://doi.org/10.2196/26030

Islam, N., Nadkarni, S. K., Zahn, D., Skillman, M., Kwon, S. C., & Trinh-Shevrin, C. (2015). Integrating community health workers within Patient Protection and Affordable Care Act implementation. *Journal of Public Health Management and Practice, 21*(1), 42–50. https://doi.org/10.1097/PHH.0000000000000084

Jonk, Y., Lawson, K., O'Connor, H., Riise, K. S., Eisenberg, D., Dowd, B., & Kreitzer, M. J. (2015). How effective is health coaching in reducing health services expenditures? *Medical care, 53*(2), 133–140. https://doi.org/10.1097/MLR.0000000000000287

Meese, K. A., Colón-López, A., Singh, J. A., Burkholder, G. A., & Rogers, D. A. (2021). Healthcare is a Team Sport: Stress, Resilience, and Correlates of Well-Being Among Health System Employees in a Crisis. *Journal of Healthcare*

Management, American College of Healthcare Executives, *66*(4), 304–322. https://doi.org/10.1097/JHM-D-20-00288

Meints, S. M., & Edwards, R. R. (2018). Evaluating psychosocial contributions to chronic pain outcomes. *Progress in neuro-psychopharmacology & biological psychiatry*, *87*(Pt B), 168–182. https://doi.org/10.1016/j.pnpbp.2018.01.017

Pollack Porter, K. M., Rutkow, L., & McGinty, E. E. (2018). The Importance of Policy Change for Addressing Public Health Problems. *Public Health Reports*, *133*(1S), 9S-14S. https://doi.org/10.1177/0033354918788880

Taylor, S. L., Bolton, R., Huynh, A., Dvorin, K., Elwy, A. R., Bokhour, B. G., Whitehead, A., & Kligler, B. (2019). What Should Health Care Systems Consider When Implementing Complementary and Integrative Health: Lessons from Veterans Health Administration. *Journal of Alternative and Complementary Medicine, 25*(S1), S52-S60. https://doi.org/10.1089/acm.2018.0445

Trinh-Shevrin, C., Islam, N. S., Nadkarni, S., Park, R., & Kwon, S. C. (2015). Defining an integrative approach for health promotion and disease prevention: a population health equity framework. *Journal of health care for the poor and underserved*, *26*(2S), 146–163. https://doi.org/10.1353/hpu.2015.0067

Tripathi, A., Das, A., Kar, S. K. (2019). Biopsychosocial model in contemporary psychiatry: Current validity and future prospects. *Indian Journal of Psychological Medicine, 41*(6), 582-585. https://doi.org/10.4103/ijpsym.ijpsym_314_19

U.S. Department of Health and Human Services (DHHS). (2021, November 16). *NCCIH Strategic Plan FY 2021-2025*. National Center for Complementary and Integrative Health. https://www.nccih.nih.gov/about/nccih-strategic-plan-2021-2025

Vadivelu, N., Kai, A. M., Kodumudi, G., Babayan, K., Fontes, M., Burg, M. M. (2017). Pain and Psychology – A Reciprocal Relationship. *The Ochsner journal*, *17*(2), 173–180.

West, C. P., Dyrbye, L. N., & Shanafelt, T. D. (2018). Physician burnout: contributors, consequences and solutions. *Journal of Internal Medicine*. *283*(6), 516-529. https://doi.org/10.1111/joim.12752