The Stone Soup Project: A Model for the Delivery of Holistic Health Services to People who Don't Know about Them and Couldn't Afford Them Even if They Did

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Introduction and Background

Statement of Need

It comes as no surprise that since insurance reimbursement is typically unavailable for complementary and integrative approaches to care (CAM), many underserved populations who might be in positions to benefit from them are often unaware of their existence. Since these services are usually out-of-pocket costs for educated and more financially secure patients, minority, impoverished and other disadvantaged groups may not even have these types of treatments on their radar screens.

This is especially true for populations for whom even conventional preventive primary care is either out of reach or not part of their customary health literacy. A Grantmakers in Health survey reported interest in "CAM therapies as a source of stress management and healing for the medically indigent. If they are accepted and adopted by our target populations, therapies – such as meditation – promise low to no-cost, sustainable, and immediate health benefits for people of very limited means."(Grantmakers for Health, 2011)

Even patients receiving conventional health care at this point in time experience poor outcomes. For example, one case in point is the Veterans' Administration challenge in reversing the alarming suicide rate for veterans returning from deployment, noted by current VA statistics as 20 suicides per day. (Veterans Administration, 2016) If conventional approaches could solve

this problem, it would have happened by now. As a result, the VA has become much more receptive to the integration of holistic services into its menu of care for veterans.

Hooker notes that "The United States, with its patchwork quilt of health care, leaves many citizens medically stranded…An understanding of why those working with the medically underserved and economically disqualified do so is needed because the demand for services often extends beyond what is typically distributed in usual health care… To be more creative in delivering resources to needy communities is a clarion call for expanding the variety of personnel to work in team-centered care systems. A diversity of providers is needed for a diversity of patient needs." (Hooker, 2008)

A Department of Health and Human Services executive summary reported that it is "unethical and morally incorrect to NOT incorporate CAM (complementary and alternative medicine) into CHCs (Community Health Centers) – that we have a moral and ethical imperative to maximize the great potential for IM (Integrative Medicine) to address disparities in the CHC setting, and that lack of access to effective self-management modalities becomes a social justice issue." (Bezold et al, 2008) They go on to identify the coding and reimbursement issues, poor education of both providers and the public, lack of policy, research and evaluation all of which remain challenges to an expanded care model to reduce health disparities in underserved populations.

Gardiner et al studied CAM use among underserved inpatients in a safety net hospital and noted that "higher health literacy was associated with more use of any CAM and provider-delivered CAM therapies for all groups other than non-Hispanic blacks…. More research…is needed to understand the barriers of low health literacy patients to relaxation techniques. Last,

health literacy experts should explore whether current CAM modalities and clinical services are accessible to low health literacy patients, and if not, how to design relaxation interventions to be more appropriate for low health literacy patients." (Gardiner et al, 2013)

Ho and colleagues report that minority and underserved communities express interest in incorporating CAM into their health regimens: "There is a lack of prior literature exploring the interests of patients from underserved regions in receiving CAM therapies from their primary care providers." Since many providers are unfamiliar/un-credentialed in these practices, patients must seek for them outside of current conventional care practices. (Ho, 2015)

Bazargan and associates noticed that lack of health care coverage remained one of the strongest predictors of CAM use and that this was especially true in underserved African American and Hispanic individuals suffering from depression. Many of these individuals seek these services when access to conventional care is not forthcoming. (Bazargan, 2008)

The purpose of this article is to describe a potentially replicable health care delivery model to provide pro bono holistic health services to underserved segments of a community. The evolution of the program from an unstructured group of holistic health care providers to a non-profit organization structured with mission statement, volunteer orientation and training, community outreach strategies, and metrics and evaluation plan is summarized.

For the purpose of this discussion, integrative approaches to care include the holistic inclusion of not only conventional allopathic (Western) treatment paradigms, but also of complementary approaches including (Eastern) approaches such as Traditional Chinese Medicine, Ayurveda, Chiropractic, and their related treatment interventions of somatic, nutritional, bio-energetic, and biological treatments. These would include but are not limited to

such interventions as Reiki, massage, Trager Approach, CranioSacral Therapies, herbal/nutraceutical/essential oil supplements, and the like. Many of these latter practices are designed to help preserve health, wellness, balance and provide relief from stress, certainly laudable goals for all of us. For the underserved, life is often more about surviving from one crisis to the next, and a health promotion approach to health care, rather than sickness care, is foreign to them. An impoverished person is more familiar with going to the emergency room for a primary care issue than s/he is with getting a massage to prevent/treat low back pain.

The Stone Soup Project

When looking for models for sustainable CAM care to underserved communities, there is scant literature available. Ladine describes the challenges of providing such care in the San Francisco Bay Area through Herban Health (Ladine et al, 2004), but otherwise organizations interested in providing such services are often left to their own devices to develop their own models.

It is with this in mind, that a casually-organized group of natural health workers started meeting in 2012 in Columbus, Ohio to discuss the feasibility of offering holistic services on a pro bono basis to populations unaccustomed to receiving them. They were invited to do so at the behest of the director of a local wellness organization, The Reiki Center, who had identified this as a community need for some time. She was interested in putting together a group of local thought leaders for the purpose of exploring various formats for the delivery of such services. The director's concept formalized an identity for the group as The Stone Soup Project (SSP) based on the children's story of a soup that is made from individual donations of a carrot, a potato, a turnip and so on, which was then provided as sustenance for the entire community.

Over a period of 2 years, the practitioners met on a monthly basis evolving a model of care, deliberating and compromising on how it took shape organizationally. Since many of these members did not know each other, much of the time was spent in relationship development. The group had to grapple early on with the tension between conventionally licensed health care providers and the more loosely organized complementary healing community which does not organize itself according to conventional professional standards of practice. As Bezold et al noted, "while licensing may make reimbursement easier,… [some] CAM practitioners do not necessarily want to be licensed/professionalized." (Bezold et al, 2008) As these conversations ensued, members were recruited and dropped out over a period of time until a solid core of committed individuals remained. As they coalesced, they became stable enough to begin to elaborate a philosophy and mission statement to guide the development of the program.

Philosophy and Mission Statement

"The Stone Soup Project (SSP) is a collaborative of holistic health practitioners who believe all individuals should have access to healing services. We are committed to ethically providing energy therapies and education in partnership with individuals and organizations that provide advocacy, education, and services towards improving the health of their target populations."

Services Offered/Definitions

The services offered by SSP are limited by the skill set of the volunteers available to deliver them. Volunteers with a highly interdisciplinary range of skill sets were recruited. Such skills include, but are not limited to, Reiki (including animal reiki), Trager Approach, CranioSacral Therapy, Massage Therapy, Reflexology, Guided Imagery, and Yoga.

Targeting Populations

Focusing on the Underserved: Health Literacy, Community Outreach and Engagement

Early on, the group grappled with which populations to work. Initially, the volunteer group worked with all comers in order to give the volunteers an opportunity to practice and trial out service delivery models. SSP members began attending organizational meetings of other groups like The Ohio National Guard to introduce its services to the Guards' membership and to develop key relationships. Attendance, for example, at CATCH Court, Changing Actions To Change Habits, a Franklin County judicial program designed to shift the paradigm of trafficked women from criminals to survivors, resulted in services delivered to them at their residential treatment facility.

Over time, SSP's targeted population came into clearer focus as the group determined criteria for inclusion. Eventual populations came to include veterans returning from deployment whose VA system did not otherwise provide access to holistic care, the institutionalized elderly, caregivers of chronically ill patients (e.g.Alzheimer's) who themselves were high risk for illness, trafficked and addicted women, amputees, the visually impaired and their service dogs, high risk pregnant women, and the mentally ill. A division of SSP composed of Animal Reiki and Canine Massage Therapists now provides free services to animal rescue agencies. Other prospective populations might include hospice patients and workers, prisoners, homeless or those suffering from dementia. As can be seen from this list, these groups represent populations who are unaware of holistic services, and even if they were, would not often be able to afford them.

Another group of skilled volunteers provides free Reiki to members of the community on a monthly basis at a free Reiki Clinic. Many of the individuals who attend this clinic, with an average of 25-40 persons each month, do not have funds for a full session yet rely on the services of the clinic for ongoing wellness support. The focus of service delivery is to introduce and educate them about how such services can help them promote their own health, and then to provide them with access to receiving said services.

Formats for the Delivery of Service: What Works, What Doesn't

The issue of where and how to deliver such services was a concern early on for the volunteers who were uncomfortable with the idea of delivering services to unknown clients in their own homes. It was decided that for the protection of volunteers and clients, all services would be delivered via their constituent organizations in public spaces. For example, if an organization like the Ohio National Guard was organizing a Labor Day picnic for its members, SSP would set up massage tables and massage chairs at the picnic event so that clients were able to come and go casually for 15 to 20 minute sessions. (Interestingly, one would anticipate that a conservative military group would not be receptive to unconventional health services; however, this particular client group enthusiastically and appreciatively participated in the program.) Organizational health fairs became a popular forum during which services could be trialed, either in parks, inside organizational offices, or during conferences. Early on, the group learned to provide sufficient opportunity for chair work since many clients were physically disabled enough to make climbing onto massage tables difficult.

Other challenges presented themselves with regularity. Some organizations did not know how to operationally make use of the services; for example, not enough ground-laying

preparation was done with the target population who either did not show up for the event or who showed up but did not make use of the service. In these instances, post-event debriefing helped the SSP group decide whether to pursue further relationships with the organization as visibility and demand for services increased in the community.

During some consultations with organizations, lack of clarity from the target organization regarding how to make use of the services resulted in either postponing or declining participation with them. SSP would later learn that political problems within the client organization were making it difficult for services to be delivered. In these cases, SSP deliberately chose to remain outside of the political struggles inside organizations and wait for clarity before proceeding with developing a working relationship.

One unanticipated teaching for the volunteers was learning that more fundamentalist members of the community seem more likely to experience holistic therapies as a religious rather than a health practice. These opportunities became teachable moments during which practitioners could educate clients about the effects of stress on health. Removing such obstacles to the reception of care made it more accessible to a group of people who could benefit from it.

Metrics and Evaluation of Services and Patient Outcomes: Proof of Concept, Seeking after Evidence-Based Practice

As SSP evolved over time, the group became more interested in demonstrating proof of concept by collecting information which could be used to provide evidence of improving client outcomes. For example, SSP collaborated with the Alzheimers Association to provide services for a grant the Association was conducting to provide respite care to patient caregivers. While caregivers selected by the Alzheimer Association were participating in SSP's wellness pilot

project, their loved ones were invited to programming at a safe location sponsored by the Alzheimer Association.

In an initial foray into collecting client-reported responses to a variety of interventions, clients were asked to complete pre- and post-intervention assessments to rate identified symptoms on a 0-10 scale, 0 being 'no problem' and 10 being 'the most difficult' the problem could be. This particular group rated symptoms such as anxiety, depression and pain, and received guided imagery, massage, and Reiki for a total of 9 hours over a period of 6 weeks.

Overall, all participants reported a significant reduction of their reported symptoms. On the average, participants exhibited a 32% reduction of symptoms after receiving a massage, a 25% reduction of symptoms after receiving Reiki, and a 21% reduction after receiving guided imagery. The largest average individual improvement after a massage was a 50% reduction of symptoms after treatment; after Reiki, 45%; and for guided imagery, 32%. The smallest average individual improvement after massage was a 17.% reduction of symptoms after treatment; for Reiki, .08%; and 10% for guided imagery. Such preliminary data collection becomes the basis of a feasibility study which is the prelude to more rigorous research about how such models of care delivery might serve as an adjunct to affecting health outcomes, not only of individuals, but also of populations in crisis since such services can be delivered to groups.

Additionally, the group started collecting statistics about its activities. For example, in 2016, SSP provided 706.5 hours of volunteer time to a total of 880 clients served. The total value of clinical services was $21,320.00. 693 administrative hours valued at $40,400.00 provided the infrastructure necessary to provide such services. As the value of service per client was $71.98,

the total value of volunteer service to the community was $66,220.00 for the year. This represents a real investment in the community by a rather small, but committed organization.

Operational Challenges

Recruitment, Screening and Training of Volunteers

Since SSP is its volunteers, the focus of all quality metrics is determined by who the volunteers are. While the emphasis is on developing an inter-disciplinary team of complementary care providers, care was taken to ensure that the nature of the services provided would be seen as legitimate by the community SSP was attempting to serve; that is, there is still sufficient stigma about receiving such services that group members needed to be sensitive as to how the community would perceive, and therefore receive intended services. Therefore, services which were ambiguously described or represented a specific religious affiliation were not selected as part of the SSP repertoire of services. Candidates who apply for acceptance in SSP must demonstrate preparation and proficiency in their chosen modality. This was especially important in light of the previously cited report that a number of holistic health practitioners are not under the supervision of a governing body.

In the end, SSP matured as a group of holistic practitioners committed to the idea that it is simply not enough to believe one is a healer, but that one must actually become qualified to be so. There were also a number of volunteer candidates who did not understand the model and whose intention to use their affiliation with SSP to build their own private practices demonstrated a disconnect with the mission statement and philosophy of the group. These individuals were precluded from participating.

Additionally, all new volunteers are screened by the Board of Directors, and go through an orientation program which familiarizes them with the purpose, mission and philosophy of the Stone Soup Project. The orientation also reviews standards of practice, common problems that might occur, resolution of such problems, and the ethical delivery of service. New volunteers then shadow and are precepted by experienced volunteers at SSP events in order to ensure that they are familiar with SSP protocols, policies and procedures, and that SSP personnel have an opportunity to supervise their work in the field.

Because a number of candidates who presented themselves to SSP for consideration were unknown to most of the members, it was important to ensure the safety of the public by vetting them through a national security clearance company. All SSP volunteers receive liability insurance coverage through SSP's parent company. Since a number of practitioners in the holistic community are not covered by such malpractice insurance, it became necessary to consider formalizing SS into a non-profit organization, such that services like security clearances and malpractice insurance would be made available to cover the group from a risk management point of view.

*The Reiki Center Relationship/*501(c)3 *Board; Administration of Services*

Due to the maturing complexity of the SSP organization, in 2015 the director of The Reiki Center, who also currently serves as SSP President, introduced the idea of shifting the volunteer portion of The Reiki Center program to a not for profit organization. This would protect the integrity of both groups, give each group its own administrative governance structure, and hopefully simplify what was becoming an increasingly complex service delivery process to coordinate. In order to do so, SSP formalized a Board of Directors comprised of the core group

so that while other volunteers matriculated through the organization, the Board could lend it some continuity. The administration for SSP had always fallen disproportionately on the shoulders of the director of The Reiki Center, so the growing organizational complexity necessitated the hiring of people into formalized positions, for example, an office manager. Emerging concerns about what would happen organizationally if the director were unable to fulfill her role led to discussions about the need for succession planning.

The shift to a 501(c)3 status gave the Stone Soup Project the legal status to apply for its own grants. Recruitment of board members with special core strengths like grantsmanship could then be successfully mounted. This organizational legitimacy makes it more possible for a volunteer organization like SSP to participate in research activities with academic institutions since it is itself not set up to have an internal review board or professional researchers. Such activities go a long way to legitimize the good works that holistic health practitioners provide to the community.

Financial Sustenance: Donations, Grants

Since volunteers are not paid for their services, and SSP itself is housed in a parent organization, overhead is relatively low. Primarily, it has been for administrative time, marketing materials (brochures, mail, printing, website, legal services, banners) and the cost for a national background check for each volunteer. True to its original intent, no actual fees are collected for services from clients who receive them. However, some organizations have been so appreciative of the services rendered that they have offered honoraria for the services offered. These honoraria are used to cover the aforementioned costs. In the future, it is hoped that the

organization will be able to procure more in the way of grant support in order to expand services, trial new modalities and develop new programs.

Summary

The Stone Soup Project was described as a potentially replicable health care delivery model to provide pro bono holistic health services to underserved segments of a community. The discussion included a review of its philosophy and mission statement, volunteer recruitment and vetting, services offered, and identified target populations. Operational issues included organizational development, service delivery models, metrics and evaluation, as well as potential for research. This group continues to evolve as a work in progress.

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