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Acceptance, satisfaction and cost of an integrative anthroposophic program for pediatric respiratory diseases in a Swiss teaching hospital: An implementation report

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ABSTRACT

Background: For the pilot phase of an integrative pediatric program, we defined inpatient treatment algorithms for bronchiolitis, asthma and pneumonia, using medications and nursing techniques from anthroposophic medicine (AM). Parents could choose AM treatment as add-on to conventional care.

Material and methods: To evaluate the 18-month pilot phase, parents of AM users were asked to complete the Client Satisfaction Questionnaire (CSQ-8) and a questionnaire on the AM treatment. Staff feedback was obtained through an open-ended questionnaire. Economic data for project set-up, medications and insurance reimbursements were collected.

Results: A total of 351 children with bronchiolitis, asthma and pneumonia were hospitalized. Of these, 137 children (39%) received AM treatment, with use increasing over time. 52 parents completed the questionnaire. Mean CSQ-8 score was 29.77 (95% CI 29.04–30.5) which is high in literature comparison. 96% of parents were mostly or very satisfied with AM; 96% considered AM as somewhat or very helpful for their child; 94% considered they learnt skills to better care for their child. The staff questionnaire revealed positive points about enlarged care offer, closer contact with the child, more relaxed children and greater role for parents; weak points included insufficient knowledge of AM and additional nursing time needed. Cost for staff training and medications were nearly compensated by AM related insurance reimbursements.

Conclusions: Introduction of anthroposophic treatments were well-accepted and led to high parent satisfaction. Additional insurance reimbursements outweighed costs. The program has now been expanded into a center for integrative pediatrics.

1. Introduction

Integrative medicine has increasing relevance and acceptance in pediatrics.[1,2] Despite its popularity with parents there are however few integrative pediatric inpatient services available in Europe.[2,3]

The different available definitions of integrative medicine generally include notions of a holistic approach to the individual in its individual context, integration of complementary with conventional therapies, and patient-centered inter-professional collaboration.[1,4]

Different models of integrative health care service level have been described.[5–7]

Mann et al., for example, have contrasted between conventional medicine practitioners that obtain complementary medicine training with multidisciplinary and interdisciplinary teams consisting of conventional and complementary medicine practitioners.[6] Templeman et al. have differentiated between the selective integration of the most effective complementary and conventional methods (based on respect of the ontological differences between different schools of medicine), and the selective incorporation of evidence-based complementary medicine interventions.[8]

As the first pediatric inpatient department in Switzerland, we wanted to provide integrative pediatric services within a public

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hospital, in response to the interest of families and interest within the nursing and physician team. Our aim was to provide an expanded and more holistic treatment offer and to further improve patient/family experience and outcomes. Our approach was to train the existing team of nurses and physicians in complementary medicine; to select one complementary medical system – anthroposophic medicine – for integration rather than selectively incorporating individual therapies from different complementary systems; and to begin the integrative approach for patients with selected, conventionally defined pathologies.

Anthroposophic medicine is an integrative medical system using multimodal treatment concepts based on a holistic understanding of man and nature. It uses medicines based on plants, minerals and animals, and different body therapies including specific nursing techniques such as compresses and massages.[9] Anthroposophic medicine is always practiced in integration with conventional medicine.

Switzerland provides a favorable context for integrative medicine following a national referendum in favor of integrating complementary medicine into regular health services. As a result, there are recognized post-graduate physician degrees for selected complementary systems and reimbursement for complementary treatments through the compulsory, basic insurance scheme.[10,11]

We here provide a report on the planning and implementation experience.

2. Methods

2.1. Project planning and implementation

The pediatrics department at Fribourg hospital serves the canton of Fribourg and includes a general pediatrics and a neonatology ward with a total of 24 beds. We opted to begin with a pilot phase of adding complementary treatments for children hospitalized for bronchiolitis, asthma/obstructive bronchitis and pneumonia. Respiratory diseases were selected as these are common in pediatrics and because of the interest of the head of the department, a pediatric pulmonologist.

Among the different complementary medical systems we choose to employ anthroposophic medicine, as there is significant inpatient experience with this approach – including in pediatrics – and because one of the attending physicians was a certified provider in anthroposophic medicine.

A project coordination group was established including two attending pediatricians, one neonatal nurse and one nurse from the general pediatric unit. No new staff positions were created and the project received no external funding. The project was proposed to the hospital director where it received full support. A pediatric department of an integrative hospital with four decades of experience in integrating anthroposophic medicine (Filderklinik, Germany) was identified as partner for technical support.

It was decided to establish a standardized treatment protocol so that integrative treatments could be provided at any time of day and night, and by physicians and nurses without expert knowledge in anthroposophic medicine.

The anthroposophic treatment protocol was established in collaboration with a pediatric expert from our partner, the Filderklinik, based on anthroposophic medical literature and experience at the Filderklinik.[12–17] The protocol included inhalations, oral medications and nursing applications (see Fig. 1). Medications included preparations from plants, minerals and animals, principally from the manufacturers WELEDA (Schwäbisch Gmünd, Germany) and WALA (Bad Boll, Germany) and were obtained through the hospital pharmacy; all WALA and WELEDA medications had registrations with Swissmedic, the Swiss national regulatory agency. A detailed nursing protocol was developed for all the nursing methods (general instructions on anthroposophic nursing applications are available at http://www.pflege-vademecum.de/[accessed October 18, 2017]).

Physicians and nursing staff were trained separately to apply the protocol. Physicians received a 2-h introduction into anthroposophic medicine with instructions how to apply the protocol by the project coordinator. Nurses received a 1-day training on anthroposophic nursing techniques by an external nursing expert (training was repeated on three occasions to ensure participation of all nurses). Nurses received a half-day training refresher 10 months into the project. Physicians had ongoing support available through the attending physician certified in anthroposophic medicine.

A flyer for parents informing about the project and the option of complementary therapy was handed out on hospital admission; a more detailed booklet about anthroposophic medicine was available on request. Private practice pediatricians in the canton of Fribourg were informed about the project through the local pediatric society. Four local pharmacies were requested to hold the medications on stock that children would need after discharge.

Implementation of the complementary treatment was begun in January 2015 for a pilot phase of 18 months. On hospital admissions for bronchiolitis, asthma and pneumonia parents were offered the complementary treatment as an optional add-on to conventional care. During hospitalization parents were taught how to apply chest compresses and massages and were encouraged to actively participate in the nursing care.

2.2. Project evaluation

An evaluation of the pilot phase from January 2015 through June 2016 was part of the project management to understand acceptance of and satisfaction with the integrative treatment program.

Number of hospital admissions for bronchiolitis, asthma and pneumonia and number of patients receiving the complementary care option were calculated from hospital records.

Parents of children receiving complementary treatment were asked to complete two questionnaires on hospital discharge. First, the Client Satisfaction Questionnaire CSQ-8 (CSQ-8 French version, © Clifford Attkisson 2012; ZUF-8 German version, © J. Schmidt et al., 1989, 1994) which has an internal consistency Cronbach alpha of 0.83–0.93.[19,28] Minor language changes were made to the CSQ-8 to improve French grammar, comprehensibility as well as consistency with the German version (Fribourg hospital is a bilingual French & German institution). For the CSQ-8/ZUF-8 the arithmetic total score was calculated.[18] Secondly, we used a questionnaire on complementary treatment satisfaction that was developed and pre-tested in-house, using a 4-scale responses, e.g. “very satisfied”, “somewhat satisfied”, “somewhat dissatisfied”, “dissatisfied” (see Fig. 3 for questions).

Physicians and nurses were asked to complete an open-ended questionnaire at 6 months into the pilot phase. Questions were asked about general impressions about the complementary treatments, sufficiency of information/training received, advantages/disadvantages in daily practice, observed effects, parent reactions and suggestions.

A cost-minimization analysis was carried out from a hospital perspective[20]: direct expenses for training and anthroposophic medicines were collected. Staff cost was not included as no additional staff time was paid for. Additional DRG-based hospital reimbursements for complementary medicine were measured. Given limited data on the efficacy of the complementary treatments provided we assumed equal outcomes with and without complementary treatment for the purpose of the cost-minimization analysis.

The project complied with the principles of the Helsinki declaration. No ethics approval was sought as this was an implementation of known, approved treatments. The evaluation was an integral part of the project management cycle.

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