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Establishing an Integrative Medicine Program Within an Academic Health Center: Essential Considerations

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Abstract

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"Integrative medicine" (IM) refers to the combination of conventional and "complementary" medical services (e.g. chiropractic, acupuncture, massage, mindfulness training). More than half of all medical schools in the United States and Canada have programs in IM and more than 30 academic health centers currently deliver multi-disciplinary IM care. What remains unclear, however, is the ideal delivery model (or models) whereby individuals can responsibly access IM care safely, effectively and reproducibly in a coordinated and cost-effective way.

Current models of IM across existing clinical centers vary tremendously in their: 1) Organizational settings, principal clinical focus and services provided; 2) Practitioner team composition and training; 3) Incorporation of research activities and educational programs; and 4) Administrative organization, e.g. reporting structure, use of medical records, scope of clinical practice as well as financial strategies, i.e. specific business plans and models for sustainability.

In this Perspective, the authors address these important strategic issues by sharing lessons learned from the design and implementation of an IM facility within an academic teaching hospital, i.e. the Brigham and Women's Hospital at Harvard Medical School; and, review alternative options considered based on information about IM centers across the United States.

The authors conclude that there is currently no consensus as to how integrative care models should be optimally organized, implemented, replicated, assessed and funded. The time may be right for prospective research in "best practices" across emerging models of IM care nationally in an effort to standardize, refine and replicate them in preparation for rigorous cost-effectiveness evaluations.

Introduction

Four national surveys support that a third or more of US adults routinely use complementary and alternative medicine (CAM) therapies (e.g. chiropractic, massage, yoga, supplements, acupuncture) to treat their principal medical conditions[1-5] with total expenditures exceeding $34 billion in 2007.[5] The majority of individuals who use CAM therapies use more than one CAM modality[6,7] and tend to simultaneously seek care from both conventional providers as well as licensed CAM professionals.[1,2,8] This combination of conventional and CAM services has been referred to as "integrative medical (IM) care.[8-18] Surprisingly little attention has been devoted to developing optimal delivery models whereby individuals can responsibly access IM care safely, effectively and reproducibly across medical settings in a coordinated and cost-effective way.[8]

In 2011, the Bravewell Collaborative conducted the first comprehensive survey of IM centers in the United States,[19] collecting data from 29 representative centers. Findings support the existing variability of settings and practice models found in IM centers in the US, but also highlight the common principles at the heart of each program. Regardless of the specific model, all need to address a number of essential strategic questions before their IM program, center or team is established within an academic health center.

The purpose of this article is to describe these strategic questions by sharing lessons we have learned from the design and implementation of one such center, i.e. the Osher Center for Integrative Medicine at the Brigham and Women's Hospital (BWH) and Harvard Medical School. A description of this Center, its history, evidence of its impact on patients with low

back pain, and rationale for specific plans and decisions relating to the Osher Center have been published elsewhere.[20-24]

In this article, we provide a summary (text and Table 1) of practical issues and organizational decision points; our responses to these organizational options in the establishment of the Osher Center as a reference point; as well as alternative options to be considered based on the findings of the Bravewell Collaborative Survey.[19] We believe these strategic questions will be directly relevant to many groups, including: (1) those considering the establishment of a new, multi-disciplinary, IM clinical center within their clinical and/or academic medical settings; (2) those currently managing such centers who are interested in further refinement of sustainable models of integrative medical care; (3) members of the IM larger medical community who routinely interact with and refer patients to clinics and centers as part of their day-to-day clinical activities; and (4) national health policy makers.

SECTION I: DECISIONS REGARDING ORGANIZATIONAL SETTINGS AND POPULATIONS TO BE TREATED

Question 1: What Will the Physical and Organizational Setting of the Integrative Care Center/Clinic/Program Be?

In each instance, a determination must be made as to whether the IM program/facility will be established as a physical entity with dedicated space or as a virtual entity with clinicians who are deployed to various clinical settings. If it is to be built as a physical entity, will the IM Center be constructed within the hospital's central footprint, within its ambulatory care pavilion(s), or at a distance from either? How "visible" and prominent will it be to the average patient? Will it be built "within the hospital" and have its functions inextricably linked to the hospital's major departments, services and electronic medical records, or will it be built as an "optional," parallel, autonomous enterprise? Will it be limited to outpatient care or will it also include inpatient treatment? This initial determination will help clarify and transmit the intentions, aspirations and levels of commitment of the organization responsible for the IM faculty, and will impact a cascade of subsequent essential, defining decisions.

Based on the Bravewell survey of IM centers, the physical and organizational settings ranged from hospital inpatient programs to integrative primary care within community health clinics.[19] In the case of the Osher Center for Integrative Medicine (which we will refer to as the Osher Clinical Center or OCC), we trained and pilot-tested a multi-disciplinary ("integrated") team prior to the establishment of the OCC itself.[20,21] We opted to place the facility within the hospital's ambulatory care pavilion at a location separate from the main hospital, both to facilitate access and parking as well as to allow the OCC to be within the same building as other practices likely to refer to and work closely with OCC practitioners. These conventional medical colleagues included members of the hospital's primary care group; women's health group; pain management specialists; rehabilitation and sports medicine experts; and specialists in rheumatology and gastrointestinal medicine.

Question 2: Who Will Be the Principal Population(s) Served by the IM Program/Facility?

The principal population or populations to be served represents another critical decision point. Options range from narrowly circumscribed (e.g. patients with back pain or persistent headache) to extremely broad (e.g. all adults and children with acute and/or chronic conditions and even health maintenance). A compromise might include a focus on major subgroups of patients, either adult or pediatric, such as with: (a) musculoskeletal and/or neurological pain-related conditions; (b) cancer diagnoses; (c) cardiovascular disease; (d) gastrointestinal conditions; (e) mental health; or (f) women's health issues.

The advantages of narrowing the clinical focus of the IM program include self-evident referral partnerships with well-defined clinical groups across the host organization/ institution and the ability to train a multi-disciplinary team with a shared clinical focus. Moreover, an IM center with a particular clinical focus lends itself to the ability to conduct research studies within the clinic population. The disadvantages of a narrow clinical focus include a narrower prospective patient base as well as the low likelihood of providing primary care alongside consultative care (see Question 3 below).

The OCC chose to focus its clinical expertise in the area of musculoskeletal and neurologic pain-related conditions. We also limited the program to adults, as the majority of healthcare professionals participating in this BWH facility routinely care for adults only. While the OCC was designed to assist patients primarily with this spectrum of conditions (e.g. back pain, joint pain, arthritis, multiple sclerosis, headache, etc.) and advertised itself as such, it did not turn away self-referred patients with other chief complaints or those seeking to optimize their health.

In the Bravewell report, 72% of the 29 clinics emphasized prevention and general wellness, while 62% offered comprehensive care, defined as complete care for a specified condition.[19] All clinics provide care for adults; 97% offered geriatric services; 72% OB-GYN services, 86% adolescent care, and 62% offered pediatric care.[19]

Question 3: Will The IM Program/Facility Offer Primary Care Services, Consultative Services or Both?

This decision has the potential to affect several other core decisions, including the setting (Question 1), the principal populations served (Question 2), and issues pertaining to billing, revenue, participation in accountable care organizations, Patient Centered Medical Homes, the proposed professional "scope of practice" for individual IM team members, and organizational oversight. It also directly relates to the need for different levels of emergency and night/weekend coverage, as well as seamless coordination of quality assurance within clinical departments and specialty groups involved. At an institutional level, this decision may enhance or decrease perceptions of competition across the organization.

In the case of the OCC, we opted to provide consultative services only and did not establish primary care or inpatient services. Of the 29 IM centers included in the Bravewell report, 90% also employed a consultative model and 55% did not offer primary care services.[19]

SECTION II: DECISIONS REGARDING COMPOSITION, RECRUITMENT, AND TRAINING OF MULTIDISCIPLINARY TEAM

Question 1: Which Practices and Practitioners Should Be Included Within the IM "Team"?

The terms "complementary medicine" and "integrative medicine" currently remain sufficiently broad to encompass dozens of commonly used therapeutic modalities.[8,19,25,26] In addition, both the regulation and licensure of practitioners of many complementary therapies (e.g. massage therapists; acupuncturists; naturopaths; chiropractors) are complex and frequently vary from state to state.[24] Lastly, several popular therapies found in a range of IM clinical centers lack established national standards, certification requirements, competency testing, or legal licensure (e.g. yoga, meditation instruction) and are routinely offered by individuals with or without state approved clinical licensure.(24)

At the OCC, we limited the team to individuals with existing state privileges to treat adult patients. In addition, as relevant, individuals had to possess state or national certification in their respected discipline, and have letters of reference from licensed medical colleagues with whom they had worked. The make-up of the OCC "team" began by including invitations to MD's (e.g. medicine, psychiatry, orthopedics, neurology), acupuncturists, chiropractors, massage therapists, nutritionists, physical therapists, registered dietitians, nurses, and occupational therapists. Preference was given to licensed candidates (conventional or CAM) who could also provide a range of therapies for which licensure does not currently exist, including: mindfulness based stress reduction; tai chi; yoga; and craniosacral therapy. Detailed scope of practice guidelines for each clinical specialty were established and approved by the hospital's accreditation committee. Clinician candidates also went through the hospital's credentialing review and, importantly, were observed by the medical director as part of their interviewing process.

Though broad consensus exists across most centers for selecting CAM practitioners based on proper credentialing and availability, the specific selection criteria vary from center to center, and state to state. According to the Bravewell report, practitioners that were most frequently employed across the 29 clinics surveyed included: physicians (96%), massage therapists (86%), meditation instructors (83%), licensed acupuncturists (79%), dieticians/ nutritionists (69%), Traditional Chinese Medicine practitioners (62%), and yoga instructors (62%).(17)

Question 2: What Kind of Initial Team Training is Required for Team Practitioner Members?

IM team models vary widely in terms of trans-professional training requirements involving referral, communication, shared decision making and reporting authority.[17,18,27] The OCC team participated in an extensive three month initial training program which required participation by all members in fourteen full day (8 hour) sessions of didactic presentations; hands-on demonstrations of team members performing diagnostic work or therapy on one another; shared patient diagnosis and treatment of subject volunteers; as well as extensive communication exercises led by a trained facilitator and a medical social scientist. Thereafter, team members met (and continue to meet) weekly to discuss complex patients or to review clinical successes or failures. These training sessions were made possible by a

grant funded by the National Institutes of Health, and philanthropic funds from the OCC's principal donor.[21]

A principal obstacle of such training and of weekly team meetings is the typical lack of financial resources to make these training sessions practical.[27,28] Whether this financial "investment" in team training is an essential predictor of clinical, organizational and/or fiscal success remains unstudied.[22]

Question 3: What Should be the Ongoing Training of the IM Team?

This is another aspect of emerging IM team models which remains unstudied, specifically what should be the optimal ongoing training of the IM team?

The OCC model established the required weekly attendance of all team members, initially to discuss the shared management of patients involved in an NIH-funded sponsored research project, and subsequently to participate in ongoing shared learning which comes from patient chart reviews, literature reviews and guest lectures. Little has been documented about the ongoing educational and clinical meetings of IM team members across existing centers and their relevance to enhanced clinical, research and fiscal outcomes. In addition, little is known about the existence of required regular team meetings and their potential impact on patient outcomes, job satisfaction, IM practitioner turnover and/or perceptions of the IM team by referring clinical and organizational leaders within the hosting organization.

SECTION III: DECISIONS REGARDING THE ROLE OF RESEARCH AND EDUCATIONAL INTITIATIVES

Question 1: What Should be the Scope and Relevance of Research Activities?

The decision as to whether the IM center should be designed to participate in or take the lead in generating original research has varied from institution to institution. According to the Bravewell report, 86% of surveyed clinics conducted research.[19]

In the case of the OCC, the model was explicitly structured to include sufficient research infrastructure and capacity to design and implement research studies as an independent entity or in affiliation with any and all other research collaborators within or external to the Harvard Medical School community. This decision was made principally because the hosting institution, the Brigham and Women's Hospital, is committed to excellence in research as well as clinical care and education, and because the founding architects of the OCC viewed prospective research as part of their core mission. Lastly, as initially envisioned, the financial sustainability of the center was expected to rely on a combination of clinical revenues, educational/training revenues, philanthropic contributions as well as research income and overhead. As envisioned in our model, the establishment of, and ongoing clinical activities based at the OCC have catalyzed novel research initiatives,[23] which in turn have supported clinical infrastructure and enhanced visibility and credibility of the clinical team. For example, initial positive outcomes of migraine patients referred from a HMS-affiliated hospital headache program led to a collaborative pilot trial evaluating a mind-body program offered at the OCC for managing migraine symptoms.[29] Similarly, a

large scale NIH-funded observational study currently underway, evaluating the effectiveness and cost-effectiveness of our clinical care model for chronic low back pain patients,[22] has contributed significantly to OCC infrastructure development and support, and findings will be used to inform the evidence base for referring complex back pain patients to our team in the future.

Question 2: What Should be the Scope of Educational Activities?

While all IM centers deliver clinical services, the decision to offer educational programs is yet another distinguishing feature. For example, should informational lectures, seminars or conferences be organized and led by the center for other clinicians locally, regionally or nationally? Should they be offered for patients, family and members of the local community? Should they be offered for trainees in the clinical disciplines included within the IM team? And should these offerings be viewed as an educational "service" or professional organizational requirement to be donated as "marketing activities," or as a means of generating supplemental operating funds to sustain the center? Should continuing education credits be offered for these programs and should tuition be charged?

In the case of the OCC, we provided internal (i.e. team member) weekly educational meetings approved for CME credits by the Harvard Committee on Continuing Education. The OCC is involved with broader institutional, regional and, on occasion, national conferences of interest to clinicians, policy makers, patients and their families. Some examples of successful educational activities leveraging the expertise of the OCC team and utilizing its infrastructure include: shadowing opportunities for fellows supported by an NIH T32 program aimed at training clinician-researchers specifically interested in IM; coordinating a monthly Integrative Therapies Grand Rounds program across HMS that showcases noteworthy outcomes observed and therapies delivered at the OCC as well as at other HMS-based IM clinics; and an about-to-be initiated residency program for internal medicine and psychiatry residents.

SECTION IV: DECISIONS REGARDING ORGANIZATIONAL, ADMINISTRATIVE AND FINANCIAL ISSUES

Question 1: What is the Organizational Reporting Structure?

Some IM facilities are separate, independent entities with an affiliation to the hosting institution/organization only. They then bear the financial, organizational and legal responsibility for their own oversight and sustainability. Others are established within departments (e.g. medicine, oncology) or trans-departmentally, with reporting requirements to the director of ambulatory services, director of the "practice," chief medical officer and/or CEO, or president of the institution/organization. Each option has implications with regard to authority, independence, billing procedures, as well as legal, financial, administrative and intra-organizational coordination or lack thereof.

In the case of the OCC, it is independent of existing clinical divisions at Brigham and Women's Hospital, as it includes staff clinicians from multiple divisions. The reporting structure is through the ambulatory care administrators to the office of the president. As a

hospital clinic, the OCC utilizes institutional patient billing, coding, and administrative infrastructure including the hospital's human relations department, chief medical officer, legal counsel, and hospital-wide EMR.

Question 2: What Should be the Relationship with the Medical Records System of Referring Clinicians?

IM center planners must decide whether to establish their own EMR systems or join the EMR of their hosting institutions/organizations. Furthermore, a decision must be made as to whether documentation and communication via EMR will involve MD's on staff only, selected non-MD IM team members (e.g. physical therapists and other established hospital affiliated allied health personnel), or all IM clinical team members, including licensed CAM practitioners. If CAM professionals are to be included in EMR participation, then a considerable amount of effort may be necessary to establish a lexicon which can be readily understood by both "conventional" care practitioners as well as CAM professionals. Without such attention, the office "notes" of some CAM professionals (e.g. acupuncturists) may be unintelligible to the average conventional medical colleague who is also caring for the same patient. (21) This is another area where current practice varies across existing IM centers. (19)

In the case of the OCC, an extensive lexicon of terms, definitions and standardized EMR templates and forms were developed, and all IM team members were required to document all clinical encounters on the hospital's shared EMR system.

Question 3: Are Sales of Herbal Products and Other Dietary Supplements Included as Revenue Generating Products of the IM Center?

The use of herbs and other dietary supplements accounts for a large proportion of CAM use by the US public.[1,2,4,5,26] Patients seeking clinical care at IM centers often request advice with regard to the judicious use or avoidance of herbs and other dietary supplements and natural products. A decision with regard to the prescribing of such products is a necessary one. In considering sales of such products, advantages regarding potentially significant revenue streams must be balanced by possible perceived conflicts of interests between IM clinics and product manufacturers.

In the case of the OCC, IM team clinicians were free to make recommendations about the use or avoidance of individual herbs, supplements and other natural products, but these were not sold at or by the center. It was the consensus view of the Center's directors that some botanical and other nutraceutical supplements lacked the necessary documentation with regard to quality assurance (i.e. reproducibility), safety, efficiency and/or effectiveness to be approved by the hospital's Pharmacy and Therapeutics Committees, a requirement for inclusion in the hospital's existing formulary. The OCC architects were also cognizant of the fact that in some instances, the explicit sale of these products at a significant profit above and beyond costs to the medical provider may run afoul of existing statutes and policies of medical regulating boards, as they could raise issues of conflicts of interest on the part of care givers.

Question 4: How Do You Define and Limit the Scope of Clinical Practice for Individual CAM Providers?

This is an area which requires internal discussion and documentation prior to the establishment of the IM center. While licensed CAM professional groups often have suggested scope of practice guidelines, individual institutions may choose to limit certain practices or procedures. By way of example, some medical institutions' clinical leaders oppose the chiropractic manipulation of the cervical spine owing to concerns about elevated risks of cerebrovascular accident. While this remains an area of controversy, it is the medical institution's prerogative to establish scope of practitioner guidelines if the CAM professional is to become an active employee of, or legal affiliate of the hospital/organization.

In the case of the OCC, cervical manipulation was limited and hospital approved informed consent was required prior to cervical manipulation. There is little information in the published literature describing national scope of practice guidelines for individual CAM practices within IM centers.

Question 5: Should "Non-Conventional" Licensed CAM Professionals be Employed as "Independent Contractors" or Hospital/Organizational Employees?

Legal pros and cons of this decision taking into consideration issues of liability have been described elsewhere.[30] However, financial considerations, including benefits, overhead costs, and costs related to cancellations also come into play regarding the decisions to recruit part- vs. full-time practitioners, and whether these positions are salaried vs. independently contracted.

In the case of the OCC, we opted to engage all IM clinical team members as employees of the hospital, with equal access to the electronic medical record, and identical confidentiality and professional practice obligations to those of their conventional medical counterparts on the IM team. Nationally, there is no consensus view regarding these issues, and currently practices vary from center to center.

Question 6: How Do You Estimate Start-Up Costs, Anticipated Patient Volume, Proposed Revenue Streams, Reliance on Philanthropy and Other Core Components of a Sustainable Business Strategy?

This is arguably the holy grail of IM center planning and, not surprisingly, another domain for which few data currently exist. Once a new IM center is proposed (or when an existing IM center is in need of "redirection"), it is advisable to review the list of key challenges summarized above. Once preliminary or final decisions have been made regarding "settings and populations to be treated," "composition, recruitment and training of IM team members," the "roles of research and education," and the aforementioned "organizational and administrative issues," it is imperative to simultaneously develop a business plan, with accompanying "deliverables" and "timelines" for review by sponsors and champions, as well as potential detractors of the model. Specific questions pertaining to this area include: acceptance of third party coverage vs. self-pay only vs. concierge practice and/or "hybrid" models of payment for IM services.

In the case of the OCC, the original business plan involved the creation of revenue streams from fee-for-service practices, with all services accepting third party payment when it was available. This translated into insurance payments plus co-pays for most clinical services with the exception of acupuncture, massage, yoga, tai chi and a minority of chiropractic services which continue to be self-pay. In addition, the original business plan envisioned additional revenue from educational (i.e. CME) offerings; from grateful patients; from local, regional and national/philanthropists; and from sponsored research which could include direct payments for clinical services and research infrastructure as well as payments to cover indirect costs to be applied to the center's overhead, including its administrative requirements.

According to the Bravewell report, IM services most often covered by insurance include: IM consultations (79%), acupuncture (62%), psychology/psychiatry (59%), nutrition (55%), pre- and post-operative care (45%), and mind-body therapies (41%). However, cash was reported to be the most frequent type of payment. In particular, the majority of surveyed clinics (86%) receive payment in the form of cash for acupuncture and massage.[19]

Issues relating to overhead, rent, clinical "taxes" and fee structures will also vary from IM center to IM center as do payment of IM staff via fee for service, salary or other contractual relationships. The medical literature does not have many well-documented examples of financially self-sustaining IM centers affiliated with sizeable academic medical centers. As such, there is still considerable variability in business planning as applied to IM Clinical Centers.

Implications and Future Directions

As of July 2015, the Academic Consortium for Integrative Medicine & Health[12] listed 62 institutions in the US and Canada as its members. As mentioned throughout this article, an increasing number of these institutions have embarked on the establishment of "Integrative Medicine" centers, clinics and programs whereby patients are afforded access to *both* conventional and CAM professionals and practices. Given the increasing number of academic health centers joining the Consortium in recent years, the presence of such integrative care clinical programs is apt to persist and may increase in the decades to come. There are many common strategic decisions that have to be made when envisioning, operationalizing and maintaining an Integrative Care Center or Program within an existing academic medical center. Currently, there is little or no consensus with regard to any one of these elemental and strategic decisions, nor has a rigorous evaluation of various models been conducted. The ultimate acceptance and re-creation of specific IM models will likely fail to occur until the abovementioned evaluations showcase an enhancement in clinical outcomes and a simultaneous reduction in overall costs or, at the very least, evidence of enhanced clinical outcomes at comparable levels of expenditure. Key to making this happen is the development of a consensus as to how Integrative Care models are to be organized, replicated and evaluated. We are still in the early days of organizational development and consensus building.

At the level of individual IM centers, clinics and programs, it may be worthwhile to reflect on aspects of any specific IM center which parallel or differ significantly from other IM centers. For institutional leaders contemplating the creation, refinement and/or expansion of IM centers, perhaps it is time for the establishment of voluntary data collection across IM centers, as has been initiated by the Bravewell collaborative. Such efforts are a prerequisite for the demonstration of clinical effectiveness, albeit using diverse models at the present time.

In this article, we have described questions which apply to a range of existing and emerging IM models. The next step will require a commitment from advocates and skeptics of this controversial area to jointly describe and evaluate Integrative Care Models more precisely in an effort to prove or disapprove their comparability, replicability, clinical and cost effectiveness (or lack thereof) for a range of patient populations. From the standpoint of national policy makers (and skeptics), what is now needed is a discussion as to whether and how IM models can and should be prospectively assessed as components of Patient Centered Medical Homes, Accountable Care Organizations, insurance plans, the Affordable Care Act (which includes mention of payments for CAM services along with explicit payment schedules for nutritional and exercise assessment for all Medicare recipients), as well as IM models being adopted by the Department of Defense and Department of Veterans Affairs. In short, it may be time for resources from both the public and private sectors to sponsor research in “best practices” across emerging models of Integrative Medical Care nationally in an effort to standardize and refine them in preparation for rigorous cost-effective evaluations.

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Table 1

Essential Issues and Considerations Relating to Establishment of Integrative Medicine Centers

Essential Issues	Key Considerations	Implications
I. Decisions regarding settings and populations		
Organization and setting	• Physical vs. virtual entity • Located within main hospital, satellite clinic, or separate from both • Outpatient vs inpatient care, or both	• Perceived legitimacy/credibility and institutional commitment • Ease and access to referrals and patient populations
Principal population	• Broad vs. focused principal populations, including clinical conditions (all vs. specialty) and ages (adult only vs. inclusion of children)	• Degree of population focus impacts specificity of team training, potential for condition-specific research, referral stream, and breadth of prospective patient base
Nature of clinical services provided	• Primary care vs. consultative services vs. both	• Affects all core decisions related to settings, populations, team, and organizational, staffing, administrative and financial issues • If provide both, offers fully integrative patient care but potentially competes with other primary care clinics
II. Decisions regarding composition, recruitment, and training of multi-disciplinary team		
Selection of CAM practices and specific providers	• Choice of modalities to match targeted clinical conditions • Rules for qualifications and competencies for CAM providers (including state privileges, national certifications, licensure, etc)	• Must take into consideration specific hospital guidelines for credentialing • Ability to work across medical cultures • Ability to work both as an independent provider of a specific discipline as well as a member of an interdisciplinary team
Original team training	• Duration, intensity, and content of trans-professional training activities (e.g. one single vs. extended program, experiential vs. didactic teaching) • Nature and philosophy of team communications (e.g. referrals, shared decision making, use of electronic medical records, etc)	• Financial resources and clinician time to make training sessions feasible
Ongoing training of clinicians/team	• Content (clinical topics and case reviews, administrative issues), format, level of requirement, and frequency	• Good for integrating of new team members • Opportunity for CME credits • Increased costs if not billable by team members
III. Decisions regarding role of research and educational initiatives		

Essential Issues	Key Considerations	Implications
Scope of research activities	• Involvement in clinical services only vs. additional participation in research activities (e.g. health services, comparative effectiveness, efficacy, or basic research)	• Initial establishment of research infrastructure requires individuals with research expertise and separate funding • Successful research program could impact academic credibility, financial sustainability of clinic, and continuing evidence-based education of clinicians
Scope of educational activities	• Nature of target audience (team members, other clinicians or employees within institution, trainees or fellows, patients and families, outside health professionals, or public)	• Impacts visibility for referrals, credibility regarding evidence-base for IM, training of next generation of providers • Programs can be structured as “service” or investment with goal of marketing, or potential for fee revenue generators
IV. Decisions regarding organizational, administrative and financial issues		
Reporting structure	• Separate entity vs. entity within a department or patient care line	• Implications for financial, organizational and legal responsibility for oversight and sustainability; authority, independence, billing opportunities and constraints; and intra-organizational coordination
Medical records	• Independent or shared electronic medical record system with parent institution • Input of notes by conventional providers only or all IM team providers	• Opportunities for communication within and between conventional and IM providers. • Requirement of development of shared medical lexicon and training in use of EMR system
Herbs and supplements	• Recommendation, prescription and sale of herbal products and supplements	• Existence of sufficient evidence for patient recommendation and/or approval for inclusion in hospital formulary • Potential for real or perceived conflict of interest on part of health care providers for direct sales • Potential for revenue stream for clinic
Scope of practice	• Degree of limitations with procedures or techniques set by either licensed CAM professional groups or individual institutions	• Guidelines may allow selective practices (e.g. no chiropractic cervical manipulation without written consent)
Nature of CAM provider employment status	• CAM providers as independent contractors vs. hospital employees	• Implications in a number of areas, including nature of payment and overhead, liability, access to electronic medical records, and professional practice obligations
Initial business plan and model for sustainability	• Deliverables and timelines for review by stakeholders • Acceptance of third-party coverage vs concierge practice and/or hybrid models • Need for ongoing philanthropic contributions and/or institutional subsidization	• Recognition of value-added and definition of “success” to the institution