

Academic Collaborative for Integrative Health (ACIH)
Project for Inter-Institutional Education Relationships (PIERs):
Examples of Real-Life Inter-Institutional Collaborations

Background

Interprofessional practice and education is essential to prepare graduates to collaborate with providers from disciplines other than their own. Academic institutions are developing collaborations with other schools and healthcare delivery institutions to help their students gain experience working in teams with other disciplines and/or working with a broader population of patients.

Key documents in the advancement of integrative health and medicine underscore this importance. In 2005, the National Education Dialogue (NED) to Advance Integrated Health Care created nine priority recommendations for interdisciplinary educational collaboration. Notably, the very first is to “facilitate development of inter-institutional relationships and geographically-based groupings of conventional and CAM institutions and disciplines in diverse regions.” (The NED recommendations most relevant to the current Project for Inter-Institutional Education Relationships (PIERs) project are highlighted in Appendix A below). In addition, many of the Academic Collaborative for Integrative Health (ACIH) *Competencies for Optimal Practice in Integrated Environments* (<https://integrativehealth.org/competencies-integrated-practices/>) are advanced directly and each can be considered advanced indirectly with an increase in inter-institutional education relationships. This is particularly so since most education of distinctly licensed integrative health and medicine professionals is in stand-alone programs and institutions outside of conventional academic health centers. Clearly, inter-institutional education relationships are of great importance to ACIH members and the communities we serve.

The purpose of the Project for Inter-Institutional Education Relationships (PIERs) is to foster optimal inter-institutional and interprofessional relationships that bridge the gaps in education and practice between the distinct integrative health and medicine (IHM) agencies and institutions, and between these and other healthcare agencies and organizations. This project highlights examples of inter-institutional experiences and shares resources for fostering inter-institutional relationships.

This document contains descriptions of inter-institutional relationship experiences as well as possible questions one might ask potential partners (see Appendix B below). A repository of practical tools and resources (including examples of agreements and other materials) to support the development of inter-institutional relationships and interprofessional learning is being developed and will be posted on the ACIH website. Future work may include developing a FAQ addressing challenges grouped by themes for fostering these relationships. These may include faculty exchanges, student-student programs, clinical opportunities, and integrated post-graduate and residency programs.

Methods for Gathering Data

Via the ACIH Clinical Working Group (CWG) and Education Working Group (EWG), a project group was created of members who identified this as an initiative of high interest to them. The PIERs project, staffed by ACIH Assistant Director Beth Rosenthal, PhD, MPH, MBA, drew the following members:

- Ron Boesch, DC, DACNB Dean of Clinics/Professor, Palmer College of Chiropractic (CWG)
- Dawn Hogue, MA, CMT Chair, Commission on Massage Therapy Accreditation; Senior Administrator, Cayce/Reilly School of Massotherapy (EWG)
- Beth Howlett, DAOM, LAc Faculty, Oregon College of Oriental Medicine (EWG)
- Anthony Lisi, DC Associate Professor, University of Bridgeport College of Chiropractic (CWG)
- Michael Sackett, DC Dean, Los Angeles College of Chiropractic (CWG)
- Mitchell Zeifman, BSc, ND Associate Dean, Canadian College of Naturopathic Medicine (CWG)

Project members began by developing a set of questions to be used as a template for describing inter-institutional experiences. The members used the questions as a guide to describe their own inter-institutional experiences and/or to interview others about inter-institutional experiences. The following eleven questions were used to describe the institution's experiences:

1. Why was this brought to your institution?
2. How was it started?
3. Who were the stakeholders with this project?
4. What were challenges/stumbling blocks you encountered?
5. Were there any financial issues/stumbling blocks?
6. What did you learn?
7. How did you manage the time (how frequently did it occur, how much time to organize)?
8. Allocation of time between institutions – did one do more work?
9. Do you have any resources/tools (ie contracts) you could share?
10. How did you communicate to the stakeholders?
11. How was the program assessed?

The PIERS resources, as presented here, are possible through contributions of the following individuals who collected information about initiatives at the institutions listed below in alphabetical order.

- Aurora Health Care, Milwaukee, WI: Nancy Conway, MS
- Canadian College of Naturopathic Medicine, Toronto, Ontario: Mitch Zeifman, BSc, ND and Nick DeGroot, ND
- Mayo Clinic, Rochester, MN: Nancy Rodgers, MT, NCTMB and Liza Dion, MT, CIMT, NCTMB
- National University of Health Sciences, Florida: Daniel Strauss, DC
- New England School of Acupuncture, Newton, MA: Stephen Cina LAc, MAOM, ATC, NASM CES
- Northwestern Health Sciences University, Bloomington, MN: Dale Healey, DC, PhD
- Palmer College of Chiropractic, Davenport, Iowa: Ron Boesch, DC, DACNB
- University of Bridgeport Chiropractic College, Bridgeport, CT: Anthony Lisi, DC

We are grateful to each contributor, and to their respective institutions, for sharing their individual experiences as part of our collaborative efforts to discover optimal practices in inter-institutional relationships.

Examples of Real-Life Inter-Institutional Collaborations

This section provides descriptions of inter-institutional experiences. The name of the organization, website(s) relevant to the program being described, the name of the person providing the description, and the date the information was provided are given before the responses to the template questions. This is a working document and we expect to continue adding descriptions and gathering helpful resources.

Aurora Health Care - Milwaukee, WI

Website: <http://www.aurorahealthcare.org/services/integrative-medicine>

Contributed by: Nancy Conway, MS

Date Contributed: March 2014



1. Why was this brought to your institution?
Aurora Health Care is an integrated, not-for-profit, and all-for-people, healthcare provider serving communities throughout eastern Wisconsin and northern Illinois. We provide a comprehensive array of health services and access points, from primary and specialty care to our hospitals, pharmacies, labs

and homecare. Aurora Health Care has a long-standing close affiliation with the University of Wisconsin School of Medicine and Public Health. Faculty have academic appointments through the University Of Wisconsin School Of Medicine. Aurora University of Wisconsin Academic Medicine provides expanded learning and clinical rotation opportunities for medical students, residents and fellowships.

There are two approaches to address with this question: The first is the opportunity for Aurora Integrative Medicine caregivers (massage, chiropractic and acupuncture) to work closely the academic medicine program. The academic medicine program pre-dates the Integrative Medicine program. Solid work began between the two groups when a physician and nurse practitioner attended the University of Arizona fellowship training program.

The second approach involved outreach from Integrative Medicine to local academic massage, chiropractic and acupuncture programs. This approach was an early strategy to form local relationships with academic institutions to inform, share and lay the groundwork and foundation for future recruitment and employment opportunities within the community. An effort was made to replicate clinical training and rotation opportunities similar to medical students and those opportunities available to allied health practitioners. It was recognized very early on that new professionals and students of chiropractic, acupuncture and massage therapy had very little exposure to the acute and chronic disease models that present to/ within hospitals, hospital based outpatient health centers, homecare, and hospice. A collaborative working relationship would be mutually beneficial to both institutions. Academic institutions would have the opportunity to extend their training programs and create another level of professional readiness. Health care organizations would have the opportunity to recruit and hire prepared professionals for their work force.

2. How was it started?

Our division initiated outreach to Aurora UW Academic Medicine and offered to provide educational in-services. Similarly outreach took place from Integrative Medicine to local massage and acupuncture schools. Schools occasionally requested education from our professionals working in the field and opportunities for students to gain clinical experience.

3. Who were the stakeholders with this project?

The stakeholders would include the individual representing the profession, for example the manager of massage would hold the relationship with the massage therapy school. Any formal relationships developed required a defined contractual relationship outlining standards for compliance, infection control, risk etc.

4. What were challenges/stumbling blocks you encountered?

It is resource intensive with slow rate of return on investment. It takes time to coordinate student schedules and mentor during the course of a patient encounter. The programs student internship coordination from the school itself was not as strong or well defined as what had been experienced in allied health (physical, occupational, speech therapy). Most of our experience had to do with massage therapy. In some instances the caliber of student was not as professional as hoped, and students were looking to fulfill their quotas. This however should not be considered a poor reflection on behalf of the school or the student. The schools were really not looking forward and planning clinical rotations from the perspective we were accustomed to running as clinical rotations. Another stumbling block for medical students and residents is time to do any additional rotations or clinical experiences. Until the academic institutions decide they have a model for inter-intuitional collaboration, time for curriculum and experiences will remain an issue.

5. Were there any financial issues/stumbling blocks?

Time is money. Internally, if a working professional takes on a student, they are deciding to give additional time, and may bill or produce less. Medical institutions offer stipends to providers for regular appointments, clinical rotations, and education.

6. What did you learn?

Health care organizations are not motivated to push clinical demand from academic institutions in the area of chiropractic, acupuncture and massage, because most have not fully integrated these services. Change will occur as consumer demand rises, and access to professionals are limited. Our learning

<p>curve with respect to chiropractic, acupuncture and massage entering a conventional medical setting has revealed we must put time, energy and budget forth to an onboarding process that must include extensive orientation to unique patient populations and competency training in high risk areas of care. Furthermore we have learned that we cannot assume individuals with an academic background in chiropractic, acupuncture and massage actually know how to work together in a collaborative model. Lastly, another gap exists between the traditional allied health group (RN's, PT, OT, SLP etc.) and integrative therapies. Emphasis is frequently placed on educating physicians. However, nursing typically holds the largest number of employed positions and are more involved in frontline care than any other professional. Academic institutions are not motivated to change unless core educational requirements change. A few dedicated and passionate individuals desire to give back to their career and propagate future growth.</p>
<p>7. How did you manage the time (how frequently did it occur, how much time to organize)?</p> <p>From a leadership perspective, we empowered individuals to become involved as leaders in their own profession, the individuals came forth with the passion, we agreed upon a limited number of worked hours that would be dedicated to the process, and then viewed the outcome of the efforts. It was organized around a professional's performance goal.</p>
<p>8. Allocation of time between institutions – did one do more work?</p> <p>Unfortunately over the years some of the schools have closed. We do not have local access to any chiropractic institutions. Outreach has occurred from students of chiropractic to do clinical rotations. However, this is initiated by the student and not the academic institution. We attempted to pursue this and model it after our medical student/resident rotation process. No resources were available to support this. It would require a business plan and developed educational processes. This would be a consuming element for the health care organization to take on. It is however part of the vision of our clinical director of chiropractic care and may be introduced in our 2015 business planning process.</p>
<p>9. Do you have any resources/tools (ie contracts) you could share?</p> <p>I do not.</p>
<p>10. How did you communicate to the stakeholders?</p> <p>Example: Massage Therapy manager met with massage schools to establish interest in person. Student liaison from the school identified as the individual responsible for coordinating student rotation and experiences. Regular communication between care provider, student and student liaison.</p>
<p>11. How was the program assessed?</p> <p>No formal program assessment in place by academic institution or our organization.</p>

Canadian College of Naturopathic Medicine (CCNM) - Toronto, Ontario

Website: <http://www.ccnm.edu/>

Contributed by: Mitch Zeifman, BSc, ND and Nick DeGroot, ND

Date Contributed: March 2014



<p>1. Why was this brought to your institution?</p> <p>The college and the hospital share a mutual board member who recommended the collaboration. The college saw this as a great opportunity to offer training to our students in a formal healthcare setting and hopefully develop a more collaborative approach to patient care.</p>
<p>2. How was it started?</p> <p>The following timeline outlines the key milestones in the project: 2011 - CCNM board member (Neil Davis) recommended that we collaborate with William Osler Health System 2011 - Delegation from William Osler visits CCNM to learn more about the profession and the college 2012 - Feb. Meeting between William Osler (CEO, Vice President of Development and Support Services) and CCNM (CEO, Dean, Neil Davis) to agree in principle to run teaching clinic out of Brampton Civic Hospital in 2013 2012 - Summer, Fall. Operational planning meetings (internal and external)</p>

2012 - December. Memorandum of Understanding (MOU) signed
2013 - January. 8 shifts start in ambulatory clinic (2 per day) running from 3 to 9pm (Tue-Fri)
3. Who were the stakeholders with this project?
<p>The major stakeholders were:</p> <ul style="list-style-type: none"> • CCNM and CCNM Board of Governors • William Osler Health Network, Brampton Civic Hospital • Patients, staff and health care practitioners at the Brampton Civic Hospital • Students, Faculty, staff of CCNM • Steering Committee engaged as the stakeholder representatives <p>The Steering Committee was a significant reason for the success of the project. It had substantial representation from CCNM and the hospital. CCNM representatives included the Dean, Associate Dean of Clinical Education, Assistant Director Clinic Services and Clinical Lead, Brampton Clinic. The hospital had the Chief Nursing Executive/Director of Nursing, Director of Quality and Patient Safety, Departmental Chief and Vice President, Development & Support Services. The committee was helpful in giving oversight to clinical operations, reviewing research proposals, setting and reviewing Key Performance Indicators and helping us with outreach in the hospital community.</p>
4. What were challenges/stumbling blocks you encountered?
<ul style="list-style-type: none"> • Educating hospital MDs, health care providers and staff regarding training of NDs and the services NDs provide. • Not being a “credentialed” provider. • Long waiting lists for new patients and for patients to have follow-up visits. • Politics of communicating what to whom and when within William Osler. • Determining outcomes - Unsure of what the KPI for success should be - needed to be beneficial to both William Osler and us. • Different objectives for the project from each institution. • Finding adequate operational space (including storage space) and negotiating times of operation. • Political fallout of a CAM clinic in a mainstream hospital. • Not having access to the hospital’s electronic health records system.
5. Were there any financial issues/stumbling blocks?
<p>The key to getting the clinic started in a public hospital was ensuring that it was free. While there were savings in reducing the number of shifts required at the main teaching clinic, the cost to the college is still significant. The cost of running the first year was around \$200,000 with the bulk going to human resources including supervisors and support staff. CCNM continues to source additional revenue for the clinic through research projects and a request to charge for patient visits. The latter is quite challenging owing to restrictions in charging patients for healthcare services in a public hospital.</p>
6. What did you learn?
<ul style="list-style-type: none"> • Clarify and double clarify all roles, responsibilities and expectations from all stakeholders. • Collaboration with medical providers has been challenging with a large teaching clinic focused on such a wide range of primary care concerns. In the future it may be worth considering imbedding naturopathic services in different departments or targeting services to specific conditions/demographics. • The clinic is unlikely to have come to fruition except for the fact that we shared a very strong board member with the hospital board – it indicates how important it is to select powerful members for your board. • Although they don’t normally use the term, hospitals have a de facto bicameral governance structure. It was important for us to keep both the administration (through the president and a VP) fully engaged as well as the key medical staff (through the Steering Committee). • Go Big--Early in our discussions with the hospital we could have chosen to push for a far lesser collaboration. It could have (potentially) taken as much (or more) work and yielded much less of an advantage to the College.

7.	How did you manage the time (how frequently did it occur, how much time to organize)?
<ul style="list-style-type: none"> • Organization required central coordination and the work and expertise of many parties. • Hired a coordinator for the clinic who was also college faculty – Liaison between college managers, hospital staff, doctors, managers and CCNM student interns, clinical faculty. • Dedicated front staff hired and expanded with expanding clientele. Front staff communicate weekly/daily with central clinical operations director. 	
8.	Allocation of time between institutions – did one do more work?
<ul style="list-style-type: none"> • CCNM had more work to do operationally. • Osler arranged space and time, made arrangements with hospital staff for sharing clinic space and maintenance. • Osler and CCNM share responsibility for directing and monitoring activities (Steering Committee), though CCNM collects most statistics. • Promotion mainly from CCNM, with internal information coming from Osler. Osler organized presentation to various hospital medical teams and other groups. CCNM did outreach to other groups independently. • Financial appeal developed jointly by CCNM and Osler. 	
9.	Do you have any resources/tools (ie contracts) you could share?
<p>We are willing to share the details of the MOU. See: http://accahc.org/images/stories/brampton_clinic_2012.pdf</p> <p>Some of the key components of Memorandum of Understanding are:</p> <ul style="list-style-type: none"> • Pilot project to assess feasibility of future endeavors between CCNM and William Osler. • 2 year trial (Jan 2013 until December 2014). • Space donated by hospital for 4 days a week. • CCNM provides supervisors, students (ratio of 6 students to 1 supervisor) and supplies. • CCNM supervisors act as independent contractors. • Liability on CCNM for medical issues. • Service will be free to patients. • Oversight of the clinic by a steering committee. • Insurance: <ul style="list-style-type: none"> ○ General Liability of 5 million (CCNM) ○ Liability for all clinical services (CCNM) 	
10.	How did you communicate to the stakeholders?
<ul style="list-style-type: none"> • Developed presentations for medical teams. • Advertised directly to the surrounding community base. • Engaged with political representatives. • Met with LHIN and other financial stakeholders. • Convened a steering committee (see above). 	
11.	How was the program assessed?
<p>We are still developing better alignment with Brampton Civic Hospital internal assessments and key performance indicators. Key measures we are currently tracking are patient satisfaction, patient volume and referrals from other healthcare providers.</p>	

Mayo Clinic - Rochester, MN

Website: <http://www.mayoclinic.org/>

Website: <http://www.mayo.edu/mshs/careers/massage-therapy>

Contributed by: Nancy Rodgers, MT, NCTMB and Liza Dion, MT, CIMT, NCTMB

Date Contributed: January 2014



1. Why was this brought to your institution?
This inter-institutional collaboration started because of a perceived need to help lower pain/anxiety scores for open heart post-surgical patients.
2. How was it started?
The Pain Free Heart Surgery Group heard from patients on rounds about ongoing back, neck and shoulder pain. The group leaders met with Dr. Brent Bauer and discussed options for massage therapy. The Department of Physical Medicine and Rehabilitation was approached about utilizing an Occupational Therapist who was also a massage therapist for a pilot program with cardiac surgical patients. After the pilot study was completed, the Division of Cardiac Surgery was approached about offering massage therapy as an ongoing option for pain management as a Healing Enhancement Program. A massage therapy full-time position working with cardiovascular (CV) patients was created and an additional randomized controlled trial of massage therapy was conducted with similar positive results as the pilot. After 5 years, this full-time position was made into two half-time positions. For the next 3 years the two massage therapists worked solely with the CV patients. Then they were given 5 hours per week to work with the thoracic patients. During this time there was a pilot study for the colon and rectal patients receiving massage post-surgery. The massage therapist was hired post study for 20 hours per week in this department. Massage therapy orders started coming from other units in the hospital. As demand increased across all services, surgical and otherwise, a fee for services model and pilot was implemented. As massage therapy services spread, these services were brought under the Complementary and Integrative Medicine Program in General Internal Medicine.
3. Who were the stakeholders with this project?
Healing Enhancement team, Department of Surgery, CV nursing staff, Complementary and Integrative Medicine Program in General Internal Medicine
4. What were challenges/stumbling blocks you encountered?
<ul style="list-style-type: none">• Nurses remembering to put their patients onto the massage schedule.• Interruptions during treatment by other healthcare workers.• General communication issues regarding which patients could have the service.• Space for the therapists to store their supplies and documentation area.• Not easily identifiable amongst other health care workers as there were only three of us.• No insurance reimbursement for massage therapy• Billing process development• Recognition of massage therapy at an institutional level as a service line• Demand exceeding the capacity of massage therapy staff• Outside providers being called to come in to see patients for massage therapy- recognizing the safety issues of this practice as well as the policy regarding not having outside providers offering services on Mayo campus.
5. Were there any financial issues/stumbling blocks?
Issues began when other units and Departments wanted the service but were not able to hire staff. Once a fee for service model was established throughout the hospital, the CV nurses felt their patients shouldn't have to pay for it and therefore stopped putting orders through at first. Once a fee for service was agreed upon billing codes had to be arranged, and an ordering system was needed and documentation had to be developed and improved. A financial effect analysis was needed to determine the price point of massage therapy services to offset the cost of salary and benefits of massage therapy staff. Review of financial reports of massage therapy services is ongoing.
6. What did you learn?
Education regarding massage and integrative medicine has been essential as allied staff order the majority of massage requests for their patients. Continuing education, an example being oncology

<p>massage and pediatric massage, for the therapist is imperative to safely serve the critically ill patients at this facility. Patients have a strong interest in massage therapy to help manage symptoms of pain, anxiety, stress and sleeplessness and are willing to pay for these services. Massage therapy offered in a medical setting required a different or added skill level and training. The medical setting is complex and massage therapists can become an essential part of the team. Communicating with the medical team is an important skill to be learned. Research and data on the outcomes of massage therapy are important for leadership to be able to recognize the value of integrative therapies and prioritize for hiring staff and contributing to positive patient outcomes.</p>	
7.	<p>How did you manage the time (how frequently did it occur, how much time to organize)?</p> <ul style="list-style-type: none"> • One therapist at 40 hours per week for 5 years serving cardiovascular patients. • Two therapists at 20 hours each per week for 3 years serving cardiovascular patients. (Monday-Friday 10-3). • One therapist at 20 hours per week serving colon and rectal patients. • Once fee for service was implemented throughout the two hospitals the therapists FTE went to .75 as they worked throughout the hospital. • Currently could use additional massage FTE
8.	<p>Allocation of time between institutions – did one do more work?</p> <ul style="list-style-type: none"> • Each therapist is now working .75 FTE • One works at Saint Marys and the other works at Methodist. • One therapist shares her time between both hospitals and out-patient services.
9.	<p>Do you have any resources/tools (ie contracts) you could share?</p> <p>We do not have contracts.</p>
10.	<p>How did you communicate to the stakeholders?</p> <ul style="list-style-type: none"> • Individual meetings • Attend divisional group and leadership meetings • Flyers and newsletters • Publications of research and program development
11.	<p>How was the program assessed?</p> <ul style="list-style-type: none"> • Research protocols • Medical record documentation of outcomes before and after massage therapy services. • Patient satisfaction surveys given out after the massage. • Financial analysis • Productive reports • Staff feedback and demand for services

National University of Health Sciences (NUHS) - Florida

Website: <http://www.nuhs.edu/admissions/chiropractic-medicine/florida-site>

Contributed by: Daniel Strauss, DC

Date Contributed: March 2014



1.	<p>Why was this brought to your institution?</p> <p>National University of Health Sciences, through the University Partnership Center, is part of a unique partnership with St. Petersburg College. St. Petersburg College Caruth Health Education Center has 15-16 different health related disciplines (such as nursing, EMS/paramedic, respiratory therapy, dental hygiene, etc.), and there are a number of certificate programs. NUHS is involved in collaborative learning experiences with several of these disciplines. Besides NUHS there are 15 other universities included in the University Partnership. NUHS however is the only doctorate in chiropractic medicine program. Though many colleges and universities offer their programs at the Caruth Health Education Center, we often collaborate together for interprofessional learning experiences. This gives faculty,</p>
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staff, and students unique learning experiences that would normally not be attainable in a traditional academic setting.

Some examples of collaborative learning experiences NUHS - Florida has been involved in include:

- Lunch and learn program and grand rounds presentations: these events are scheduled during lunch periods where a guest speaker or speakers presents on particular health topics- this often involves speakers from NUHS. The presentations have expanded to include integrative collaborative learning exercises such as working through cases together in a multidisciplinary healthcare setting.
- Cadaver Workshops are unique learning experiences provided by NUHS to other colleges and universities. NUHS faculty and students will offer cadaver workshops where faculty and students from SPC and the University Partnership will be invited to observe and learn from our faculty and students through NUHS cadaveric dissection in a laboratory setting.
- Lectures and presentations: NUHS sponsored National Public Health Week. A NUHS faculty member, Dr. Prakash who is also on that board for the American Public Health Association spearheads activities involving NUHS and SPC to bring awareness to public health topics.
- Involvement in IPE presentations such as with Dr. Eric Black of the University of Florida during a discussion on collaborative learning. Students from different disciplines learned together, case studies.

2. How was it started?

Though the partnership already existed, Dr. Stiefel, current President of NUHS, was instrumental in building relationships and encouraging participation.

3. Who were the stakeholders with this project?

Dr. Stiefel was at forefront with the support of NUHS President emeritus- Dr. Winterstein

4. What were challenges/stumbling blocks you encountered?

When NUHS came to Florida to offer the DC degree program, we were not yet well known in the community. It took some time to gain recognition but Dr. Stiefel immediately became immersed in the rich academic environment, building relationships through the University Partnership. Every trimester we became more involved with lunch and learn presentations and grand rounds. Trying to find how to incorporate interprofessional learning experiences, while still following guidelines and of course structure and accreditation are certainly challenges and considerations. Fortunately NUHS may not have had difficulty collaborating with other health disciplines because we teach integrative care and our University already has many different disciplines working together from chiropractic medicine, naturopathic medicine, acupuncture, oriental medicine, massage, etc.

5. Were there any financial issues/stumbling blocks?

Not really. We had a lot of faculty volunteers involved with presentation and integrative activities. We also have a lot of support from St. Petersburg College and the University Partnership Center.

6. What did you learn?

Communication is the key and is something we've taken advantage of and nurtured; we have continuously openly communicated with other disciplines, pursuing the common goal of health education.

7. How did you manage the time (how frequently did it occur, how much time to organize)?

There are sometimes conflicts in scheduling with our faculty, students and other institutions but we make accommodations when available. We continue trying to navigate those challenges, taking time to plan ahead for these learning experiences. Typically, we have integrative learning experiences at least once a month.

8. Allocation of time between institutions – did one do more work?

Depends on the learning experience. We are pursuing expanding on grand rounds presentations and case study presentations; we are investigating incorporating other institutions to present cases in a multidisciplinary setting. Each institution involved in the learning experience has been respectful in time allocation.

Allocation of time most certainly requires communication and we have been quite fortunate to work with many great individuals from other colleges and universities. The time usually works out just fine; where

one event may have a stronger presence from one institution but the next month another may- it has worked out really well.
9. Do you have any resources/tools (ie contracts) you could share?
No. Hasn't come up.
10. How did you communicate to the stakeholders?
We have always been sensitive to other institutions' policies and protocols including following the appropriate chain of command. It is always good to know what everyone's doing and how they're doing it.
11. How was the program assessed?
Challenging because we haven't done a learning assessment for the program but the feedback has been excellent.

New England School of Acupuncture (NESA) - Newton, MA

Website: <http://www.nesa.edu/>

Website: <http://publichealth.tufts.edu/Academics/MS-Pain-Research-Education-and-Policy/MS-PREPMac-with-the-New-England-School-of-Acupuncture/NESA>

Contributed by: Stephen Cina LAc, MAOM, ATC, NASM CES

Date Contributed: February 2014



1. Why was this brought to your institution?
In 2006, Dr. Richard Glickman-Simon, serving as Chair of NESA's biomedical department, was serving as director of the Tufts Pain Research, Education & Policy Program (PREP), a Tufts University stand-alone Master's granting program. Richard thought collaboration between Tufts and NESA could be mutually beneficially as both institutions/programs were interested in increasing student enrollment. This affiliation could bolster NESA's enrollment through showing collaboration with an ivy league medical institution and the Tufts PREP program's enrollment would be increased via NESA graduate students. There was also a genuine interest in training the "acupuncturist of tomorrow" by graduating students who were well versed in both Western and Eastern medicine.
2. How was it started?
Since both programs would operate independently, neither program would require much curriculum change.
3. Who were the stakeholders with this project?
Both NESA and Tufts. Tufts needed the student numbers and NESA needed a marketing edge which helped differentiate it from other acupuncture institutions. Both institutions are in charge of running their program without oversight from the other. Both NESA and Tufts were interested in increasing student enrollment and in educating a newer type of acupuncturists who could provide a greater degree of medical integration.
4. What were challenges/stumbling blocks you encountered?
NESA did make a concession for dual NESA/Tufts PREP students by waiving a few elective requirements.
5. Were there any financial issues/stumbling blocks?
Students would need to manage the cost of 2 graduate programs.
6. What did you learn?
To create any collaboration, an institution needs a champion for the other. In this case, Richard knew it could be a win win for both institutions and NESA's president was fully onboard.
7. How did you manage the time (how frequently did it occur, how much time to organize)?
None for NESA or Tufts other than allocating webpage space for marketing and collaborating on a brochure.
8. Allocation of time between institutions – did one do more work?
Tufts PREP Director and other physicians would visit NESA to pitch the PREP program to current students usually in the Summer semester before students decide on a NESA track. What we now see are prospective NESA students being made aware of Tufts PREP before they are accepted to NESA via brochures, website, etc.

9.	Do you have any resources/tools (ie contracts) you could share?
	None
10.	How did you communicate to the stakeholders?
	Communication between the new director of Tufts PREP, NESA's president and Academic Dean is solid. The new director of Tufts PREP has accepted a position on NESA's Board of Trustees.
11.	How was the program assessed?
	N/A

Northwestern Health Sciences University (NWSU) - Bloomington, MN

Pillsbury House – Community Clinic

Website: <https://www.nwhealth.edu/pillsbury-house/>

Contributed by: Dale Healey, DC, PhD

Date Contributed: March 2014



1.	Why was this brought to your institution?
	Pillsbury House Integrated Health Clinic was started in an effort to bring care to an underserved community, provide a clinic learning environment that would give students exposure to diverse populations and conditions they would not otherwise be exposed to, and provide for integrated, team-based learning experiences that combine multiple disciplines (CAM and allopathic.)
2.	How was it started?
	Mike Wiles, former provost, had a chance encounter at a conference with Carter LeBares, a medical student at the University of Minnesota. Carter grew up in the Powderhorn park neighborhood (very diverse, underserved community) and had a vision to start a free, integrated community clinic in the area. The two brainstormed, arranged follow-up meetings, met with the staff of Pillsbury House (social service community resource center, which now houses the clinic), and other interested parties from Northwestern and the University of Minnesota. The clinic started slowly and has grown tremendously over the past several years.
3.	Who were the stakeholders with this project?
	University of Minnesota medical school – faculty and students, Center for Spirituality and Healing at the University of Minnesota, Northwestern faculty and students, University of Minnesota school of Nursing, Adler Graduate School of Psychology – faculty and students. The community itself and Pillsbury House were obviously significant stakeholders.
4.	What were challenges/stumbling blocks you encountered?
	Space at Pillsbury House was limited. The clinic started in the basement and shared space with a day care. During clinic hours, we had to pull all the tables and equipment out of storage for the clinic hours. We have since been given dedicated space on the third floor, which works much better. Medical students are excited to participate for the most part, and faculty have volunteered their time to supervise, but the medical school itself has not taken the final step of making Pillsbury an official clinical site with all that goes along with that. Sometimes the medical students have been challenged to find their role in the clinic. Part of this has been due to the limited support from the medical school and therefore scope of the medical students, but a bigger issue perhaps has been the question of “what do the medical students do in a clinic that is focused on wellness?” Chiropractors, massage therapist, acupuncturists and counselors always had plenty to do for the patients, but I think the medical students felt at a bit of a loss unless they had a very specific disease or condition they were treating. Scheduling of supervisors, students and patients has sometimes been a challenge. We used to be strictly walk in, but now patients do need to schedule which has helped.
5.	Were there any financial issues/stumbling blocks?
	There is no reimbursement at Pillsbury House. All care is free, so the model is not sustainable without the backing of Northwestern or volunteers. There is significant cost with operating the clinic at Pillsbury House and during lean years, that line item on the budget gets targeted.

6.	What did you learn?
<p>We have learned plenty over the years.... There is a great need for care in this neighborhood (and many others of course), but no easy answers regarding how to pay for it. The open concept of the clinic is great for interdisciplinary learning. Supervisors that push students to learn from each other and are passionate about the clinic make all the difference in the success of the clinic.</p>	
7.	How did you manage the time (how frequently did it occur, how much time to organize)?
<p>Many, many evening planning sessions have taken place over the years (and continue). The clinic started as a one evening a week thing and now is open three days a week – Monday, Wednesday, and Saturday. The clinic takes at least as much time outside of scheduled hours as in, to keep it going. It's been operating for about 9 years (as of March 2014).</p>	
8.	Allocation of time between institutions – did one do more work?
<p>I don't think any parties involved would disagree that Northwestern shoulders the majority of the work involved. Individuals from other institutions have been very committed over the years in terms of volunteering, but the vast majority of budget, meeting space, equipment, management etc. has come from Northwestern.</p>	
9.	Do you have any resources/tools (ie contracts) you could share?
<p>We would be happy to share all documents associated with the Pillsbury House Integrated Health Clinic. See: http://accahc.org/images/stories/pillsbury_operations.pdf http://accahc.org/images/stories/biotone_grant_application.pdf</p>	
10.	How did you communicate to the stakeholders?
<p>Signage for Pillsbury house and word of mouth worked well to bring in patients. Lots of networking, press releases to build our visibility. Meetings, brown bags, email blasts...</p>	
11.	How was the program assessed?
<p>We've looked at various things over the years – patient numbers, student satisfaction surveys, patient satisfaction surveys.</p>	

Palmer College of Chiropractic - Davenport, Iowa

Website: <http://www.palmer.edu/>

Contributed by: Ron Boesch, DC, DACNB

Date Contributed: December 2013



1.	Why was this brought to your institution?
<p>Palmer College's main program is to educate and train Doctors of Chiropractic, and rather than add another program, we partnered with programs that are already out there. It is a better use of resources. Palmer was looking at healthcare and how it's changing and reviewed the job survey (NBCE), and one of the integrative areas was massage therapy (MT). 67% of DCs refer to MT or have MT on staff. We needed to show DCs how to interact with MTs, and didn't have a course, so looked at other educational institutions in the area to learn about MTs. We brought in 3 programs from the area, and went through their checklist of educational requirements, their overall program, licensure, and instructors.</p>	
2.	How was it started?
<p>We formulated a plan for pilot program, put together a memorandum of understanding (MOU) and a plan for evaluation the success of the pilot.</p>	
3.	Who were the stakeholders with this project?
<p>The stakeholders were faculty, clinicians, front desk staff (scheduling), students (so they would learn how to integrate with MT), admin, MT on their end, their students, and their administration. There were quite a few people to talk with and give a say in what was happening. There was a win-win with the program and the pilot.</p>	

4.	What were challenges/stumbling blocks you encountered?
	Real estate -- where do we put the MTs? Alumni - who may have pre-conceived ideas about what we should be teaching; Blackhawk Community College coming over on campus; Patients, this would be a service we charge for, not for free; insurance, how do we bill appropriately.
5.	Were there any financial issues/stumbling blocks?
	How do you do marketing? Who would pay for the instructor? Need a licensed MT -- who pays for that? Blackhawk offered to cover the cost initially and found an educational grant to extend past the pilot program.
6.	What did you learn?
	How to engage students to participate? Everyone had good foundation for anatomy, so communication was not an issue. DC students learned some of the verbiage in MT profession and set hours for scheduling and referral; MT students learned verbiage, deeper appreciation of anatomy. Students enjoyed working together on complex cases (musculoskeletal, post-surgical needs, very sick patients). Learning worked well both ways.
7.	How did you manage the time (how frequently did it occur, how much time to organize)?
	The program is on campus for 8 hours 1 day a week providing massage therapy to patients, staff and interns. The direction of the program falls to Dr. Juehring the director of Rehab and Sports Injury Dept.
8.	Allocation of time between institutions – did one do more work?
	We did more of the paperwork for referral and documentation; MT did more work on operational side with their licensed therapists. Overall the collaboration worked very well. Blackhawk got an innovative learning grant to help cover instructor costs that has allowed for the program to continue past the pilot.
9.	Do you have any resources/tools (ie contracts) you could share?
	MOU; paperwork, documentation that was used for each patient.
10.	How did you communicate to the stakeholders?
	Set up -- emailing between stakeholders. Approximately 5-10 hours meetings, to make sure everyone had right materials, insurances.
11.	How was the program assessed?
	Surveys of students, and patients, satisfaction. Very positive findings. Utilization was very good. MT there 2 days/week. 3 hour blocks in the morning, 4 hour blocks in afternoons. 60-70% full. Not a global massage, worked on regional components. We are looking at adding nurse practitioners and MDs to the mix, so students can see how integration can work best, how to do it, how to evaluate. We look at the NBCE job task analysis - who are DCs referring to? Students need to learn to integrate with those practitioners. We are looking to do more partnering with PCMHs and ACOs.

**University of Bridgeport Chiropractic College (UBCC) –
Bridgeport, CT**

Website: <http://www.bridgeport.edu/academics/graduate/chiropractic-dc/>

Contributed by: Anthony Lisi, DC

Date Contributed: March 2014



1.	Why was this brought to your institution?
	This was identified as a means to provide enhanced clinical training to a subset of UBCC students. UBCC and the Veteran's Administration Connecticut Healthcare System (VACHS) were the participating institutions. I obtained approval from my superiors at VACHS, and Dr. Frank Zolli, who was the Dean of UBCC at the time.
2.	How was it started?
	VA has formal policy and processes to establish affiliations with academic institutions in various healthcare professions. VA aims to develop mutually beneficial partnerships that allow for training of future healthcare professionals while maintaining appropriate quality in patient care. Appropriate training affiliations require a functioning clinical service with appropriate patient workload, clinician staff with academic experience suitable to supervise trainees, and available physical space. The VACHS chiropractic clinic was appropriately functioning and integrated at the facility to meet these requirements.

3.	Who were the stakeholders with this project?
	The VACHS director, chief of staff, associate chief of staff for education, chief of physical medicine; myself; Drs. Zolli and Onorato at UBCC.
4.	What were challenges/stumbling blocks you encountered?
	There was no prior precedent for student rotations; the development of student selection process; and student assessment process.
5.	Were there any financial issues/stumbling blocks?
	No; this is no cost/no salary for students.
6.	What did you learn?
	There was and continues to be strong interest in participation among UBCC students. Over time we have increased the number of available rotation slots yet there is typically an excess of applicants. Students report high satisfaction in their training experience, in particular citing their exposure to complex cases, interdisciplinary case management, and hospital procedures. Supervising student trainees places an additional burden on the VA chiropractic clinicians. This burden must be managed appropriately and balanced with other competing responsibilities for the program to be sustainable.
7.	How did you manage the time (how frequently did it occur, how much time to organize)?
	The planning took place over a 12 month period. Since I was UBCC faculty at the time of my VA appointment, the UBCC administration and I had ample opportunity and motivation to develop this. I would estimate about 80 hours of actual planning work at first, then about 10-15 hours of work per month ongoing.
8.	Allocation of time between institutions – did one do more work?
	By the nature of clinical training most of the work takes place at the VACHS.
9.	Do you have any resources/tools (ie contracts) you could share?
	The VA Associated Health Affiliation agreement is public domain. See: http://accahc.org/images/stories/vha_10_0094g_fill.pdf
10.	How did you communicate to the stakeholders?
	I work closely with all. Informal and formal communications.
11.	How was the program assessed?
	VACHS has internal reporting/assessment of student training and performance. UBCC has processes for assessing student clinical competence, and perception of training.

APPENDICES

Appendix A

National Education Dialogue to Advance Integrated Health Care: Creating Common Ground: Priority Recommendations for Interdisciplinary Educational Collaboration

From the NED Progress Report, November 2005

After 15 months of planning and collaborative project execution, three days onsite, and two surveys of participants, the National Education Dialogue to Advance Integrated Health Care identified 9 priority areas for action in which there was significant “common ground” (>80% agreement) (Weeks et al, 2005; p. 3).

- Facilitate development of inter-institutional relationships and geographically-based groupings of conventional and CAM institutions and disciplines in diverse regions. Promote student and faculty exchanges, create new clinical opportunities, facilitate integrated post-graduate and residency programs, and provide opportunities for students to audit classes and share library privileges.**
- Create resource modules on teaching about distinct CAM, conventional and emerging disciplines (approved by the disciplines), which can be used in a variety of formats – from supporting materials in such areas as definitions and glossaries to full curricular modules.
- Share educational and faculty resources and information on inter-institutional relationships, including samples of existing agreements and existing educational resources through development of a website.**
- Continue multidisciplinary work to create a concise statement of core values which have resonance across the disciplines and can guide efforts to create quality integrated healthcare education.
- Collaboratively develop and sponsor continuing education initiatives designed to draw participants from diverse disciplines.
- Create collaboratively developed educational resources to prepare students and practitioners to practice in integrated clinical settings.
- Develop an outline of skills and attitudes appropriate for those involved in collaborative integrated health care.
- Assist individuals with making institutional changes by offering support for leadership in change creation. Explore strategies for overcoming the challenges of prejudice, ignorance and cultural diversity.
- Explore third-party clinical sites that serve the underserved (such as community health centers) as locations for developing clinical education in integrated healthcare practices.**

Appendix B

Questions to ask potential partners, and feedback given from Hospital Based Massage Therapy (HBMT) partners. Thanks to Dale Healey at Northwestern Health Sciences University for sharing this information from a presentation he made at the AMTA National Convention in 2010.

1. *In a traditional hospital environment, who would be the best person to approach about setting up a partnership?*

“Typically this would run through a nursing department or ancillary service department and education department. Most hospital run their student clinical (non-physician) through their general education departments with nursing leadership taking the management responsibility as patient care.”

Lori Knutson, Director of the Penny George Institute for Health and Healing, Abbott Northwestern Hospital

“I would approach the person responsible for alternative and integrative approaches to health care. In the event you do not know the name of the person, contact the hospital person responsible for students and/or contracts or the central education or nursing department.”

Katie Becker, Learning Specialist, University of Minnesota Medical Center, Fairview

“I think approaching the manager of the complementary therapies department/integrative medicine area would be the best place to start. Usually this person works closely with their VP or director and has oversight of the budget and can visualize how this partnership would best work with their staff's schedules and the patients they work with.”

Renee Sauter – Complementary Therapies - Regions Hospital

“If there is a school associated with the hospital you would start there otherwise other educational departments. It is always good to have a connection to clinical care though that has an interest in massage to help provide support.”

Susanne M.Cutshall, R.N., C.N.S. Mayo Clinic, Rochester, MN

2. *If a school were to approach you about getting their students into the hospital to do clinical rotations, what would like to hear from them?*

“Vision, Mission of the school itself and then the intention/goals for why they want to partner. Are they an accredited school and by whom, overview of the student body from an academic perspective, student conduct requirements from the school, what is school leaderships expectations and responsibilities, how will success be measured, forms of communication for both students and the site and leadership between sites.”

Lori Knutson, Director of the Penny George Institute for Health and Healing, Abbott Northwestern Hospital

“The specific student objectives, the timeline - when to start, how many hours total, how many students, will an instructor be on site.”

Katie Becker, Learning Specialist, University of Minnesota Medical Center, Fairview

“I would like to hear that they are willing to provide/partner in providing supervision of their students, that they train their students in specifics for "patient care" (similar to your hospital based course), and have a strong emphasis on professionalism and timeliness.”

Renee Sauter – Complementary TherapiesRegions Hospital

“I would like to hear about the content of the program (if there is any hospital based education), how many hours the student are required to have, who would provide supervision, how would the student be referred. What would be required for evaluation of the experience.”

Susanne M.Cutshall, R.N., C.N.S. Mayo Clinic, Rochester, MN

3. *What questions would you have for the school?*

“The initial question for someone like me is whether the school will sign a student affiliation agreement and agree to non-negotiable language such as requiring student background checks, requiring various immunizations and vaccinations for the students providing care, liability and malpractice insurance, etc.”

Katie Becker, Learning Specialist, University of Minnesota Medical Center, Fairview

“In addition, I'd ask why are they interested in partnering with us? What kind of vision do they have for their program? What kind of standards are their students held to? (Do they want to know about attendance, performance, etc.) Then there are the basic questions of how are their students prepared for the hospital environment? Do they have their immunizations, etc.”

Renee Sauter – Complementary Therapies-Regions Hospital

4. *In your opinion, what would be the most important initial steps a school could take to form a partnership with their local hospital?*

“Be prepared to discuss how this partnership will benefit the hospital (short term - ability to provide services to patients, long term - prepared massage therapist for the hospital environment)

Demonstrate passion for hospital-based massage and know the evidence for practice.”

Lori Knutson, Director, Penny George Institute for Health and Healing, Abbott Northwestern Hospital

“The University Program Director should approach the hospital initially. I believe how you and Carol and Lyn worked together was the right approach. I would use that as the best practice.”

Katie Becker, Learning Specialist, University of Minnesota Medical Center, Fairview

“I think things that stand out to me are: A) Going out to the hospital to meet face to face - talk about the school and why a partnership would be a win/win for both. B) Show off the professionalism of their massage program!! There is nothing worse than working with a school and the students end up not showing, are unprofessional, are not held accountable, etc. Students need to be prepared that they are going into a professional environment, working with professionals and vulnerable adults - hence, they are a representative of their school. (NWHSU students have been fantastic!!) Those would be the 2 biggest things that come to mind for me.” Renee Sauter – Complementary Therapies - Regions Hospital

“Provide information on the programs and highlight programs that have been successful at other facilities. Talk with an Integrative Medicine program leadership at the facility to identify programs or areas of interest.” Susanne M.Cutshall, R.N., C.N.S. Mayo Clinic, Rochester, MN

5. *Anything else you think I should share with schools considering a HBMT program?*

“Will having your students benefit both parties? - remembering that the patient is our prime concern. Hope this helps” Katie Becker, Learning Specialist, University of Minnesota Medical Center, Fairview

“I said this above, but I believe it's a win/win for both businesses. Schools considering this type of partnership make their students stand out in the field I would guess. There aren't a ton of opportunities for students to gain this type of hands on experience - working with patients (in a lot of pain, are in "fragile" states, and they see everything from post-op patients to end of life issues.) My guess would be this would make them well prepared to deal with any type of patient population. Esp. in this economy, students (and schools) would want any advantage they can get to be competitive.” Renee Sauter – Complementary Therapies - Regions Hospital

“I think it would be important to focus on safety in the hospital environment, positioning in the hospital, infection control, confidentiality issues and working with the health care team.”

Susanne M.Cutshall, R.N., C.N.S. Mayo Clinic, Rochester, MN