Survey of MDs/Administrators of Integrative Clinics to Gather Information on Competencies of Licensed Acupuncturists for Practice in Hospitals, Integrated Centers and Other Conventional Healthcare Settings

Produced by the:
National Education Dialogue to Advance Integrated Health Care
Academic Consortium for Complementary and Alternative Health Care

For the:
Integrated Healthcare Policy Consortium

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Sponsor:
National Certification Commission for Acupuncture and Oriental Medicine

December 2007

Survey of MDs/Administrators of Integrative Clinics to Gather Information on Competencies of Licensed Acupuncturists for Practice in Hospitals, Integrated Centers And Other Conventional Healthcare Settings

Abstract: An increasing number of licensed practitioners of acupuncture and Oriental medicine (AOM) are working in environments where overall clinical decision-making is dominated by medical doctors. These include integrative medicine clinics, hospitals and community health centers. *Survey*: This survey and interview process was engaged with conventional medical doctors and, in one case, a board certified holistic nurse (RN, HN-BC) to explore the competencies of AOM practitioners which they had hired in order. The project focus was to determine those factors which best support AOM practitioners playing an optimal role in patient care in these settings. The 3 page survey was modified from a similar survey given to licensed acupuncturists on this topic. That survey was developed with reviews from two multi-disciplinary teams. Survey sections focuses on identifying useful training and quantifying the importance of a set of 25 topics in a session to prepare AOM practitioners. This survey followed a parallel survey of 25 licensed acupuncturists, allowing for some comparison in perception. *Participants*: Sixteen (16) experienced MD or nurse administrators who were believed to meet the criterion were identified and emailed the survey. Three indicated that they did not. Ten (63.5%) participated. The respondents indicated that the AOM practices were entirely or principally in outpatient settings. Of these, 9 (90%) participated in a follow-up telephone interview. *Findings*: Preparation of the AOM practitioner was limited. Virtually no written resources were identified or utilized. Skill areas which scored highest ("very important") were "recognition of high priority acute management" (90%), "charting and documentation" (80%), "strategies and skills for developing relationships" (80%), "management and referral to conventional providers" (70%) and "communication with MDs and nurses." Interviews found particular importance on subjective criteria for provider selected. These included an ability to work with a team, passion for integration, patience with institutional processes and a willingness to allow his or her clinical interests and abilities to be secondary to the larger effort to change the system. Multi-disciplinary, team meetings were the most important strategies for developing competencies. *Conclusion*: Written, web-based materials or review courses for those entering, or seeking to enter, integrated practice environment would be useful tools for those with this clinical interest. The survey was carried out through the National Education Dialogue to Advance Integrated Health Care and the Academic Consortium for Complementary and Alternative Health Care. The project was supported by a grant from the National Certification Commission for Acupuncture and Oriental Medicine.

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Introduction

An increasing number of licensed practitioners of acupuncture and Oriental medicine (AOM) are working in environments where overall clinical decision-making is dominated by medical doctors. These include outpatient integrative medicine clinics associated with academic health centers, health systems and community health institutions as well as, to a lesser extent, inpatient care in hospitals.

Facilitating the *optimal* role for complementary and alternative health care practitioners in patient care in such settings is an evolving challenge. The specific competencies which support optimal participation may be unknown to, or under-developed in, licensed AOM practitioners who are interested in engaging the challenges of practicing in these facilities. Educators interested in providing useful services which facilitate this integration may not know how to best shape their programs.

This survey project was developed with the goal of gleaning information from medical doctors or other administrators of these integrative clinics regarding the competencies of AOM practitioners in these settings. The project sought to identify the types of competencies and tools which will best prepare other AOM professionals for making the most of these integrated care opportunities. This project followed a separate, parallel survey of 26 licensed AOM practitioners regarding their experiences in these facilities.

Project Leaders and Sponsors

This project was carried out through the National Education Dialogue to Advance Integrated Health Care: Creating Common Ground (NED) in concert with the Academic Consortium for Complementary and Alternative Health Care (ACCAHC). Both are initiatives developed by the multi-disciplinary Integrated Healthcare Policy Consortium (IHPC) (www.ihpc.info). ACCAHC is slated to become an independent organization (www.accahc.org) in January 2008.

NED and ACCAHC share a common vision which includes the following statement: *We envision a health care system that is multi-disciplinary and enhances competence, mutual respect and collaboration across all CAM and conventional health care disciplines.* Priorities for NED efforts were set at a national NED gathering of 70 educators from 12 distinct disciplines. One of the nine priorities is to "develop an outline of skills and attitudes appropriate for those involved in collaborative integrated health care." A second is to "create collaboratively-developed educational resources to prepare students and practitioners to practice in integrated clinical settings." (NED Progress Report, 2004-2005)

This project was engaged to fulfill on these priorities. The project was supported by funds granted from the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM – www.nccaom.org).

Selection of the Medical Doctor and Nurse Administrators

Individuals who were surveyed were all leaders of integrated health environments in which AOM practitioners delivered services. A subset was identified through queries to the leaders of NED and ACCAHC on their regular conference calls. Others were located through direct contact with various hospitals and educational centers. Half were from member institutions of the Consortium of Academic Health Centers for Integrative Medicine (http://www.imconsortium.org/). Others were selected by project director

Weeks based on his knowledge of health system integration initiatives gained through his work as the publisher-editor of the *Integrator Blog News & Reports* (www.theintegratorblog.com).

Survey Development and Interview Process

The survey was developed based on the parallel survey used in surveying the licensed acupuncturists. The latter was created through a multi-disciplinary process which grew out of themes discovered in prior work of the multi-disciplinary NED and ACCAHC teams. The instrument was reviewed by representatives of NED, ACCAHC and NCCAOM and the survey was administered through e-mail. Non-responders were e-mailed a second time to increase participation.

The instrument had three fields. The first focused on the respondent's background, the second on specialized training they have had in the field, and the third on quantifying the level of importance of a set of competencies.

Interviewees were selected through a field in the survey which asked for their phone number for a follow-up interview. Each who was reached was typically interviewed within two weeks of filling out the survey. Interviews varied in length from 20 to 75 minutes. The survey was informally structured around the importance the participant placed on specific competencies, or comments made in their survey form. Participants were given the opportunity to comment on their view of the value of the project itself. The survey and interviews were engaged in September and October of 2007.

Findings

The findings of the project first look at the survey outcomes and subsequently (Part IV, below) at the gleanings from the interviews.

Part I: Background of the Survey Participants

Nine (9) of the participants were medical doctors. One of the medical doctors was also an MPH, another also an RN. The 10th was a board certified holistic nurse (RN, HN-BC). (Table 1) The participants have clinical experience in 10 separate integrated care facilities. (Table 2) Eight (80%) had over 3 years of experience with their AOM staff, with 6 (60%) noting more than five years. Only 1 (10%) was in their first year of such experience. (Table 3)

Of the group, 2 (20%) had some affiliation with an AOM school. (Table 4) All but one (90%) noted an affiliation with a conventional medical school and the 10th indicated that her health system was a clinical training facility. (Table 5)

Table 1: Medical/Healthcare Training

MD: 7
MD/RN: 1
MD/MPH: 1
RN, HN-BC (board certified, holistic): 1

Table 2: Locations of Practices

Advocate Medical Group Center for Complementary Medicine, Chicago, Illinois
Mayo Clinic
Institute for Health & Healing, Abbott Northwestern Hospital, Allina Hospitals & Clinics
Saint Barnabas Medical Center-Siegler Center for Integrative Medicine
American WholeHealth
Carolinas Integrative Health
Mercy Hospital, Portland, Maine
Oregon Health & Science University
Samaritan Health Services
Evanston Northwestern Healthcare

Table 3: Experience working with LAc in integrative center

Duration	0-12 mo.	13-2yr	3-5 yr	>5 years
Total (LAc)	4 (15%)	3 (12%)	11 (42%)	8 (31%)
Total (MD/admin)	**1 (10%)**	**1 (10%)**	**2 (20%)**	**6 (60%)**

Table 4: AOM School Affiliation

Yes: 2
No: 8

Affiliation with NWUHS acupuncture program
Oregon College of Oriental Medicine

Table 5: Med School Affiliation

Yes: 9
No: 1

Rosalind Franklin &University of Health Sciences; Northwestern Medical School
George Washington University; Georgetown
Mayo Clinic
University of Minnesota – via organization
University of Medicine & Dentistry of New Jersey
UNC Chapel Hill School of Medicine; University of Arizona College of Medicine
Dartmouth Medical School; University of Vermont Medical School; U New England College of Osteopathic Medicine
Oregon Health & Science University
Northwestern Medical School

Part II: Specialized Training and Useful Resources

Few of the indicated s respondents responded affirmatively in any of the six categories which explored any specialized training that they may have received to prepare them for their work in integrated settings. (Table 5) Those responding in the affirmative typically provided information on the kinds of training which were helpful.

- *From the hospital or clinic* Of respondents, 5 (50%) recalled useful content from the sponsoring system. Most referenced boilerplate training on the hospital's policies and procedures. Few noted specific training related to the integrative environment. Where provided, inter-active sessions and speaking engagements with conventional practitioners were deemed to be most helpful.

- *Reading/CD/DVD/Web-based resources* Notably, not one of the respondents pointed to any specific resource as being useful.

- *Other resources* The MDs/Administrators focused on human-to-human exchanges such as the importance of team meetings, weekly team conferences, mentorship by the MD, and in one case the consultation with a respected LAc with significant prior experience.

- *Attitudes* 70% of the MDs/Administrators noted attitude issues among the LAcs were important. This compares with just 26% of the LAcs noting having encountered significant attitude problems among conventional practitioners. Once called the attitude "key." To be avoided was the "Lone Ranger" attitude of some LAcs.

Table 6: Specialized Training Notes by Participants

	Yes LAc	No LAc	**Yes MD/ admin**	**No MD/ admin**
Hospital/clinic Did the clinic/hospital/institution provide the LAc any training to prepare him/her for the role?	9 (36%)	16 (64%)	**5 (50%)**	**5 (50%)**
Reading/CD/DVD Is there reading and/or CD/DVD(s) that you recommend to the LAc to prepare him/her for the work?	4 (16%)	21 (84%)	**0 (0%)**	**10 (100%)**
Web Resource Is there any website or web resource that you think is particularly useful for preparing LAcs for this work?	10 (40%)	15 (60%)	**0 (0%)**	**10 (100%)**
Training/conference Was there any training/conference/class/seminar that you think is particularly useful for preparing LAcs for this work?	8 (32%)	17 (68%)	**3 (30%)**	**7 (70%)**
College or prof. assn	9 (36%)	16 (64%)	N.A.	N.A.
Other resource Was there any other resource has been particularly useful for preparing LAcs for this work?	11 (44%)	14 (56%)	**5 (50%)**	**5 (50%)**
Attitudes Were there attitudes among the LAc(s) that have interfered with the ability of the LAcs to perform?	6 (26%)	17 (76%)	**7 (70%)**	**3 (30%)**

Part 3: Key Topics in an Optimal Training

The third section of the written survey focused on ranking of 1-5 on a Likert scale ("not important" to "very important") of 25 potential topics which might be in "an educational session to prepare AOM practitioners for practice in an integrated care environment."

Of the 25 topics selected for ranking as to their importance (see Appendix 2):

- 13 (52%) were marked either a 4 or 5 ("important" to "very important') by 80% or more of the respondents. This compares to 12 (48%) in the LAc survey. (Table 6)

- The topics which scored highest under "very important" were "recognition of high priority acute management" (90%), "charting and documentation" (80%), "strategies and skills for developing relationships" (80%), "management and referral to conventional providers" (70%) and "communication with MDs and nurses." In the LAc survey, these were: recognition of high priority acute management" (76% for LAc), "charting and documentation" (69%), "useful medical language" (69%), "communications with MDs and nurses" (70%; 65% among LAc).

- 21 were marked either a 4 or 5 ("important" to "very important") by 50% or more of the participants. This compared to 19 for the LAcs.

Table 7: Areas Ranked Important are Better by 80% of More of Either LAcs or MDs/Administrators [bold is problematic due to error in the instrument]

% is of those marking the issue as important (4) or very important (5)

Topic Area	% LAc	% MD/ admin
Communication with MDs/nurses and other providers	96%	100%
Communicating AOM concepts in a language which works with conventional practitioners	91%	90%
Speaking-presentation skills to help build relationships	**89%**	**70%**
Leadership skills to give my services a more effective presence	**88%**	**40%**
Skills in articulating to the MDs/staff the value I offer patients	**88%**	**80%**
Charting/documentation in a conventional environment	88%	100%
Recognition of high priority acute management clinical presentations (red flag)	88%	100%
Skills needed for multi-disciplinary collaboration	85%	100%
Strategies/skills for developing relationships with MDs/Nurses to enhance referrals	85%	100%
Useful medical language/medical terminology	84%	80%
Assessment and evaluation of a conventional medical record	**83%**	**50%**
Management & referral to conventional providers	81%	90%
Management & referral to other CAM providers	75%	80%
Quality assurance and quality improvement processes	**72%**	**90%**
Outcomes studies and documentation	**61%**	**80%**
Cross cultural communication	68%	80%

The topics prioritized by the MDs/Administrators were typically aligned with those highlighted by the LAcs. Indications of differences were visible in a few areas. A licensed acupuncturists "leadership skills" were not viewed as being as necessary by the MDs (88% vs. 40%). The same can be said of the ability of a LAc to assess and evaluate a conventional medical record (83% vs. 50%). The MDs/Administrators ranked a few areas as more important than the LAcs. Among these were "quality assurance and improvement processes" (90% vs. 72%) and "outcomes studies and documentation" (80% vs. 61%). The latter may be attributed to the high percentage of MDs/Administrators with a medical school affiliation.

Part IV: Findings from the Interviews

The 9 interviews with participants varied in length from 20 to 75 minutes based on passions of the interviewees and the direction taken by the interview process. The core intent was to gather their insights in order to pass them on to others. The interviews yielded an array of general and specific ideas. These are captured below. More detailed information is in Appendix 5.

Core Themes in Choosing the Right AOM Professional

The interviews focused particularly on the characteristics of the optimal licensed acupuncturists. Some repeated points were:

- *Intuition as much as credentialing* Much focus on choosing the right person. This was viewed as a team player who was not merely an advocate for their discipline. Someone who has a passion for integration.

- *Being a System Player* The individual should have an appreciation of working in a system, that the system, the institution, has its own time frames.

- *Loyalty to process over patient* A tough area, frequently mentioned, was the need of the LAc to be willing to not use some of her his or her tools in patient care – moxa or herbs, for instance – if the system's protocols did not allow them. In more than one case, early prohibitions were followed by a relaxation and broader practice scope. Similarly, being willing to be under supervision of an MD, for a time at least. Again, more than one noted a need to start with more supervision, which was subsequently limited.

Additional Themes

Other themes stressed by the MDs/Administrators who were interviewed were:

- *Team meetings* Most underscore the absolute value of team meetings, multi-disciplinary grand-rounds, shared case review, for building competency.

- *Mentorship* One spoke specifically of the importance of the LAc being mentored, and being willing to be mentored, by the conventional staff.

- *Medical language and documentation* Those familiar with medical mores in terms of language and documentation clearly have the advantage. Sense among many that if the right person were found, these skills could be gained.

- *Basic hospital training* Some, but not all of the systems require all new employees to have training. All viewed these as useful for learning basic procedures on safety, cleanliness, medical records, and etc.

Conclusions

The 9 MDs and one nurse administrator who participated in the project indicated that the list of competencies in Part III of the survey pretty well covered the kind of competencies that they would like to see in a licensed acupuncturist who worked in their facility. The point was not that the practitioner would need to have the skills to start. In fact, most under-scored that the right skilled clinician with the appropriate character traits could pick up what they needed with experience. A practitioner would have a jump on the job of creating an *optimal* place for AOM in the system the more of the listed competencies the person has.

The wildcard in the process is clearly identifying and choosing the right person with these appropriate characteristics. The set of 5 competency areas from Part III which 100% of the MDs/Administrators marked as either "important" or "very important" provides a hint. Other than identifying "red flags," the other 4 reflected communication and collaboration skills, including the written communication of charting. The MDs/Administrators were clear that they needed people who were willing to submit to, or at least be patient with, the demands of the institution and its conventional medical ethos.

If we proceed from the perspective that the issues identified by these MDs/Administrators reflect the likely interests and needs of most others in the AOM field, this project has significant value. The survey and interview findings serve to clarify critical competencies which support integrated care practice. Yet these MDs/Administrators virtually unanimously drew a blank when it came to identifying any books, websites, CDs or periodicals that might be useful.

The project findings suggests that the there is value from additional investment in developing the resources and programs noted in this report and the report on the prior survey of licensed acupuncturists on the same topic. The beneficiaries will not only be the AOM practitioners who are learning to work in new environments. Benefits can be anticipated to flow to the systems in which they work, and the patients they are seeking to serve.

Appendix 1: Notes on Specialized Training/Learning

Note: Each participant was numbered for the purpose of maintaining anonymity.

	What
Hospital/clinic *Did the clinic/ hospital/ institution provide any training to prepare you for your role?*	No: 5 Yes: 5 • Medical terminology, dictation guidelines #2 • Our newly employed acupuncturists have an orientation over a 4-6 week time period. The orientation includes a shadowing with an acupuncture mentor to learn the hospital environment and system (i.e., electronic medical record documentation, policies/procedures, and to identify team assignment) #3 • Training in regard to cross disciplines in an integrative center and multidisciplinary patient rounds. We also had specific discussions on semantics and nomenclature. #5 • The hospital requires 10 observed sessions and orientation to the hospital. #7 • Training on electronic medical records; indoctrination on institution's orientation #10
Reading/CD/ DVD *Is there reading and/or CD/DVD that you found particularly useful in preparing you for your work, or which you have since discovered?*	No: 10 Yes: 0
Web Resource *Was there any website or web resource that was particularly useful to you, or which you have since discovered?*	No: 10 Yes: 0 • Our environment is a unique clinical environment with integrated teams. I have not found a similar clinical environment on which to draw from to prepare acupuncturists for their employment with us. #3
Training/ conference *Was there any training/ conference/class/ seminar that has proved particularly useful in preparing you, or which you have since discovered?*	No: 7 Yes: 3 • We developed our own training. #5 • UCLA acu course for MD/DO #9 • Observing grand rounds, making hospital rounds, going to tumor board #10
Other resource *Was there any other resource has been particularly useful to you, or which you have since discovered?*	No: 5 Yes: 5 • Attending team meetings #1 • Consultation with Pat Culliton, Hennepin County Medical Center #2 • Personal interaction with other practitioners in the group #6 • mentorship by M.D. #8 • Our weekly team conferences: patients were presented and discussed via various perspectives including conventional #10
Attitudes *Were there attitudes among the health professionals with whom you work that have interfered with your ability to fully practice AOM in this setting?*	No: 3 (No) the attitude is all with the doctors in our experience (although I know what you mean as I have encountered it with other practitioners) (No) but our circumstance was somewhat unique #6 Yes: 7 • Lone ranger attitude among CAM providers #1 • In the hiring process of Acupuncturists those who demonstrated/articulated an openness and genuine desire to work in partnership with conventional practitioners were hired. We have 10 acupuncturists on staff. #3 • Need to willing to integrate/communicate with the conventional medical establishment #4 • Feelings of being treated as "less than physicians" and in some cases, disrespected. #5 • Not sure if individual specific or profession specific so would prefer to not specify. #8 • Checking for attitude is key for hire! We looked for "bridge" personalities and those experienced with conventional medicine #9 • Perhaps not always mindful of the importance of involving other team practitioners – though this was rate on this particular team #10

Appendix 2: MD/Admin Views on Importance of Specific Topics

If you were to provide an educational session meant to prepare AOM practitioners for practice in an integrated environment, please note the importance of these topics:

Key: 1= Not important, 3 = Somewhat important, 5 = Very important, NA = Not applicable

#		**1**	**2**	**3**	**4**	**5**	**NA**
1	Credentialing processes and procedures			3 (30%)	3 (30%)	4 (40%)	
2	Charting/documentation in a conventional environment				2 (20%)	8 (80%)	
3	Useful medical language/medical terminology			2 (20%)	3 (30%)	5 (50%)	
4	Communication with MDs/nurses and other providers				3 (30%)	7 (70%)	
5	Liability issues			4 (40%)	3 (30%)	3 (30%)	
6	Management & referral to conventional Providers			1 (10%)	2 (20%)	7 (70%)	
7	Quality assurance and quality improvement processes			1 (10%)	5 (50%)	4 (40%)	
8	Insurance/payment and billing issues	1 (10%)	1 (10%)	3 (30%)	4 (40%)	1 (10%)	
9	Outcomes studies and documentation			2 (20%)	5 (50%)	3 (30%)	
10	Research methodology and grant-writing	2 (20%)	5 (50%)	1 (10%)	2 (20%)		
11	**Skills in articulating to the MDs/staff the value I offer patients**		**1 (10%)**	**1 (10%)**	**2 (20%)**	**6 (60%)**	
12	**Facility with the scientific literature which might support broader use of my services**		**1 (10%)**	**2 (20%)**	**4 (40%)**	**3 (30%)**	
13	Cross-cultural communication			2 (20%)	3 (30%)	5 (50%)	
14	Strategies/skills for developing relationships with MDs/Nurses to enhance referrals				2 (20%)	8 (80%)	
15	Skills needed for multi-disciplinary collaboration				5 (50%)	5 (50%)	
16	Recognition of high priority acute management clinical presentations (red flag)				1 (10%)	9 (90%)	
17	Leadership skills to give my services a more effective presence			6 (60%)	1 (10%)	3 (30%)	
18	Communicating AOM concepts in a language which works with conventional practitioners		1 (10%)		5 (50%)	4 (40%)	
19	Speaking-presentation skills to help build relationships		1 (10%)	2 (20%)	6 (60%)	1 (10%)	
20	Knowledge of the skills, competencies and training of other practitioners (such as DC, DO, MD, RN, ND, PT, OT, etc.)		1 (10%)	4 (40%)	3 (30%)	2 (20%)	
21	The roles of other healthcare personnel such as medical technologists, nurses assistants, nurses, etc.		2 (20%)	5 (50%)	2 (20%)		1 (10%)
22	Fluency in “evidence-based medicine”	1 (10%)	1 (10%)	2 (20%)	5 (50%)	1 (10%)	
23	Assessment and evaluation of a conventional medical record			5 (50%)	2 (20%)	3 (30%)	
24	Negotiation/mediation skills		5 (50%)	3 (30%)	2 (20%)		
25	Management & referral to other CAM providers		1 (10%)	1 (10%)	3 (30%)	5 (50%)	

Appendix 3: LAc Views on Importance of Specific Topics (from initial survey)

If you were to provide an educational session meant to prepare AOM practitioners for practice in an integrated environment, please note the importance of these topics:

Key: 1= Not important, 3 = Somewhat important, 5 = Very important, NA = Not applicable

#		**1**	**2**	**3**	**4**	**5**	**NA**
1	Credentialing processes and procedures	0	1 (4%)	11 (42%)	5 (19%)	9 (35%)	0
2	Charting/documentation in a conventional environment	0	0	2 (8%)	5 (19%)	18 (69%)	1 (4%)
3	Useful medical language/medical terminology	1 (4%)	0	3 (12%)	4 (15%)	18 (69%)	0
4	Communication with MDs/nurses and other providers	0	0	1 (4%)	7 (27%)	18 (69%)	0
5	Liability issues	1 (4%)	2 (8%)	6 (23%)	5 (19%)	12 (46%)	0
6	Management & referral to conventional Providers	0	0	5 (19%)	8 (31%)	13 (50%)	0
7	Quality assurance and quality improvement processes	0	2 (8%)	4 (16%)	10 (40%)	8 (32%)	1 (4%)
8	Insurance/payment and billing issues	1 (4%)	4 (15%)	9 (35%)	7 (27%)	5 (19%)	0
9	Outcomes studies and documentation	0	5 (19%)	5 (19%)	11 (42%)	5 (19%)	0
10	Research methodology and grant-writing	1 (4%)	5 (20%)	9 (36%)	6 (24%)	3 (12%)	1 (4%)
11	Skills in articulating to the MDs/staff the value I offer patients	0	2 (8%)	1 (4%)	6 (23%)	17 (65%)	0
12	Facility with the scientific literature which might support broader use of my services	1 (4%)	2 (8%)	6 (23%)	5 (19%)	12 (46%)	0
13	Cross-cultural communication	0	1 (4%)	7 (28%)	8 (32%)	9 (36%)	0
14	Strategies/skills for developing relationships with MDs/Nurses to enhance referrals	1 (4%)	0	3 (12%)	6 (23%)	16 (62%)	0
15	Skills needed for multi-disciplinary collaboration	0	0	4 (15%)	7 (27%)	15 (58%)	0
16	Recognition of high priority acute management clinical presentations (red flag)	0	1 (4%)	1 (4%)	3 (12%)	19 (76%)	1 (4%)
17	Leadership skills to give my services a more effective presence	0	1 (4%)	2 (8%)	14 (56%)	8 (32%)	0
18	Communicating AOM concepts in a language which works with conventional practitioners	1 (4%)	1 (4%)	0	8 (33%)	14 (58%)	0
19	Speaking-presentation skills to help build relationships	0	0	3 (16%)	8 (31%)	15 (58%)	0
20	Knowledge of the skills, competencies and training of other practitioners (such as DC, DO, MD, RN, ND, PT, OT, etc.)	0	0	6 (24%)	6 (24%)	13 (52%)	0
21	The roles of other healthcare personnel such as medical technologists, nurses assistants, nurses, etc.	0	2 (8%)	9 (35%)	9 (35%)	6 (23%)	0
22	Fluency in “evidence-based medicine”	1 (4%)	2 (8%)	8 (31%)	9 (35%)	6 (23%)	0
23	Assessment and evaluation of a conventional medical record	0	0	4 (17%)	7 (29%)	13 (54%)	0
24	Negotiation/mediation skills	0	2 (8%)	13 (52%)	4 (16%)	5 (20%)	0
25	Management & referral to other CAM providers	0	2 (8%)	4 (17%)	12 (50%)	6 (25%)	0

Appendix 4: All Additional Notes on Other Knowledge, Skills or Attitudes as Provided by on Written Survey

Note: These include comments at the end and comments inserted by some respondents after specific questions.

#1
Keys are: Team spirit; self-motivation; active CME program; awareness of medical culture; actions which reassure physicians; acupuncture needle risk management. My comments relate to all nontraditional modalities which may work within an integrative medicine environment.

#3
I would add that understanding of the acute care political environment is extremely helpful. In other words the ability to ability to navigate the elements within the hospital system allows an acupuncturist to both appreciate the complexity of acute care and minimize the frustrations of moving practice integration forward.

#6
While I believe it important for a LAc to be able to function effectively within an integrative environment, I also do not want to be presumptuous or paternalistic. We sought and hired the best practitioner of TCM we could find. We discussed expectations and potential limitations in our community (for example, a much greater emphasis on acupuncture over Chinese medicinal herbs). We discussed potential problem "cases" / red flags (for example, the older man with new onset lower back pain), and developed clear lines of communication. We then referred people to him trusting in his training, expertise and healing demeanor.

#7
I think you have covered it pretty well. I think to be successful in the conventional setting you have to find the people who are open to this modality, create a project (research or otherwise) within which outcomes are documented and then get the success stories out in the institutional community. You need support from the administration and you need money to start the project and run it. Once you are a fixture in the institution and people know you and what you are doing you have a chance of getting the other foot in the door. We have limited the diagnostic categories for use of acupuncture in the hospital to pain, nausea and addiction. We have tried to get projects going but have not had the money and administrative support to succeed. We have provided limited services to mostly women in labor. We don't have a lot of experience with providing care but we have a LOT of information and experience in credentialing and setting up the program. At our clinic, the LAc is a nurse and is self-employed as are all our practitioners. She has her own panel of patients as well as collaborating with other practitioners. All our practitioners are licensed by the state and credentialed internally.

Appendix 5: Notes from Interviews

#1

- Integrative providers don't know anything about medicine and don't know anything about each other. The great fragmentation in western medicine also exists in natural medicine.
- Big picture: You have 2 cultures, one is linear thinking and reduction, the other intuitive and secrecy. The work became anthropological as well as medical. Have to help them meet in the middle
- Marketing/value: Go after the highest hardest group, that's the physicians – do this by appealing to their natural desires for: accountability, limits to care, accountability, good communication. This appeals to their comfort level and familiarity. Make the physician population feel safe.
- Evidence: My model has always been, you can't build on evidence, you have to build on trust. The beauty is, it has very little to do with medical reality, but has to do with communication. They may be interested in evidence, but has more to do with prudence and thoughtfulness.
- Team building: Team meetings are a continuing indoctrination. W/o any threat to anyone's ego, teaches each practitioner where they are good, where they are not; having an educational milieu is very useful.
- Credentialing: I use preventive hiring, I only hire people who want to work in team. There is a question I always ask, if you are in a team meeting and a case is discussed, if it's very clear that this is a no brainer for you, this is an easy intervention, and the team decided to do something else, how will you feel? The good response is, well, I'll work with the team. Some will say, I will try to convince them that I am right, and that's a problem.
- Communication: Need for getting an MD comfortable – "create a medical safety net" – create a setting where diagnose don't get misses – you are in higher risk, because you are treating people who are skirting the system – the allegiance is with the patient not to allopathy or naturopathy – "empower the physicians."

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#2

- Used a skilled at integration and respected local acupuncturist to guide us
- Credentialing: there is an intangible quality you want, came out in interview; want ability to fit in; want compassionate, a healer quality you can at least get an inkling of; we had person do acu with something on the team "there has to be some benefit"
- We chose a person with a lot of skills in terms of professionalism, parents are employees, grew up here, she knows there is a particular culture
- Required someone who could start in restrictive practice and have 5 year view of potential. Had to be able to not do recommendations for dietary change, or prescribe herbs. Some didn't work cause they wanted to push too hard too fast.
- In our system, comfort in being restricted to areas where evidence base exists in important. No need to have research skill – just be able to stay in the box.
- On referral management: What is critical now is acu. feels free to knock on my door, Ann's door.

#3

- We have students from AOM school who do 16 week rotations, we've now employed 3 of these. When I was looking for LAc, I interviewed 35 to find 1 – I interviewed 35 who would be integrative. I needed someone to stand firm in their practice, takes a certain personality, and a willingness to be in a political environment and be persistent.
- They are TCM practitioners, not acupuncturists "it would be like calling a nurse a stethoscope"
- Key piece is the ability to be very open minded in the acute care environment, be able to be part of a team. Have to be team in our Dept of IM, but with the whole hospital.
- Some said "well I don't plan to interact' I just want to do my work. Why then did you choose to apply?" Check out belief systems, and also the patient care they are used to – how do you deal with interruptions; need to be fluid in their ability to provide care.
- There is more use of beads (tape with beads) – they have old beads, not pre-taped – also using Korean hand therapy, w/o using needles, for inpatient.

- We train all of them in GI, in use of reflexology, beyond Tui Na, also use of essential oils, they incorporate the integrative – this has been a very organic process – there has been more affinity with the medical physician to partner with the acu than any other provider (but for nurses). The MDs, after they started seeing the effects for such things as anxiety and pain reduction, allowed them to do what they wanted to do.
- Traditional hospital orientation: infection control, CPR, compliance, same as any other provider; also peer mentoring for a period of time
- We understand they are clinically competent, but here it is the ability to make clinical decisions rapidly, different than in a clinic when you have more time.
- Attitudes: looked for those ho had some interest at some level in research, I looked for that, belief systems, openness, ability to be in diverse culture, create a bridging language.
- Assertive w/o being aggressive
- In discussion of hiring Acu, needed to understand that they were committed to our fundamental purpose, transforming the process for our patients. Needed to be able to call on them outside their clinical practice – when all is said and done, it's not about therapies, it's about changing paradigm in the org.

#4

- I was looking for someone who had the right attitude; the willingness to integrate; for right or for wrong, my challenge as medical director was to develop an integrative program that would be acceptable to the conventional medical staff, to find a balance that would not tie the hands of the practitioners
- Concern was based on feedback from medical staff, on use of herbs, drug-herb interactions.
- I was looking for someone who appreciated that our mission was larger than the individual patient.
- I've seen pictures of cupping, whole back with cup marks. We try not to do things that will leave bruising., The choice had nothing to do with my personal belief
- Communicating: Over the years a continuous struggle with all CAM on how to communicate with conventional HC providers.
- Marketing: In a more general sense, how to market themselves. I don't know if it based on who applies, or if system creates the idea, providers think the system should be promoting us. I haven't felt the salaried CAM providers have the same level of enthusiasm.
- Clarification of difference in presenting to there a lay audience, different for conventional professional audience, want more of evidence-based, more graphs; be careful not ot overstate your case, be careful not to be against conventional medicine even if you believe it. Don't start with the negativity. We're trying to create a sustainable model which requires finess,
- Referral mores not known; no understanding of relationships; I feel the CAM practitioners do a better job referring among themselves than referring back to me.

#5

- Training: Multidisciplinary grand rounds – one of the most helpful, 3X week; combination of a case report with presentations by whatever practitioners worked on the patient; occasionally brought in; always paid attention for semantics, and respect for practitioners being egalitarian. This was always a hidden agenda of mine, part of the cultural change.
- Materials: We developed manuals of expectations, anywhere from dress code to consulting w one another, forms for cross consultations – actually was pretty efficient – introductions to philosophy, mechanics of center, training on cross communication regarding the disciplines.
- Attitudes: there were times when certain physicians came from other places, there was a feeling of inferiority either suppressed or blatantly expressed by acu; there was some feeling of embarrassment in front of the group, despite an atmosphere of what was intended to be an egalitarian type center, in the first months, spend a lot of time with almost like psych counseling that they are equal that everything will work out fine.
- Language: We had training on how to not provoke fear on issues and language that could abut against their believe system

- Evidence-based: With an acu, doing their own thing in their own way – we would rather have them comfortable in their own sphere … due to the semantics and difference interpretations, it would take us an hour to agree on what we mean by evidence-based medicine.
- General: Many of the questions in the survey are dependent on the precise mission of the center; if you are hanging out around more academic bent of folks – so there is more of a focus – in many clinics, there is little research – but we had many people rotating from medic al schools, our atmosphere was more entrepreneurial.

#6

- Credentialing: once our TCM practitioner was asked to come inside, considered emergency credentialing. Used an anesthesiologist with acu, patient was not pleased, wanted TCM.
- Hospital training: mostly safety, cleanliness hygiene, corporate compliance.
- Started w/o herbs, but now have it them.
- Started more conservatively, reviewing all charts. We were trying not to be paternalistic, we were unsure of each other – in time, he would come to me with question, I never had to look over his shoulder, if anything he had to look over mine.
- Docs are afraid that something done will interfere with what MDs are doing, so if can hold a conversation on this, it can go a long way.

#7

- For integration training, sign contract with LAc to send 1.5 hr week, donated, in circle
- Require participation in outcomes research
- LAcs both way more skilled and had more experience than MD acupuncturist, but in hospital, Dr. has to supervise.
- Attitude: "chip on the shoulder is an attitude that is a lack of respect for what the other person knows … from the LAc it is 'you doctors have everything, you get paid well, you have everything, but I am the one that is really helping people.' The closer you are to looking like a doctor, the bigger the chip. It is biggest in chiropractors and naturopaths. We've worked incredibly hard to find an ND and DC who don't have a chip. We look for a person who's not threatened, who puts his shoulder to the wheel."
- Part III questions are "good laundry list of things that would make it easy to get LAc into a hospital setting."
- Key part of credentialing is gauging how collaborative: "We ask them for letter from teachers, colleagues and/or their patients. People who work with them. Once on board, we have our team process. We say people have to come to circle."

#8

- Basic training is what all clinical faculty gets: training on HIPAA, electronic medical records, respect ion the workplace, module on supervising residents, documentation –required for everybody – 30 hours or required modules
- Enhanced by mentorship. We have regular monthly meetings plus informal times, work in same office.
- Attitudes - have found a personality issue, had a person with weak communication, especially with anything about conflict.
- Documenting has to be interpretable to others.
- The best promoter for business may be lousy at documentation
- Have some problems with a practitioner closing charts.
- Being aware of scientific literature is "such a paradigm gap for the average LAc, it's chasm for a mentor; it needs to be culturally introduced in their education; it's NOT a low hanging fruit.
- Top areas to look for: 1) ability to self promote 2) abilities in medical record/billing, 3) never a question of sexual oppression in the exam room. Don't know how strong the training is in #3. Need to have very good training on boundaries; an incident could set us back for decades.
- They can do their job better if they understand the medical record. There is a wealth of information that can help them do their job better if they can interpret it.
- General recommendations: start slow be careful, don't assume people will respond to emails, don't assume they will be in a certain way. Don't assume it. This is a cross cultural thing.

#9

- Credentialing: focused on personality, not have a hidden chip on their shoulder. I tend to have pulse on community; when push comes to shove. I am paying attention to subtle signs; that they really want to be on board as part of a system. Even have a passion for it. Make sure they are not against allopathic medicine. Part of the character analysis is having reliability on a lot of fronts.
- Language: Ours both had hospital training, so I didn't have to think about it; being conversant and comfortable with medical language is key. Needle location, needs to be framed in language doctors thing. I often feel like a translator.
- Meetings: We do cross talk all the time, this is key, all the time back and forth – this is inside the clinic. we've covered the basic, team work, character, personalities – to be successful as a genuine integrative practice, need outcome in with that attitude

Appendix 6: Survey Instrument

Survey of Medical Directors and Administrators to Gather Information Regarding Competencies of Licensed Acupuncturists (LAcs) for Practice in Hospitals, Integrated Centers and Other Conventional Healthcare Settings

We anticipate that the time required per respondent will be 15-30 minutes, for the written survey, and 15-30 minutes for the interview. While your written surveys will be used as the basis for your oral interview, none of the specifics of your survey and interview process will be shared in the project report, in a way that will link back to you, without your prior approval. Basic contact is johnweeks@theintegratorblog.com

Sponsorship: This survey is a project of the National Education Dialogue to Advance Integrated Health Care: *Creating Common Ground* (NED) and the Academic Consortium for Complementary and Alternative Health Care (ACCAHC). The survey is funded through a grant from the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM – www.nccaom.org). NED is a project of the Integrated Healthcare Policy Consortium (http://ihpc.info/).

Project Description and Goal: Creating the *optimal* role for licensed practitioners of acupuncture and Oriental medicine (LAcs) in conventional medical settings, such as hospitals and integrative clinics, may be facilitated by certain competencies. These may have been unknown to, or under-developed in, some licensed AOM practitioners who are interested in practicing in these facilities. The goal of this survey project is to glean from medical directors and administrators who are experienced with hiring LAcs into these settings which types competencies and tools will best prepare other LAcs for making the most of these integrated care opportunities. This project follows a prior survey of 25 experienced LAcs on the same topic.

Individuals Surveyed: The project will receive completed surveys, and then carry out oral interviews, with 10 experienced managers of LAcs in these settings. These will be medical directors or administrators in hospitals, and clinics associated with institutions which are part of the Consortium of Academic Health Centers for Integrative Medicine (http://www.imconsortium.org/).

1. Basic information

First name:
Last name:
Phone contact for follow-up interview:

List all professional degrees and licenses (MD, RN, PhD, MPH, MHA, MBA, other.)

List all professional licenses (MD, RN, massage, etc.)

Name of Conventional Hospital(s) or Center(s) where you hired/worked with the LAc:
A. Name:
Experience together: ___0-12 mo ____13mo-2 yr ___ 3-5 years ____> 5years

B. Name:
Experience together: ___ 0-12 mo ___ 13mo-2 yr ___ 3-5 years ____> 5years

Do you teach or otherwise have any relationship with an AOM school?
Yes:
No:
If Yes, please name:
Your Title/Position(s):

Do you have a conventional academic medical center affiliation?
Yes:
No:
If Yes, please name:
Your Title/Position(s):

II. Specialized training/learning to prepare you for this position, or which you have since engaged.

A. Did the clinic/hospital/institution provide the LAc any training to prepare him/her for the role?
Yes
No
If yes, what in particular was useful:

B. Is there reading and/or CD/DVD(s) that you recommend to the LAc to prepare him/her for the work?
Yes
No
If yes, please list/describe:

C. Is there any website or web resource that you think is particularly useful for preparing LAcs for this work?
Yes
No
If yes, please list/describe:

D. Was there any training/conference/class/seminar that you think is particularly useful for preparing LAcs for this work?
Yes
No

If yes, please describe:

E. Was there any other resource has been particularly useful for preparing LAcs for this work?
Yes
No
If yes, please describe:

G. Were there attitudes among the LAc(s) that have interfered with the ability of the LAcs to perform?
Yes
No
If yes, please describe:

III. Creating an Optimal Training Program

If you were to provide an educational session meant to prepare AOM practitioners for practice in an integrated environment, please note the importance of these topics:

A. Credentialing processes and procedures

_____	_____	_____	_____	_____	_____
1 Not important	2	3 Somewhat Important	4	5 Very Important	N.A. Not apply

B. Charting/documentation in a conventional environment

_____	_____	_____	_____	_____	_____
1 Not important	2	3 Somewhat Important	4	5 Very Important	N.A. Not apply

C. Useful medical language/medical terminology

_____	_____	_____	_____	_____	_____
1 Not important	2	3 Somewhat Important	4	5 Very Important	N.A. Not apply

D. Communication with MDs/nurses and other providers

_____	_____	_____	_____	_____	_____
1 Not important	2	3 Somewhat Important	4	5 Very Important	N.A. Not apply

E. Liability issues

_____	_____	_____	_____	_____	_____
1 Not important	2	3 Somewhat Important	4	5 Very Important	N.A. Not apply

F. Management & referral to Conventional Providers

1	2	3	4	5	N.A.
Not important		Somewhat Important		Very Important	Not apply

G. Quality assurance and quality improvement processes

1	2	3	4	5	N.A.
Not important important		Somewhat Important Important		Very Important Important	Not apply

H1. Insurance/payment and billing issues

1	2	3	4	5	N.A.
Not important		Somewhat Important		Very Important	Not apply

H2. Outcomes studies and documentation

1	2	3	4	5	N.A.
Not important		Somewhat Important		Very Important	Not apply

H3. Research methodology and grant-writing

1	2	3	4	5	N.A.
Not important		Somewhat Important		Very Important	Not apply

J. Skills in articulating to the MDs/staff the value I offer patients

1	2	3	4	5	N.A.
Not important		Somewhat Important		Very Important	Not apply

K. Facility with the scientific literature which might support broader use of my services

1	2	3	4	5	N.A.
Not important		Somewhat Important		Very Important	Not apply

L. Cross-cultural communication

1	2	3	4	5	N.A.
Not important		Somewhat Important		Very Important	Not apply

M. Strategies/skills for developing relationships with MDs/Nurses to enhance referrals

1	2	3	4	5	N.A.
Not important		Somewhat Important		Very Important	Not apply

N. Skills needed for multi-disciplinary collaboration

1	2	3	4	5	N.A.
Not important		Somewhat Important		Very Important	Not apply

O. Recognition of high priority acute management clinical presentations (red flag)

1	2	3	4	5	N.A.
Not important		Somewhat Important		Very Important	Not apply

P. Leadership skills to give the LAcs services a more effective presence

1	2	3	4	5	N.A.
Not important		Somewhat Important		Very Important	Not apply

Q. Communicating AOM concepts in a language which works with conventional practitioners

1	2	3	4	5	N.A.
Not important		Somewhat Important		Very Important	Not apply

R. Speaking-presentation skills to help build relationships

1	2	3	4	5	N.A.
Not important		Somewhat Important		Very Important	Not apply

S. Knowledge of the skills, competencies and training of other practitioners (such as DC, DO, MD, RN, ND, PT, OT, etc.)

1	2	3	4	5	N.A.
Not important		Somewhat Important		Very Important	Not apply

T. The roles of other healthcare personnel such as medical technologists, nurses assistants, nurses, etc.

1	2	3	4	5	N.A.
Not important		Somewhat Important		Very Important	Not apply

U. Fluency in "evidence-based medicine"

1	2	3	4	5	N.A.
Not important		Somewhat Important		Very Important	Not apply

V. Assessment and evaluation of a conventional medical record

1	2	3	4	5	N.A.
Not important		Somewhat Important		Very Important	Not apply

W. Negotiation/mediation skills

1	2	3	4	5	N.A.
Not important		Somewhat Important		Very Important	Not apply

X. Management & referral to other CAM providers

1	2	3	4	5	N.A.
Not important		Somewhat Important		Very Important	Not apply

IV. Please note any other additional knowledge, skills or attitudes which you think would be important parts of such a training session

Any additional comments (use as much space as necessary):

Please email to John Weeks/NED johnweeks@theintegratorblog.com or mail to 3345 59th Avenue SW, Seattle, WA 98116; 206-932-3899 ***Thank you for your time & participation!***