Business and Clinical Models in 27 Hospital-Sponsored Integrative Clinics: *A Special Integrative Medicine Report*

-- John Weeks

[Author note: From 1996 to 2001, Weeks wrote a monthly newsletter on the business of integration for which he developed the *Integrative Clinic Benchmarking Project*. The 27 clinics featured here all completed a four page, multi-faceted survey of their models and operations. The is report was originally written in 2001 for the *Integrative Medicine Consult.*]

1. Overview

For hospitals and health systems in the United States, sponsorship of specialized facilities for offering complementary or integrative medicine services has passed through infancy into childhood. A ballpark estimate would place the number of specialized, hospital-sponsored programs at between 100 and125. Working groups in at least as many institutions are presently empowered to evaluate the creation of such clinics, service areas or departments.

Useful data on the clinical offerings and business models of these integrative medicine programs is only beginning to be developed. (See *Resources*.) This report represents the most thorough information presently available on the diverse models for health system exploration of complementary and alternative medicine (CAM). It is based on survey data from 27 clinics gathered over a two-year period from October 1998 to December 2000.A follow-up surveyfocused on challenges, breakthroughs and priorities and a second follow-upon profitability, income, and the role of philanthropy This report is the first published analysis of this survey data, which reflects information provided at the time of the survey gathered and which is also informed by information gathered for other special reports and by interviews conducted in conjunction with the surveys. The relative newness of these sponsored integrative medicine experiments is evident in this set of 27 clinics; over 80% (22) are less than four years old and 64% (19) hadn't yet completed their third year of operation at the time of the survey.

There is a great deal of diversity in these sponsored facilities; in fact, as more than one analyst has commented, *if you've seen one integrative clinic … you've seen one integrative clinic.* This report attempts to identify trends, shared features, and common denominators in this evolving subsection of mainstream health care delivery.

The survey approach is described in detail in the side-bar, *Report Methodology*.

Part 1: Clinic Size, Initial Operations and Projected Break-even

Health systems forays into CAM delivery range from the provision of massage services in a 300 square foot space inside a hospital wing to 10,000 to14,000 square foot integrative care centers. Initial investment may be as low as $1500 or as high as $4 million. Monthly operating costs – which do not include donated real estate or subsidized staff—also vary significantly. One health system's monthly outlay is only $1500 while two clinics report monthly operational costs of over $100,000.

One striking finding revealed by this survey is the lack of any clear relationship between the size of the clinic and initial outlay on the one hand, and the projected time to break-even on the other. The leaders of the now defunct 10,000 square foot center in Phoenix sponsored by Catholic Healthcare West (CHW) anticipated a 12-month break-even, while a 1150 square foot operation sponsored by Cedars Sinai was pencilled in as a 4-year run to profitability. The variation reflects

the immaturity of the market. Some clinics started in the last 2 to 3 years have extended their own break-even projections based on the experience of CHW.

Most operate under a 501c3, charitable business structure. While the current survey did not distinguish between programs operating as hospital departments and those that are separate entities, informal comments and experience of leaders at CHW, George Washington University, and elsewhere support the view of integrative clinic consultants such as Nancy Schulman (September 2001 *Consult*) and Linda Bedell Logan that location inside the sponsoring entity is not recommended.

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Table 1: Size, Initial Expenses, Monthly Operations and Scheduled Breakeven

Sponsor	Size (sq ft)	Pre-opening (in $1000)	Monthly operating (in $1000)	Projected break-even (years)
U Massachusetts Memorial Healthcare	300 initial/ to 2600	1.5	10	3-4
Longmont United Hospital (CO)	300 initial/ to 2800	5	<10	3
Pinnacle Healthcare (PA)	500*	--	<10	--
Harvard Vanguard Medical Associates	600*	1	2	.2
Kaiser Permanente (Mid-Atlantic)	600+	<15	<10	--
George Washington University Medical Center	850	25	2.5	2
Cedars-Sinai	1150	--	--	4
U Arizona Medical Center	1200	65	--	3
Columbia Hosp. for Women & Children	1325	10	6	0.5
Community Hospitals of Indianapolis	1400	90	27	1.5
Hennepin Faculty Associates	1600	-	--	1
Medical University of South Carolina	1800*	--	--	--
Advocate Medical Group	1975	32	25	2.5
Yale-Griffin	2000	10	--	1
California Pacific Medical Center	2000^	350	25	3
U Pittsburgh Medical Center	2000/ 5300	--	--	3
TriHealth (OH)	2200	25	40	2
UCSF Stanford Healthcare	2350	150	33	1
Thomas Jefferson University Hospital	2600	60	43	2
Jupiter Medical Center	2800	150	20	1
Catholic Healthcare West (San Jose)	3600	250	30	1.5
Saint Barnabas Healthcare System (NJ)	4800	100	--	1.5
Presbyterian Healthcare (NC)	9000	--	--	2

Catholic Healthcare West (Phoenix)	10,000*	>1,000	>100	1
Health Alliance (OH)	11000	>500	75	2
New York Beth Israel	13,000	>4,000	>100	3
Mercy Health Partners (OH)	14,000*	250	135	3

* Expanded to multiple locations
^ 1000 plus 1000 medical office
+ "two exam rooms, two doctors offices"

Note: Data based on written surveys from the clinics completed between October 1998 and December 2000.

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2. Clinical Services

Selection of Providers

Consumers who use the services in these clinics will find that their own interests in CAM are not always reflected in the services offered. Table 2, *Clinical Services and Practitioner Types*, shows that the top two CAM services typically used by consumers, massage and chiropractic, are offered by 93% and 19%, respectively.

Another service that may be under-represented relative to consumer interest is natural pharmacy. While some surveys have shown that over 30% of adult Americans use botanicals, less than one-half of the clinics surveyed provide pharmacy services. Those that do tend to offer a small range of products—typically, 60 or fewer. Not surprisingly, those clinics that derive a high percentage of revenues from natural products sales (>20% of total revenues) offered significantly greater product selection.

Consumers' growing interest in relaxation and mind/body approaches is strongly reflected in the offerings of clinics surveyed. General education services (93%), group-focused mind/body programs (70%), yoga (70%), and multi-week, condition-specific programs (67%) are all widely available.

Unlike chiropractic, which in spite of its general acceptance, is offered in just 19% of those clinics surveyed, acupuncture, used by just 1 to 3% of consumers, ranks third highest in these clinics (89%).

The 1997 NIH Consensus Conference on Acupuncture, and a similar conference in 1995 on mind/body approaches to pain, are widely acknowledged as the evidence base which supports inclusion of these services. Yet the evidence for chiropractic, captured in clinical practice guidelines from what was then the Agency for Healthcare Policy and Research, has not shown a parallel dose-of-researched efficacy/inclusion response-from-clinics relationship. The relative absence of chiropractic in these clinics is typically attributed to opposition from conventional medical staff rather than to lack of evidence of efficacy.

Table 2: Clinical Services and Practitioner Types

Individual Provider Services (n=27)	**Percent**	**Number**
Massage/body work	93%	25
Group/education	93%	25
Acupuncture	89%	24
MD-Acu only	*26%*	*7*

LAc only	*41%*	*11*
MD-Acu and LAc	*22%*	*6*
Nutritional services	72%	21
Registered Dietitians	*30%*	*8*
Yoga	70%	19
Group/multi-week mind/body programs	70%	18
Group/multi-week condition specific programs	67%	18
Tai Chi	52%	14
Natural pharmacy ^	48%	13
Psychology professional ^^	44%	12
Homeopathy	37%	10
Manipulation	37%	10
Chiropractor	*19%*	*5*
Naturopathic physician	*4%*	*1*
Other (DO/MD)	*15%*	*4*
Naturopathic physician	15%	4

^ In some HHS facilities, the pharmacies may be nearby but offsite. As such they may be in a separate cost center.
^^ The survey is not clear on whether these services are provided by psychologists, social workers, psychiatrists, or other providers.
^^^ While chelation is not listed among the potential service offerings in the table accompanying the survey, no respondents included chelation as an additional offering.

Choice of Practitioners

An ongoing issue in the integration debate involves selection of practitioners to provide a particular CAM modality. The question is whether acupuncture, manipulation, or massage should be provided by a distinctly trained and licensed acupuncturist, chiropractor, or massage therapist or whether these services should be provided by conventionally trained practitioners who have developed some skills in a specific treatment option.

Licensed acupuncturists, providing services in 71% of the 24 clinics that offer acupuncture, are better accepted by clinic managers than are licensed chiropractors. Chiropractors, who provide the vast majority of all manipulation services nationally, are providers in just 50% of the 10 clinics that offer this treatment.

However, the survey data does not reflect the area where the decision to choose a distinctly licensed provider or a conventional provider with modality training may be most significant: massage and body work. Interviews with clinic managers in these health system-sponsored facilities suggests a strong preference for the use of conventional providers – typically nurses. Cross-trained nurses who are trained to provide various mind/body and energy medicine therapies such as meditation, therapeutic touch, yoga and Tai chi are frequently the preferred practitioners.

For some sponsors, the initial experiment is only with integrating “complementary” services into their clinics. In roughly one quarter of the clinics surveyed, there is no integrative-oriented medical doctor on staff or acting as medical director. Most of those clinics without an active medical director noted that this creates a significant void, particularly if the clinic seeks to build referrals from the health system’s staff physicians. The claim that medical doctors listen to medical doctors is certainly confirmed in the CAM integration environment.

Table 3: Presence of MDs

MD-services provided	20
Paid medical director	21
Medical director 1.0 FTE	7^
Medical director <0.5 FTE	9

^ Usually the 1.0 is partly administrative and party clinical services.

Developing Clinical Integration

Clinic operators find that both CAM practitioners and conventional practitioners tend to operate independently. They have little experience, awareness, or skills when it comes to knowing when cross-referral to a distinct practitioner in the clinic makes the most sense. Table 5 shows some of the strategies used in creating quality integration teams. The most popular strategy for building an integrated team is a weekly meeting of 60 to 90 minutes.

Donald Novey, MD, integration leader with Advocate Healthcare, is among those medical directors with a passion for CAM, but little prior direct experience delivering CAM modalities. Novey has found these team meetings to be excellent investments. As a condition for credentialing at Advocate Healthcare, clinic practitioners agree to contribute their time to weekly team meetings. Novey credits the investment in team work for creating a "word of mouth referral" which led the clinic to operational break-even in its second year. He views the team meetings as possibly the best clinical education in the value of CAM for medical doctors in the United States today.

Table 4: Practitioner Integration Strategies

Strategy	#
Sometimes see patients as team	15
Hold routine joint case review	18
Weekly	11
Bi-weekly	2
Bi-monthly	2
Monthly	3

Salaried or Contracted?

The clinics offer diversity in their contractual relationships. Just over half of the 25 clinics that responded to this survey have both salaried practitioners and those who are on incentive-based contracts. As is evident in Figures 1 through 3, conventional medical personnel, in particular medical doctors, are significantly more likely to be salaried than are distinctly licensed CAM providers.

This differential is due to the system's prior relationships with the conventional medical doctors and nurses who now spend a portion, or all, of their time at the clinic. The experimental nature of these operations also accounts for some of this double-standard. CAM practitioners on split-fee, incentive contracts are told, in effect, that they must earn their keep.

Incentive-contracting varied from an arrangement at Pinnacle in which CAM practitioners received 70% of the gross revenues generated by their services to a low-end of just 30-45% of gross revenues going to the practitioners in the Longmont clinic. Notably, the Longmont program has found a way to cover overhead and reach operational break-even. Pinnacle operators were struggling with their payment model at the time of the interview.

Most of these operators agree that, from a business perspective, linking payment to production in integrative services makes sense, just as it typically does in most conventional business models.

Figure 1: Type of Institutional Relationship
N=25

Employed only	6 (24%)
Contracted only	5 (20%)
Both employed and contracted	12 (48%)
Employed, contracted and leased	1 (4%)
Leased space only	1 (4%)

Figure 2: Type of MD/DO Compensation in 18 HHS-Sponsored Clinics
N=18

Employed MD/DO only	12 (67%)
Contracted MD/DO only	3 ^ (17%)
Both employed and contracted MDs	3 ^^ (17%)

^ In both instances, the facility has no employed providers.
^^ In 2 of 3 instances, the contracted provider plays a relatively minor role as a single modality provider.

Figure 3: Type of Distinctly Licensed CAM Provider Compensation
(N=25)

Employed CAM only	6^ (24%)
Contracted CAM only	14 (56%)
Both employed and contracted CAM	5^^ (20%)

^ In 5 of 6, all providers are employed. In some instances, the "employed" provider
^^ In 3 of 5, the employed CAM providers are massage therapists or therapeutic touch practitioners whose CAM training is in addition to a conventional medical training and who also provide conventional services in the hospital.

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3. Provider Mixes and Profitability Issues

The clinical models of the 27 clinics tend to fall into four distinct types. Each has specific profitability challenges and advantages.

- *Complementary Health Services*

In this model, services are typically limited to education, massage and body work, and some energy therapies such as therapeutic touch. Business planning is squeezed by a bad news/bad news scenario in which services are time-consuming but only generate $45-$65 per visit. Third-party payment is typically minimal or non-existent. Revenue from these time-intensive practices cannot usually support much overhead. Health systems typically donate space, and may loan a part-time manager, or even a limited, part-time, medical director. Without funded overhead, actual integration, including referral creation and clinical program development is difficult to achieve. The Massachusetts Memorial Health Care clinic was such an example. Despite high satisfaction from patients (many of whom were employees) the clinic was unable to secure a place as a valuable contributor in the view of the system physicians, and was terminated.

- *CAM-centric Models*

In these centers, the services of distinctly licensed providers, typically acupuncturists, but also chiropractors or naturopathic physicians, are added to the mix seen in the above model. Small sets of CAM providers may be introduced into under-utilized space in outpatient facilities. Pinnacle, Medical University of South Carolina, Longmont and Harvard Vanguard all follow this model. Direct involvement of any medical doctor is limited, even in a part-time, salaried, non-clinician medical director capacity. One benefit of lack of medical doctor staff is that initial outlays and overhead are much less costly, but both income production and penetration into the health system are limited. The most mature of such facilities is one sponsored by Minnesota-based, Hennepin Medical Associates. The clinic is more than breaking even, according to a May 2001 follow-up report. The clinic has achieved relatively high penetration of managed care reimbursement (30%) as well as a growing percentage of referrals from conventional medical doctors (18%). A positive bottom line is often linked to adding a chiropractor, who can help drive patient flow as well as insurance participation.

- *Integrative, CAM-centric Service Delivery*

This model, typified by the clinics sponsored by Chicago-based Advocate Healthcare and St. Barnabas, is led by an MD/DO. Most services, however, are provided by non-MD/DO practitioners. The medical director may not have extensive clinical experience in offering integrative care but is still considered to be the team leader. The MD/DO provides clinical strategy guidance, clinical program development, outreach to the system, intake or management of complex patients, and triage skills. Respect for the distinct skills of each member of the CAM provider team is critical. The MD provides reassurance to the system's more conservative conventional physicians. The model may use relatively low-cost, frequently productivity-based CAM providers, while also starting with part-time, salaried MD/DO participation. This model has the potential to create a high level of actual integration, mutual respect, and appropriate cross-referral between the CAM practitioners, all of which can stimulate a positive reputation among both system physicians and satisfied patients.

- *Integrative, MD-centric Service Delivery*

This model bases most care provision on services of "integrative physicians," MD/DO practitioners who have skills in one or more CAM modalities, typically acupuncture and some therapeutic nutrition, botanical medicines, or homeopathy. The New York Beth Israel model, with 5.3 FTE MDs generating a majority of revenues, surrounded by diverse CAM providers, is an example. Another is the 10,000 square foot, Cincinnati-based Health Alliance clinic led by two medical acupuncturists. Revenue potential is high, with CAM services income enhanced by revenues from conventional treatment. Overhead may also be significant In these clinics. A challenge to this type of clinic is that managed care contracting does not typically have payment categories which reflect the diversity, individualization, and time-intensity of integrative treatment.

Some findings that apply across the models are as follows:

- Large clinics (6,000 or more square feet) are not likely to achieve operational break-even without a core of integrative MD/DO providers.
- Chiropractors, while controversial, can prove to be significant patient draws, even in MD/DO-centric models.
- Creating thorough integration into hospital or health system clinical programs is unlikely to be accomplished without the involvement of an MD/DO ambassador from the clinic.
- Systems that only offer complementary health services should anticipate needing an ongoing system subsidy.

4. Business Models: Referral and Income

The national dialogue around consumer use of CAM typically notes the grassroots nature of this emerging interest. In the “alternative medicine” of the 1980s and early 1990s, patients typically paid cash and were self-referred or referred by family members or friends.

One of the most significant findings of this survey is that, while owned by mainstream delivery organizations, the business model of these hospital and health system sponsored clinics remains largely “alternative.” Word-of-mouth is still the top source of new clients. Revenues reflect little third-party payment.

Table 5, and Figures 4-14, describe the practices. Sample findings:

- 75% receive less than one quarter of their referrals from conventional physicians.
- Nearly two-thirds (65%) of the clinics receive 90% or more of their revenues as cash.
- 87% have 30% or less of their payment from managed care.
- Almost none do any direct contracting with employers.
- Word-of-mouth is viewed as the most successful marketing strategy.

Even tThe relatively minor role of physician referral in this data may overstate the level of actual, affirmative integration of these CAM services with conventional treatment The reason is that high levels of referral in three of these clinics is a result of a defensive move by clinic managers to assuage concerns of conservative medical staff about CAM by requiring physician referral before the patient accessed the clinic’s services. In an additional example, Kaiser Mid-Atlantic, the centrality of the primary care provider to Kaiser’s care model also mandated physician referral to CAM services. If the clinics that require referral are removed from the analysis, it becomes clear how minor the role of conventional physician referral is in the economic status of these clinics.

With experience, initial concerns of conventional medical staff tend to be assuaged. In addition, clinic profitability urges opening direct access. Eventually, direct consumer access to CAM services tends to be more readily facilitated.

Another potential for referral is from CAM providers in the community who may come ot view an integrative clinic as a supportive place to send patients who may either need to see a medical doctor or for services the community provider does not offer. As Figure 13 shows, few of the clinics have successfully positioned themselves as partners with the community CAM providers Only one clinic receives more than 15% of its referrals from community CAM providers.

Model is non-integrated

In these first stages of hospital-sponsored clinic development, the model that emerges is remarkably non-integrated into either mainstream payment (via third party compensation) or mainstream delivery (via routinely-utilized referral from conventional MDs/DOs).

The operators, in both the initial interview and in subsequent follow-ups (particularly the May 2000 report), underscored the laborious nature of developing referrals from conventional physicians. In addition, only a few noted success in developing special relationships with managed care firms. The notable example is the medical doctor-naturopathic physician co-management model offered through the Yale-Griffin clinic that Oxford Health Plans has chosen to cover for a limited, pilot project period.

Adam Perlman, MD, MPH, director of integrative medicine for New Jersey-based St. Barnabas Health System, is among those who link economic sustainability of integrative clinics to the integrative services' penetration into the health system’s conventional practice. One example of his recent success is a relationship with a breast cancer specialist who routinely refers her patients to Perlman’s clinic for supportive, integrative care. Perlman is now taking a “centers of

excellence" approach in which he is developing integrative programs designed to can piggy-back on existing health system clinical initiatives.

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Table 5: Overview of Sources of Referral and Income

Business Model	% of responding clinics
Referral **(n=24)**	
60% or more of referrals from self-family-friend	75%
Less than 25% of referrals from MD/DO	75%
10% or less of referrals from managed care	87%
10% or less of referrals from direct employer contracting	87%
Income **(n=23)**	
90% or more of income via cash	65%
Less than 5% of income via managed care	70%
30% or less of income via managed care	87%
Less than 5% of income via employer contracting	96%

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Figures 4-8: Income Sources

Figure 4: Direct Cash Income

0-5%	0 (0%)
6-30%	5 (22%)^
31-60%	4 (17%)
61-90%	3 (13%)
91-100%	11 (49%)

^ Includes an estimate for one facility, Kaiser, where the patient is only responsible for co-payment.

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Figure 5: Traditional Indemnity Income

0-5%	15 (65%)
6-30%	7 (30%)
31-60%	1 (4%)
61-100%	0 (0%)

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Figure 6: Cash Plus Traditional Income

0-5%	0 (0%)
6-30%	1 (4%)^
31-60%	7 (30%)
61-90%	2 (90%)^^
91-100%	13 (57%)

^ Includes an estimate for one facility, Kaiser, where the patient is only responsible for co-payment.
^ Two clinics report 90%.

Figure 7: Managed Care Income

0-5%	16 (70%)
6-30%	4 (17%)
31-60%	2 (9%)
61-100%	1 (4%)^

^ Kaiser, where the patient is only responsible for co-payment.

Figure 8: Direct Income from Employers

0-5%	24 (96%)
6-30%	1 (4%)
31-60%	0 (0%)
61-100%	0(0%)

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Figures 9-13: Referral Sources

Figure 9: Referrals from Self/Family/Friends

0-25%	2^
21-60%	5
61%-90%	15
91%-100%	2
No answer	3

^ Both are clinics in which the clinic's policy requires physician referral.

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Figure 10: Referrals from MD/DOs

0-25%	17
21-60%	6
61%-90%	0
91%-100%	1^

- The 100% with physicians referral is mandated by the health system. Two other clinics have a formal physician referral requirement but the percentages used in this chart were estimates of actual origin: did the patient ask the physician for a referral or did the or the physician initiate?

Figure 11: Referrals from Managed Care

Total clinics	24
10%	3
0-10%	4
0%	17

Figure 12: Referrals from Employers

Total clinics	24
20% or more	1
10-20%	2
0-10%	4
0%	17

Note: The high referring employer was the sponsoring health system sending its own employees.

Figure 13: Referrals from Community CAM Providers

Total clinics	24
15% or more	1
5%-14%	7
0-5%	5
0%	11

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Marketing Strategies

The marketing priorities of the clinics both respond to, and reinforce, prevailing practices. (See Figures 14-16) Over half find that stimulating word-of-mouth is their most successful approach. An additional “mouth” that has played an important role for 16% of respondents is the free advertising gained through media reports.

In general, the clinics do not report significant value from direct mail, newspaper, television, or radio advertising. It may grant the clinic internal legitimacy by creating visibility within the health system. As one medical director said, "It put us on the map.” But after a kick-off marketing campaign, this expensive approach -- his sponsor spent $40,000, mainly on radio advertising -- tends to be set aside for more direct, face-to-face approaches.

Despite struggles in developing referral support from the health system’s staff physicians, a growing number of clinic operators were beginning to consider a breakthrough in this area as critical for the sustainability of their clinics. Figure 15 shows that 38% of responding clinics spent over 31% of resources on developing referrals from conventional physicians.

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Figure 14: Marketing Strategies Deemed Most Successful

Direct mail	1 (3%)
HMO	1 (3%)
Media reports^	5 (16%)
MD/DO outreach	4 (13%)
Print ads	1 (3%)
Stimulating word-of-mouth^^	17 (55%)
Employers	2 (6%)

^ Articles in ky
the media which were, typically, generated by the media rather than through a formal media campaign.

^^ This category includes “community presentations.”

Figure 15 Percent of Marketing Devoted to Building MD/DO Referrals

N=24

0-5%	6(25%)
6-30%	9 (38%)
31-60%	6 (25%)
61-100%	3^ (13%)

^ This figure includes two clinics in which referral from conventional physicians is required of all consumers accessing clinic services.

Figure 16: Percent of Marketing Devoted to Paid Advertising

N=24

0-5%	8 (33%)
6-30%	8 (33%)
31-60%	3 (13%)
61-100%	5^ (21%)

^ In some cases the high percentage may reflect the ease in assessing direct dollars to purchased advertising, relative to estimating the time-costs of, for instance, providing or speaking at community programs.

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5. Data Collection and Research Strategies

Most operators of the clinics surveyed realize that whether or not the sponsoring organization formally calls the venture a “pilot” or “demonstration project,” the integrative clinic has something to prove. Research, for most clinics, is considered a core part of their mission.

Table 6 reports on the kinds of data gathered by clinics, some of which lends itself to analysis, together with whether or not they have plans to undertake formal research . Over 80% of clinics surveyed report routinely gathering quality of life information and measuring patient satisfaction. A like percentage state they are using standardized forms for intake. A rich body of data appears to be accumulating in these clinics.

Two-thirds (18/27) announce a formal research intention, with half of these planning to explore the question of cost-offsets, which is of critical interest to third party payers. Just over two-thirds of clinics report being presently linked, or easily associated with, a research partner either in their own academic center or one nearby.

At the time of the survey, few clinics had completed research projects. The differential between expressed intention and reported outcomes is partly a function of the youth of the enterprises. Interviews with some of the clinic managers suggest that another factor may be the immediacy of economic pressures to create sustainability, pressures which have shifted research to a secondary priority. Data, while gathered, may not have been efficiently examined.

Table 6: Data Gathering and Research Intentions

Measured *(n=27)*	#	%
Use standardized forms which could be used for outcomes	22	81%
Have research affiliation(s)	19	70%
Are doing client satisfaction surveys	23	85%
Are routinely evaluating health status/quality of life	24	89%
Plan to undertake research on outcomes	18	67%
Will evaluate whether CAM is an add-on or replacement	9	33%

Side-bar #1:

Report Methodology

In a series of 5 reports since October 1998, data on 27 hospital-based integrative clinics are provided in table formats. The data include extensive information on business and clinical operations. Leaders of each of the clinics were interviewed as part of the information-gathering process.

The survey instrument includes a total of 75 questions in 8 separate categories. The categories, sample content and total questions per category are as follows.

1. *General Characteristics* (10): length of planning, date of opening, square feet, legal status.
2. *Clinical Services* (15): modalities offered, % conventional, types of group services, use of networks of community providers.
3. *Natural Products Dispensary* (3): whether included, number of products, sales of other resources.
4. *Laboratory Services* (5): if provided, typical tests, special lab contracts, special tests.
5. *Clinical and Administration Staff*: personnel by type, contract (employed, contracted, leasing space), planned changes, medical director time, role of sponsoring organization, computerization, billing service.
6. Research/Outcomes (7): role, affiliations, types (health status, cost-offset, satisfaction), use of standardized intake.
7. Marketing (6): targets (patients, referrals, managed care), percent by source, success.
8. Revenue and Expense (18): dollars spent prior to opening, expected break-even and break-even performance, anticipated profitability, % of revenues from diverse sources.

The data were reported in chart format in issues of THE INTEGRATOR *for the Business of Alternative Medicine* in October 1998 (3), February-March 1999 (5), August-September 1999 (4), May 2000 (8) and December 2000 (8) [1] In addition, two other special reports (March 2000, April 2001) went back to this same set of clinics with a limited set of focused questions. The first targeted challenges, breakthroughs and priorities. The latter looked at profitability, income and the role of philanthropy.

This report is the first published analysis of the data gained from these combined surveys. Note that this is not a snapshot of these clinics in 4th quarter, 2001. Rather, the outcomes reflect information provided at the time of the survey. (Four of the operations, for instance, are no longer offering services.) The analysis also reflects information gathered through the other special reports and through interviews accompanying the surveys.

[1] This supplement does not include activities in one of the clinics included in that report.

Side-bar #2

Additional Resources Available

The following are additional useful resources which focus on operational issues involved in health system sponsored integrative clinics.

- John Weeks, INTEGRATOR *Integrative Clinic Benchmarking Project Back Issue Set* (Integrative Medicine Communications). Those interested in complete data, including the full tables in which data was reported, for these health system-sponsored clinics more may purchase the entire set of 7 INTEGRATOR issues for $100. Individual issues are $35.
- Nancy Faass, Integrating Complementary Medicine into Health Systems (Aspen). $125
- Michelle Bowman and Frank Lawlis. Complementary and Alternative Medicine Management: Forms and Guidelines (Aspen). $249
- John Weeks. *Report from the Integrative Medicine Industry Leadership Summit 2000*. Offered free online at onemedicine.com/summit.
- Harvard Medical School and Stanford University School of Medicine. Conference tapes: *Complementary and Alternative Medicine: Practical Applications and Evaluations 2000*.