The purpose of the study was to identify and examine critical factors that either promote or hinder acute care hospitals decision-making on adopting complementary and alternative medicine (CAM). All acute care hospitals in the states of Oregon and Washington were included in the study. Individual interviews were conducted at the first phase of the study to elicit in-depth information and personal experiences related to a hospital’s decision-making process of adopting CAM services, as well as how critical factors influenced the decision making. An e-mail survey was conducted at the second phase of the study to assess the relationship between a set of critical factors and whether hospitals offer CAM services. Data collected from interviews were sorted and synthesized by themes. Survey data analysis was conducted with generalized logistic regression, Chi-square test, multivariate analysis of variance, and descriptive analysis.

The interview results suggested that the facilitators for hospitals to adopt CAM included favorable organizational mission and philosophy of
providing care, patient and community interests in CAM, physician champions for CAM services, organizations’ strategic positioning towards a competitive business environment, and the availability of financial and human resources for CAM programs. The barriers for hospitals to adopt CAM services included low reimbursement of CAM services, lack of physician support, lack of nationally accepted standards and criteria for credentialing CAM practitioners and quality control, and lack of resources and qualified CAM practitioners in certain geographic area.

132 email surveys were sent with approximately 30% response rate. The survey results confirmed that patient and community interest in CAM services and organizational mission and philosophy of providing care were two factors that significantly differentiated hospitals that offered CAM services from those that didn’t. Descriptive analysis suggested that survey respondents tended to be smaller hospitals with lower operation margin, compared to the non-respondents. However, this difference was not statistically significant.

The major findings of this study appeared to support Diffusion of Innovation theory, suggesting that an innovation is more likely to be adopted when it is more compatible with existing values and needs of potential adopters. The results of this study also were supportive of strategic management perspective in which adoption of an innovation can be a result of an organization’s strategic positioning to environmental and market forces.
Based on the findings of this study, a list of practical recommendations for hospitals that are considering adopting CAM services were made.

Suggestions for future studies were also discussed.
Factors Influencing Decision-making of Acute Care Hospitals on Adopting Complementary and Alternative Medicine

by
Xiaowei Tian

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Xiaowei Tian, Author
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Factors Influencing Decision-making of Acute Care Hospitals on Adopting Complementary and Alternative Medicine

CHAPTER 1

INTRODUCTION

Complementary and Alternative Medicine (CAM), as termed by western countries, refers to a group of diverse medical care practices and products that are not currently considered as part of conventional medicine (Barns, Powell-Griner, McFann, & Nahin, 2004). The National Center for Complementary and Alternative Medicine (NCCAM), established by the National Institutes of Health (NIH), classifies Complementary and Alternative Medicine into five categories (National Center for Complementary and Alternative Medicine [NCCAM], n.d.):

1. Alternative medical systems: these systems are built upon complete systems of medical theory and practice. Most of them have evolved earlier than the conventional medical approaches used in United States. Examples of alternative medical systems include homeopathy and naturopathic medicine that are developed from western cultures, and traditional Chinese medicine and Ayurveda that are developed from eastern cultures.

2. Mind-Body interventions: these interventions enhance the mind’s capacity to affect bodily function and symptoms, including
but not limited to meditation, prayer/spirituality, yoga, creative art, music, or dance.

(3) Biologically based therapies: these therapies use substances found in nature, such as herbs, foods, and vitamins, as well as other dietary supplements to treat ailments and promote health.

(4) Manipulative methods: these therapies are based on manipulation or movement of parts of human body. Chiropractic manipulation and massage are the most commonly utilized therapies in this category.

(5) Energy therapies: biofield and bioelectromagnetic-based therapies are two main types of energy therapies. These therapies are used to affect energy fields that purportedly surround and penetrate human bodies. Examples of energy therapy include therapeutic healing touch and Reiki.

CAM modalities are widely used to treat various health conditions. A 2002 national health survey revealed that most people used CAM to treat or prevent muscular-skeletal conditions or other conditions associated with chronic or reoccurring pain, anxiety, or depression (Barns, Powell-Griner, McFann, & Nahin, 2004). A study designed to assess the use and referral patterns of CAM by conventional medical practitioners found that muscular-skeletal conditions, headaches, skin conditions, chronic fatigue syndrome, allergic conditions, and other chronic pain conditions were the most common
conditions conventional medical practitioners referred to CAM treatment (Haselen, Reiber, Nickle, Jakob, & Fisher, 2004). Physicians who practice CAM in addition to conventional medicine were found most likely to use CAM to treat psychological problems, muscular-skeletal disorders, headaches, smoking cessation, and weight problems (Makowski, 2004). The NIH consensus statement of 1997 about the efficacy of acupuncture concluded that evidence supporting the use of acupuncture was as strong as those for many accepted conventional medical therapies, and the incidence of adverse effects from acupuncture was substantially lower than that of many drugs or medical procedures used for the same condition (National Institutes of Health [NIH], 1997). The NIH consensus statement also suggested that postoperative pain syndrome, nausea and vomiting post chemotherapy, osteoarthritis, fibromyalgia, headaches, menstrual cramps, tennis elbow, and addictions were some examples of conditions for which acupuncture might be beneficial (NIH, 1997).

Statement of the Problem

CAM practices apparently have gained increasing popularity in the United States in the recent years. The 2002 National Health Interview Survey (NHIS) of 31,044 interviews with adults 18 years of age or older suggested that 62% of adults in the United States used some form of CAM therapies during the past 12 month (Barns, Powell-Griner, McFann, & Nahin, 2004). The
2007 National Health Interview Survey estimated that the U.S. public spent about 33.9 billion dollars out of pocket on visits to CAM practitioners and on purchase of CAM products, classes, and materials in 2007, which equaled 11.2% of the total out-of-pocket health care expenditures in the U.S. in 2007 (Nahin, Barnes, Stussman, & Bloom, 2009).

CAM practitioners have been traditionally found in solo practice or in small group practice of multiple CAM modalities in the U.S. history. With CAM growing into a multi-billion dollar business, conventional health care delivery systems in the U.S. have also begun to look for ways to incorporate CAM services (Ruggie, 2005).

As a major part of American mainstream health care system, hospitals have cautiously started to adopt CAM services. The American Hospital Association surveyed over 6000 acute care hospitals in the U. S. in 2005 and found that about 26% of responded hospitals offered some type of CAM services, including massage, yoga/Tai Chi, acupuncture, meditation, guided imagery, music/art therapy, therapeutic touch, and relaxation training (Health Forum, 2006). It is notable that the response rate of 21% in this survey was relatively low and may not be representative of all hospitals. The number of hospitals offering CAM services was also relatively small, given the prevalence of CAM utilization by the public. However, the number of hospitals adopting CAM services has grown steadily in the recent years, reportedly from just under 8% in 1999 to about 26% in 2005 (Health Forum, 2006).
Even though there seems to be a trend of integrating CAM into hospital services, the number of hospitals that have adopted CAM is still only a small representative of the total. Critical factors that may facilitate or hinder hospitals’ decision making on adopting CAM services remain speculative. Hospitals that have adopted CAM services reported in the 2005 AHA survey that patients’ satisfaction was their main reason to offer CAM services (Health Forum, 2006). However, the 2005 AHA survey questionnaire had only one question with limited choices in trying to identify the reasons for hospitals to adopt CAM. The survey also did not ask for information regarding the perceived barriers that might hinder hospitals from adopting CAM. It is unclear whether consumer demand is the only reason that hospitals would consider when making their decision to offer CAM services. Hospitals that offer CAM services could encounter challenges that are unique to CAM services, which range from a lack of health insurance coverage to issues concerning licensing and credentialing CAM practitioners (Cohen et al., 2005; Martin & Long, 2007). Clement and her colleagues (2006) raised concerns about the accreditation issues that hospitals might have towards adopting CAM, because hospitals were increasingly required by their accreditation agency (i.e. JCAHO) to adopt scientific and evidence-based medical practice, while CAM services were seemingly less likely to have been validated with scientific studies. How do hospitals weigh the potential benefits of offering CAM services against the challenges and risks CAM services may post to their business practice? Are
considerations given to adopt CAM services by hospitals different from adopting any given new service line? The nature of the critical factors that may influence the decision making of hospitals on adopting CAM services remains unclear.

**Study Objective**

The objective of this study is to identify and examine the critical factors that may influence the decision-making of acute care hospitals on adopting CAM services.

**Research Questions**

In order to carry out the objective of this study, the following research questions will be addressed:

1. What are the main reasons for acute care hospitals to adopt CAM services?
2. What are the main barriers that prevent acute care hospitals from adopting CAM services?
3. How do critical factors influence acute care hospitals’ decision-making on adopting CAM services?
Significance of Study

In the past decade, American public has shown a growing interest in utilizing CAM therapies and products. In 2007, four out of ten American adults reported to have used CAM therapy during the past 12 month (Nahin, Barnes, Stussman, & Bloom, 2009). The National Center for CAM, one of the 27 centers that make up the NIH, has conducted and funded a wide variety of CAM studies. Conventional medical journals including JAMA and New England Journal of Medicine have published a number of CAM related research, and medical schools have started to include CAM education into their curriculum (Ruggie, 2005). Preston Gee, the senior vice president of strategic planning for St. David’s HealthCare Partnership in Austin, TX and a health management consultant, recommended in his book “Seven Strategies to Improve Your Bottom Line: The Healthcare Executive’s Guide” that hospitals and health systems to derive financial benefits from CAM by offering CAM services in a way that is “politically astute and economically sound” (Gee, 2001). Martin and Long (2007), professors of management from DePaul University and Tulane University, also called for innovative ways for conventional healthcare organizations to offer CAM services and stated that “what is clear is that CAM represents a significant and growing share of the health care dollar, and the revenue potential will only increase through time”.

Integration of CAM and conventional health care delivery system has become a much-discussed theme among academic and clinical researchers.
(Bodeker & Kronenberg, 2002; Gee, 2005; Martin & Long, 2007). Although studies have been published supporting the legitimacy of the integration between CAM and conventional health care, most of them come from clinical perspectives (Helene & Ford, 2000; Sarnat, Winterstein, & Cambron, 2007). Very few studies have approached this theme from health care management and organizational point of view (Chi, 1994; Clement, et al., 2006; Makowski, 2004). Little is known about how health care executives view the integration of CAM and conventional health care delivery system, particularly on the business and organizational aspects of the integration. The current study attempts to fill this void by examining critical factors that may influence hospitals’ decision making on adopting CAM services, and shed light on the perspectives from hospital executives on the issue of adopting CAM in rural and urban hospitals of Oregon and Washington.

Chapter Summary

Complementary and Alternative Medicine has gained increasing popularity in the United States and has emerged as a new billion-dollar industry in the U.S. health care market in recent years. Published studies have documented the prevalence of the public’s use of CAM services. Conventional health care organizations have also started to tap into CAM market through funding CAM research and training, publishing CAM related studies, and increasingly incorporating CAM therapies with conventional hospital services.
The current study attempts to investigate the facilitators and barriers that conventional hospitals may encounter towards the adoption of CAM, and assess how these critical factors would influence the hospitals’ decision-making process.

Chapter 2 provides the theoretical framework of this study and a review on literature related to the critical factors influencing the integration of CAM and conventional health care delivery system in the U.S. Chapter 3 contains a description of the methods used to conduct the current study. In chapter 4, the data that were collected from this study are presented and analyzed. Chapter 5 contains a summary of the current study, discussion of findings, conclusions that appeared warranted, and recommendations for future research.

CHAPTER 2
REVIEW OF RELATED LITERATURE
Conventional health care delivery organizations such as hospitals, which have traditionally stayed away from “alternative” medical practice, have just begun to integrate CAM into their services (Ruggie, 2005). Several organizational theories explain why health care organizations want to provide new lines of services and how this process is determined. These perspectives provide a theoretical framework for the current study to explore why hospitals are willing or unwilling to integrate CAM services. In addition to the theoretical perspectives, recent studies have also provided empirical analysis on an array of factors that may influence, either positively or negatively, the integration of CAM and the conventional health care system.

This chapter reviews the recent development of CAM integration with conventional health care in the U.S., then discusses the critical factors identified by the recent literature as either facilitators or barriers to the integration, and finally presents the theoretical frameworks for the current study and their applications in the field of health care by reviewing previous published studies.

Integration of CAM and Conventional Health Care

The increasing use of CAM therapies in the United States appears to lead a movement of integration of CAM and conventional health care services (Boon, Verhoef, O’Hara, Findlay, & Majid, 2004). A new terminology, integrative medicine or integrative health care, is coined to address this trend
in the health care industry. The National Center for Complementary and Alternative Medicine (NCCAM) of the NIH defines “integrative medicine” as “combining mainstream medical therapies and CAM therapies for which there is some high-quality scientific evidence of safety and effectiveness” (NCCAM, n.d.).

Boon, Verhoef, O'hara, Findlay, and Majid (2004) suggests that the term “integrative health care” is more accurate as opposed to “medicine” based on acknowledgement that human health has a broad range of determinants such as socioeconomic status, personal education, social support networks, security of home and employment, workplace conditions, lifestyles, accessibility to health care, and other factors. Medical care is but one of these many factors that contribute to personal and population health. The authors also propose a theoretical model of integrative health care with four key themes, namely: (1) philosophy and values, which describe an underlying worldview or values as the fundamental basis for guiding the emergence of integrative health care; (2) structure, where integrative health care is described by its constituent elements and the infrastructure that links them together; (3) process, where integrative health care is described by the unique process of interaction between the patients and practitioners; and (4) outcomes, which focus on the possible results or products that might occur when integrative health care is operational. The philosophical base of integrative care lies in the view that human health includes physical, mental,
emotional, spiritual, social, and environmental aspects; therefore the focus of medical care should not be merely the treatment of disease but also promoting health and healing. The structure of integrative care requires a non-hierarchical and collaborative team of conventional health care and CAM practitioners. The process of integrative care reflects effective interdisciplinary communication and decision-making among practitioners, and encourages patients’ participation and shared responsibility in making their health decisions. Integrative care aims at providing cost-effective and high quality patient care. The outcomes of integrative care come from synergistic effect of coordinated care that is greater than the combined effects of individual practice.

Other models have also been proposed to address the feasibility and conduct of the integration. In his careful examination of the role of Chinese medicine in Taiwan’s health care system, Chi (1994) drew the experiences of the integration of Chinese medicine and modern allopathic health care in Taiwan as an example, suggesting that communication among different medical systems, rigorous research in CAM, national policy to promote coexistence of different medical systems, adequate resources, and integrated training programs for both CAM and allopathic medicine were key strategies to achieve a truly integrated medical system. Tararyn and Verhoef (cited in Boon, Verhoef, O’hara, Findlay, & Majid, 2004) argued that consumers’ demand for more access to CAM is a primary force of the integration movement and the
authors identified six levels of integration, including consumer, practitioner, clinic, institution/organization, profession/regulation, and health policy.

Similarly, Leckridge (2004) proposes a patient-centered integrative health care model, suggesting a shift in the balance of power from practitioners to patients, and creating an idea of "expert patients" with the power to choose services available. The increased consumerism in current health care market echoes the proposed patient-centered integrative care model that focuses on patient autonomy and empowerment in making their health decisions. This model also emphasizes teamwork and effective communications between CAM and conventional health care providers, which are considered to be crucial elements for providing the best and most appropriate care for patients.

Besides theoretical models developed for the integration of CAM and conventional health care, the actual integration, or at least co-operation between CAM and conventional health care, is happening rapidly. Since 2000, the National Center for Complementary and Alternative Medicine at the NIH has funded programs from 14 medical and nursing schools and American Medical Students Association to incorporate CAM education into their curricular with the goal to accelerate the integration of CAM and conventional medicine (Pearson & Chesney, 2007). The majority of medical schools in the Untied States now offer courses in the field of CAM practices, and some medical schools and academic medical centers have made significant steps
towards integrated CAM education and services (Barrett, 2003). Perhaps the most progressive move so far towards the integration is in the State of Washington, where all private health insurance plans are required by law to cover every category of CAM services (Ruggie, 2005).

Theoretical Framework

The theoretical framework of this study is derived from Diffusion of Innovation theory, strategic management perspective, and institutional theory. The following sections describe each of the theory and previously published studies that are pertinent to the current study.

Diffusion of Innovation Theory and Related Studies

In his seminal work of diffusion of innovation theory, Everett Rogers defines innovation as “an idea, practice, or object perceived as new by an individual or other unit of adoption”, and diffusion as “the process by which an innovation is communicated through certain channels over time among the members of a social system” (Rogers, 2003; p35-36). Although alternative and complementary medicine has been in practice for centuries in some parts of the world, it is relatively new in the United States and certainly a nascent practice among mainstream hospital services. Therefore, the constructs and rules of diffusion of innovation theory may apply to the current study in exploring the decision-making process of hospitals’ adoption of CAM services.
Rogers (2003) proposed a model of five sequential stages in the process of innovation decision making, through which an individual would pass from gaining knowledge and understanding of an innovation (the knowledge stage), to forming a favorable or an unfavorable attitude towards the innovation (the persuasion stage), to making a decision to adopt or reject the innovation (the decision stage), to implementing the innovation into use (the Implementation stage), and to seeking reinforcement and re-evaluation of the innovation decision already made (the Confirmation stage). As Rogers (2003) further stated, the innovation-adoption process in organizations, which also consisted of a sequence of five stages, was somewhat similar to that of individuals. These five stages include agenda setting, matching, redefining/restructuring, clarifying, and routinizing. Agenda-setting and matching refer to the process of information gathering, conceptualizing, and planning for the adoption of an innovation and leading up to the decision to adopt; redefining/restructure, clarifying, and routinizing refer to the implementation stage of an innovation, consisting of all the events, actions, and decisions involved in putting the innovation to use.

Rogers (2003) suggested that the attributes of an innovation would influence the likeliness of adoption. He identified five general categories of such attributes: relative advantage – the degree to which an innovation is perceived as better than the idea it supercedes; compatibility – being consistent with existing values and needs of potential adopters; complexity –
the degree of difficulty to understand and use an innovation; trialability – the degree to which an innovation can be tried or experimented; and observability – the results of an innovation can be easily observed. An innovation with higher degree of relative advantage, higher compatibility, higher trialability, higher observability, and lower complexity would be more likely to be adopted.

Diffusion of Innovation theory has been widely applied to research in various disciplines such as public health, sociology, anthropology, education, communication, marketing and management, geography, engineering and science (Rogers, 2003). Typical innovation studies in health field range from adoption and diffusion of new drugs or medical technology, to family planning methods, HIV/AIDS prevention, and smoking cessation (Glanz, Lewis, & Rimer, 1997). Since the 1980s, there has been an increasing academic interest in innovation-diffusion studies in organizations. These studies varied from investigating particular variables, such as the size and structural characteristics of an organization, in predicting the innovativeness of the organization, to studying innovation adoption-implementation process in organizations (Rogers, 2003).

In their 6-year field study of medical innovation process in hospitals, Meyer and Goes (1988) examined 300 processes of organizational decision making in adopting medical innovations (such as CT scanner, ultrasonic imaging, laser surgery, and others) among 25 hospitals. The authors found that the degree to which a hospital would adopt and implement a given
innovation was explained by the perceived attributes of the innovations, environmental factors such as urbanization and affluence level within the hospital’s service area, organizational factors such as the size, complexity, and market strategy of the hospital, the hospital’s leadership factors such as CEO tenure and education, and innovation-decision compatibility. A hospital would be more likely to adopt and implement an innovation when the innovation had high observability, low risk, and low complexity, and the hospital was large in size and located in an urban affluent area. The findings also suggested that the advocacy from a hospital’s CEO and other innovation champions was crucial to the progress of the innovation process.

In a similar study of investigating the adoption of new medical technologies in community hospitals, Koch and her colleagues conceptualized the technology-adoption processes as three sequential decision-making stages. The first stage was “knowledge-awareness stage”, which was a period of informal gathering of information and discussion. The second stage was the “evaluation-choice stage”, which was a period of formal organizational decision-making, including acquisition proposal, and medical, fiscal, political strategic evaluation. The last stage was the “adoption-implementation stage” – a period of trial, acceptance, and expansion of the newly acquired technology. The authors also suggested that hospitals’ decision making in adopting technology innovations appeared to come from four main forms of rationalities throughout the stages of the decision-making process. These rationalities
included: clinical rationality – whether the new technology was going to advance medical knowledge and provide benefits to patients; fiscal rationality – whether the new technology would improve the hospital’s financial position considering its costs versus return; political rationality – whether the new technology would give the hospital more legitimacy and increase its bargaining power among physicians and other coalitions; strategic rationality – whether the new technology would address a particular market niche for the hospital, and was going to be compatible with the hospitals’ overarching strategic plan (Koch, Lam, & Meyer, 1996).

A number of studies have applied diffusion of innovation theory to examine factors influencing health information technology adoption in hospitals. Wang and his colleagues conducted a cross-sectional analysis on data collected from 1441 acute-care hospitals from metropolitan statistical areas in the United States to examine how market, organizational, and financial factors would influence hospitals’ adoption of health information system. The findings of the study suggested that larger, system-affiliated and for-profit hospitals with adequate operating revenue were more likely to adopt health formation systems (Wang, et al., 2005). Similarly, in a study of adoption of health care information technology among 98 Florida hospitals, the researchers demonstrated that specific organizational characteristics such as hospital size, system membership (stand-alone versus system-affiliated), and tax status (for-profit versus non-profit) significantly influenced hospitals’
adoption of healthcare information technology. However, the study suggested that hospitals’ geographic location was not related to the adoption (Hikmet, et al., 2008). Tabak and Jain (2000) surveyed top executives from 1181 medium-sized (100-199 beds) community hospitals across the United States to examine the impact of organizational context on adoption of new imaging technology in these hospitals. The findings of the survey indicated that hospitals were more likely to adopt a technology innovation when they had an aggressive overarching market strategy, slack resources, and highly interactive top management teams. In a similar study of examining critical factors influencing the adoption of Picture Archiving and Communication Systems (PACS) in Taiwan hospitals, the researchers found that support and advocacy from the top management, perceived benefits of using the new technology, as well as favorable government policy were crucial factors for hospitals to adopt PACS in Taiwan (Chang, et al., 2006).

Strategic Management Perspective and Related Studies

Besides diffusion of innovation theory, the constructs from strategic management perspective also contribute to shape the conceptual framework of the current study. The strategic management perspective links environmental forces, internal organizational characteristics, and strategies of an organization. It emphasizes that an organization needs to position itself relative to its environment and competitors in order to achieve its objectives
and ensure survival (Shortell & Kaluzny, 2006). Studies of strategic management theory include two main streams of investigation: strategic content and strategic process. The content research mainly focuses on the relationship among an organization’s strategies, its environment, and its performance. The process research focuses on strategy formulation and implementation, including strategic planning, decision-making process, the alignment of strategy and structure (Shortell & Zajac, 1990).

As Shortell and Zajac (1990) noted, the development of strategic management theory has been reinforced by Porter’s work on competitive advantage and value creation. Porter (1985) suggested that the goal of much of business strategies is to achieve competitive advantage. A competitive advantage exists when a firm can deliver the same benefits as its competitors but at a lower cost (cost advantage), or deliver benefits that exceed competing products/services (differentiation advantage). Thus competitive advantage enables the firm to create superior value for its customers and superior profits for itself (Porter, 1985). The strategic management perspective explicitly suggests that organizational leaders and managers have control over choosing specific strategies that would better position the organization in line with its external environmental demands and internal organizational capabilities, and therefore obtain competitive advantage. The classic SWOT (strengths, weaknesses, opportunities, and threats) analysis is generally used as an analytical tool to assist strategic decision-making process, in which
multiple motivating rationales and determinants are considered simultaneously (Luke & Walston, 2003).

Strategic management theory has been widely applied in studies of health care organizational behavior and practice. Strategy, as Mick and Wyttenbach (2003) stated, is “the element that makes the potage of diversity of health care environments and their constituent organizations what it is” (p.18). Luke and Walston (2003) reviewed in their article on the unprecedented change in health care in the 1990s and the shape and reshape of strategies from health care organizations in response to the change, suggesting strategic decisions made by health care organizations were often influenced by economic, institutional, and market factors.

Similarly, in their study of the timing of strategic decision making in hospitals’ adoption of MRI technology in the early 1990s, Friedman and Goes (2000) found that hospitals operating in a highly competitive and turbulent environment adopted MRI due to market forces, while in a less turbulent environmental context, hospitals were more likely to acquire MRI when physicians were champions of the technology. The findings suggested that environmental turbulence exerted relative influence in shaping strategic decision-making, and strategies were one way for organizations to respond to the turbulence in their environment.

In their longitudinal study of strategic changes of over 400 Californian hospitals in the 1980s, Goes and Meyer (1990) found that the frequency of
strategic changes was relatively low over time, but strategy changes were more common in lower performing hospitals and associated with major environmental shifts, suggesting strategic changes in hospitals might be difficult to achieve and managers needed to better understand the change process.

Despite the difficulties in achieving strategic change as indicated in Goes and Myers’s study (1990), from strategic management perspectives, managers nonetheless play an important role in making strategic decisions to position organizations in their environment. A study on factors influencing the adoption of health information system in American hospitals also drew on strategic management theory to illustrate how hospitals’ top managers utilized strategies to position their organizations relative to the environment and competitors (Wang, Wan, Burke, Bazzoli, & Lin, 2005). The authors argued that the pressure from managed care to reduce costs in medical care contributed to the change of hospital information system, and hospitals responded to the environmental pressure by adopting technology-related strategies.

In their study on physician-organization relationship, Shortell and Rundall (2003) suggested that strategic adaptation and strategic intent provided important conceptual framework in understanding why physicians have become more organized and have increasingly formed partnership with other organizations. Strategic adaptation is the “behavioral actions taken by
organizations to shape their environment and performance”, and strategic intent has to do with the purpose of forming alliance or partnership (Shortell & Rundall, 2003). Rooted in social network concepts, strategic adaptation of an organization and strategic intent of networks enables an organization to position itself in securing resources and gaining competitive advantage.

**Institutional Theory and Related Studies**

In addition to diffusion of innovation theory and strategic management perspectives, institutional theory is also a part of the theoretical basis that informs the current study. Institutional theory suggests that organizations are adaptive organisms that respond and conform to external environmental circumstances in order to receive legitimacy and support. One of the key constructs of institutional theory is isomorphism. Isomorphism describes an organization’s propensity to imitate other organizations in its environment where a similar set of environmental pressure exists. This particular organizational behavior is sometimes referred as a “rational myth” (Alexander & D’Aunno, 1990) in the sense that they’re not necessarily empirically supported. In their highly influential essay on the new institutional theory, DiMaggio and Powell (1983) argued that isomorphism occurs because non-optimal forms are selected out of a population of organizations or because organizational decision makers learn appropriate responses and adjust their
behavior accordingly. The similarity of organizations is a result of organizational competition for institutional legitimacy and market position.

DiMaggio and Powell (1983) concurred with other institutional theorists that there are two types of isomorphism: competitive and institutional. Competitive isomorphism emphasizes market competition, niche change, and fitness measures. It may apply well to early adoption of innovations. However, competitive isomorphism does not present a full picture of organizational behavior. As DiMaggio and Powell (1991) further suggested, organizations compete not only for resources, but also for political power, institutional legitimacy, as well as social and economic fitness. This is where institutional isomorphism becomes useful in understanding certain organizational behaviors. Institutional isomorphic change occurs through three mechanisms, including coercive, mimetic, and normative isomorphism. As DiMaggio and Powell (1983) stated, coercive isomorphism is a result of pressures exerted on organizations by other organizations or the society upon which they are dependent. Coercive isomorphism suggests that political influences, government mandates, societal or cultural expectations can be coercive forces for organizations to behave similar to others in the field. Some examples of coercive isomorphism include auto manufactures adopt new pollution control techniques in response to environmental regulations; and utility companies re-design their accounting and financial information system in order to meet financial transparency requirements from their regulatory agencies (DiMaggio
An example of coercive isomorphism in the health care field is hospitals’ continuous efforts at quality assurance and improvement. It can be viewed as hospitals’ response to the newly emerging norms and standards of practice that are set by regulatory power (Shortell & Kaluzny, 2006).

Mimetic isomorphism describes the tendency of organizations to model themselves after the leaders in their field in order to receive legitimacy and respond to uncertainty (Mizruchi & Fein, 1999). The unprecedented change and restructuring of the health care industry in the 1990s, such as the rapid rise of then “faddish” vertical and horizontal integration of health care systems and physician practice consolidations, as Luke and Walston (2003) argued, are one example of how susceptible health care organizations are to institutional pressures, and result in irrational imitation of behaviors. It should be pointed out that mimetic isomorphism explains what occurred in the 1990s, but is limited in explaining what did not occur. In their insightful examination of what and why integrated health care delivery networks have failed, Friedman and Goes (2001) found an array of problems and sources of the problems for integrated health networks ranging from structural to functional and process of the integration, suggesting that the failed strategies of integration in the 1990s was an inevitable result of the irrational imitation of behaviors, and health care organizations needed to assess each of their individual situations and develop their own mechanism for change.
Normative isomorphism primarily stems from professionalism. As DiMaggio and Powell (1983) stated, professionals behave similarly to their professional counterparts of same occupation across various organizations, and the sources of this type of isomorphism come from standardized professional training from universities and training institutions, as well as professional networks and associations that define and promote the norms and rules about professional conducts.

The turbulent environment in the filed of health services challenges long-established structures and norms of health care organizations, and what constitutes the standards of practice for health services organizations are rapidly changing (Alexander & D’Aunno, 2003). In their thorough review on organizational change in health care, Goes, Friedman, Seifert, and Buffa (2000) developed a conceptual framework for the changes in health care field, and provided practical guidance to navigate in the turbulent field of health care. It could be argued that a health care organization’s effort in offering a new service line, for example, may not be motivated so much by substantive needs from patient population but rather by non-favorable perceptions from the public if it did not have such service. In other words, from an institutional theory perspective, it is common for health care organizations to change their behavior in response to newly emerging norms and standards of practices, as Fennell (1980) noted that hospitals often offer services to match what other hospitals in the area offer in order to be considered as fit and legitimate.
Summary of the Theoretical Framework

The theoretical framework of the current study is developed from a triage of diffusion of innovation theory, strategic management perspective, and institutional theory. Diffusion of innovation theory believes that the characteristics of an innovation, as well as organizational size, structure, and resource availability will influence the diffusion of the innovation in organizations. Although most of CAM therapies have been practiced for centuries, integrating CAM into conventional medical services is still a nascent concept for most hospitals in the United States. Therefore, the rules of diffusion of innovation theory are applicable to the current study. The current study also employs the perspectives of strategic management in examining the critical factors influencing hospitals’ adoption of CAM. Strategic management perspectives emphasize the positioning of an organization in response to its environment. Strategic decision-making, such as adopting a new service line, reflects the organization’s strategy in gaining competitive advantage among its competitors. Strength-Weakness-Opportunity-Threat (SWOT) analysis is a common tool used in strategic management. The current study utilizes SWOT analysis in examining the external/environmental factors and internal/organizational factors that may influence hospitals’ adoption of CAM. Institutional theory explains the isomorphic behaviors of organizations and the importance of legitimacy. Based on institutional theory, factors such as
whether or not the leading hospitals of a given healthcare market have adopted CAM services, as well as the perceived credibility and legitimacy of CAM, are likely to influence hospitals’ adoption of CAM. The following describes the conceptual framework of the current study:

![Conceptual Framework Diagram]

Figure 1. Conceptual Framework.

Facilitators and Barriers to the Integration of CAM and Conventional Health Care

Multiple factors may influence, either positively or negatively, the integration of CAM with conventional health care systems in the United States. Barrett (2003) suggests several factors, such as consumer demand, market competition among health care provider groups, perceived clinical efficacy and cost-effectiveness of CAM therapies by the public, and promising results from
a number of vigorous studies on CAM in recent years, could facilitate and promote the process of the integration. On the other hand, recent literature has also identified a number of factors that prevents CAM to be integrated into conventional health care system. These factors include but not limit to a lack of health insurance coverage on CAM therapies, uncertainty of profitability, and credentialing and liability concerns (Barrett, 2003; Makowski, 2004; Pelletier & Astin, 2002). The following literature review discusses critical factors influencing the integration of CAM and conventional health care systems from three domains: external environment, internal/organizational environment, and characteristics of CAM practice.

External Factors

External factors such as consumer demand and market competition may affect the integration of CAM and conventional health care systems. CAM is one of the fastest growing segments of the health care industry in the United States, with studies suggesting that about 30% - 50% of American adults regularly use CAM therapies in recent years (Makowski, 2004). Clement and her colleagues (2006) found in their study of 4000 general acute care hospitals between 1999 and 2003 that hospitals offering CAM service were located in markets where overall competition among hospitals was more intense and other hospitals offered CAM services. The study also suggested that hospitals were more likely to offer CAM services when they were located
in areas with a more highly educated population, a higher female population between ages of 30 and 59, and a more affluent population (Clement, Chen, Burke, Clement, & Zazzali, 2006). A recent American Hospital Association annual survey on hospital-based CAM services indicated that patient demand was one the top reasons for hospitals to offer CAM services (Health Forum, 2006). Similarly, a study on the integration and reimbursement of CAM services in managed care organizations also found that consumer demand was a primary motivator to offer CAM services (Pelletier & Astin, 2002).

The public’s demand for CAM services is evident. In 2007 alone, 38.1 million American adults made an estimated 354.2 million visits to CAM practitioners, resulting in estimated $11.9 billion dollars out-of-pocket expenses (Nahin, Barnes, Stussman, & Bloom, 2009). With growing consumer demand for CAM services, some conventional health care organizations offer CAM services as a positioning strategy to differentiate themselves from competitors in a highly competitive health care market. Makowski (2004) suggested in her study that integrating CAM and conventional ambulatory care would provide a unique market niche for any ambulatory centers to gain market recognition and potentially thrive in a competitive health care market.

Internal Factors

In addition to the external environment factors, the internal environment of a health care organization also plays an important role on the integration of
CAM and conventional health care. The choice of service lines often reflects the mission of a health care organization. One study on the trend of CAM development in hospitals suggested that hospitals with missions that include objectives other than profit maximization are more likely to have CAM services (Clement, Chen, Burke, Clement, & Zazzali, 2006). The 2005 American Hospital Association annual survey also found hospitals’ mission as one of the top 3 reasons for hospitals to offer CAM services (Health Forum, 2006).

Another group of factors that appear to impact the choice of services to be provided by a health care organization are the resources the organization possesses, including its physical, financial, and human resources. Vohra, Feldman, Johnston, Waters, and Boon (2005) interviewed nine academic medical centers in U.S. and Canada that were considered by the authors as leaders in the integration of CAM and conventional medical research, practice, and educational programs. The study revealed that the initiation of an integrative medicine program required a significant amount of funding, highly qualified clinicians, and motivated champions of CAM practice. Similarly, Clement and colleagues (2006) found in their analyses on data collected from over 4000 acute care hospitals that nearly 50% of hospitals with 500 beds or more offered CAM services, comparing to only 11% of hospitals with fewer than 100 beds that had CAM services, suggesting that organizations with more physical, financial, or human resources are more likely to offer CAM services.
Physicians’ attitude towards CAM may also influence the integration of CAM and conventional health care. Physicians with knowledge about CAM practices tend to be more open to refer patients for CAM treatment. A recent study assessing conventional primary health care providers’ perspectives on providing CAM services in primary care concluded that the main reasons for primary care providers to refer their patients for CAM treatments were: patients’ requests, conventional treatments failed, and evidence of efficacy of CAM treatment (Haselen, Reiber, Nickle, Jakob, & Fisher, 2004). Ruggie (2006) found that good relations with hospital physicians are crucial to the success of integrative medicine clinics, and many directors of integrative medicine clinics are conventional medical doctors, who have to work closely to foster acceptance and gain support from their peer physicians.

Quality control of CAM practices and liability concerns are two main issues often expressed by physicians who oppose the integration of CAM and conventional health care (Makowski, 2004). A descriptive study on 19 U.S. hospitals that offer CAM services found that there is a lack of consensus on policies governing issues related to CAM practice in hospitals, including licensing, credentialing, scope of practice, malpractice liability, and the use of dietary supplements (Cohen, Hrbek, Davis, Schachter, & Eisenberg, 2005). Similarly, because CAM includes a wide range of therapies and products, and only some categories of CAM practices such as acupuncture, massage, chiropractics, and naturopathy are formally regulated and licensed by state
government, there is a lack of consistency in effectiveness and safety assurance in all categories of CAM services. As health care delivery organizations are required to meet increasingly high standards set by their accrediting agencies such as JCAHO for delivering high quality, safe, and evidence-based practice, it appears that credibility and safety concerns of CAM practice remain to be impediments to the integration of CAM and conventional health care.

**Financial Factors of CAM Practice**

One of the unique characteristics of CAM practice, as compared to conventional medical modalities, is its payment mechanism. Although health insurance plans have increasingly extended coverage on CAM modalities in recent years, CAM visits are still largely paid out-of-pocket by patients. A study conducted by a Seattle based health service research team found that the national average out-of-pocket payments per visit for CAM providers in 1996 was about $49 for nutritional advice, $44 for acupuncture, $33 for massage, $23 for herbal therapies, and $9 for spiritual healing (Bridevaux, 2004). According to the 2007 National Health Expenditure Survey conducted by the National Center for Health Statistics, adults in the U.S. spent $33.9 billion out of pocket on visits to CAM practitioners and purchases of CAM products, classes, and materials in 2007. This amount equals 11.2% of total out-of-
pocket health care expenditure in the U.S. in 2007 (Nahin, Barnes, Stussman, & Bloom, 2009).

There are inconsistent findings regarding whether CAM posts financial risks or opportunities to its host health care organizations. It remains unclear in regard to how do these financial factors that uniquely associate with CAM services affect health care organizations’ the decision-making on adopting CAM. Because CAM services usually require a high percentage of out-of-pocket payment, it’s arguable that consumers may have limited access to CAM services, and hospitals and clinics might be reluctant to offer CAM services due to the financial risks (Barrett, 2003; Makowski, 2004). Ruggie (2006) suggested that financial viability was a major obstacle facing the integration of CAM and conventional health care, because CAM services were generally more labor-intensive and time-consuming, and were reimbursed at a lower rate by health insurances.

However, Martin and Long (2007) argued that by not involving third-party reimbursement for CAM care, it would benefit CAM providers financially because receiving cash payment could greatly improve cash-flow and lower administrative burden. Similarly, others researchers also believed that CAM practice could be fiscally attractive and it would provide financial incentives for health care organizations to adopt CAM services (Makowski, 2004; Sarnat, Winterstein, & Cambron, 2007). CAM practice generally requires less up-front resources compared to conventional medical care, and therefore the start-up
costs of CAM services are relatively small, which lowers the financial risks to adopt CAM services (Martin & Long, 2007). In addition, introducing CAM services to a conventional health care center may provide patients a new entry point to the continuum of care and generate referrals to other services (Makowski, 2004).

Chapter Summary

The conceptual approach of the current study is rooted in diffusion of innovation theory, strategic management perspective, and institutional theory. Recent literature has identified an array of factors that may either positively or negatively impact the integration of CAM and conventional health care. Consumer demand for CAM services and increasing competition in health care market may have propelled conventional health care delivery organizations to consider offering CAM services. An organization’s internal environment, such as organizational mission and resources, as well as physicians’ attitudes towards CAM, may play a role in the decision-making process of integrating CAM and conventional health care services. The reimbursement mechanism and operational characteristics of CAM services appear to post both financial challenges and opportunities for the hosting health care organization, and therefore may impact the willingness of the organization to adopt CAM services.
Chapter 3 contains a description of the method that is used to conduct the current study. In chapter 4, the data that are collected are presented and analyzed. Chapter 5 contains a summary of the current study, discussion of findings, conclusions that appears warranted, and recommendations for future research.

CHAPTER 3

METHODOLOGY

The purpose of this study was to identify and examine the critical factors that might promote or hinder the decision-making of non-federal acute
care hospitals on adopting CAM services. Because of the exploratory nature of this study, both qualitative and quantitative research methods were employed in this study. Approval from the Institutional Review Board at Oregon State University for this study was obtained prior to the initiation of the study.

Selection of Participants and Research Scope

All non-federal general acute care hospitals of Oregon and Washington were eligible participants of this study. The name and contact information of each hospital are listed as public information on the websites of Oregon Association of Hospitals and Health Systems (OAHHS) and Washington State Hospital Association (WSHA). Both OAHHS and WSHA are statewide trade associations for health care organizations. All hospitals and health care systems residing in the states of Oregon and Washington are members of OAHHS and WSHA. The study participants represented a diverse pool of hospitals, including both for-profit and not-for-profit hospitals, and large hospitals with over 500 staffed-beds as well as small hospitals with less than 25 staffed-beds. Teaching hospitals, trauma centers, regional medical centers, and community hospitals are represented in the pool. This pool of hospitals was also geographically diverse, locating in both urban and rural areas and serving all counties in Oregon and Washington. There were 58 non-federal general hospitals in Oregon and 86 such hospitals in Washington at the time when this study was conducted. Some of these hospitals already adopted
CAM services, while others did not. Opinions were elicited from all hospitals that agreed to participate in this study.

Interview Methods

Individual interviews were conducted at the first phase of this study. Individual interviews are considered most appropriate for collecting in-depth information because they encourage participants to delve beneath the surface of topics and to describe their knowledge, beliefs, or experiences in their own words (Meenan & Vuckovic, 2004). Individual interviews in this study focused on identifying the critical factors that either drive or hinder hospitals’ adoption of CAM services, as well as examining how these factors influence the decision-making process of adopting CAM services. The results of the interviews were used to inform and develop a survey questionnaire in the second phase of this study.

The individual interviews were conducted either by phone or in-person. The sampling frame of the interviews was developed with the guide of the theoretical framework employed in this study. Diffusion of Innovation theory suggests that the organizational factors such as size, complexity, resources, as well as the geographic location of an organization influence the organization’s willingness to adopt innovations (Rogers, 2003). As Miles and Huberman (1994) suggested that sampling techniques used in qualitative studies were often theory-driven and purposive, the current study selected
nine hospitals with a wide range of organizational characteristics for the interviews.

This study used semi-structured individual interview to elicit in-depth information regarding the critical factors that influenced a hospital's adoption of CAM services and the process by which the organizational decision was made. Consent to participation was obtained prior to the interviews. An interview guide was used to ensure uniformity of key issues to be covered. Open-ended questions were asked during the interview with probes for eliciting additional information and clarification. The order of questions and the number and types of probes varied in each interview depending on the flow of conversations during the interview. Hand-written notes were taken during the interview, and the full course of interview was audio taped with consent of the interviewee. The interview audiotapes were transcribed and the accuracy of transcription was reviewed by the match of audiotape to transcription.

The following provides a summary of the interview guide for hospitals that have adopted CAM services:

1. General introduction of the CAM program;
2. What were the primary reasons to start the CAM program?
3. How did the CAM program start?
4. What factors did the hospital consider when making the decision to offer CAM services?
5. Who were the champions of CAM services?
6. What was the decision-making process like?

7. Were considerations given to offer CAM services different from any other type of medical services?

The following provides a summary of the interview guide for hospitals that do not offer CAM services:

1. What are the reasons specific to your hospital for not offering CAM services?

2. What barriers in general do you think that would prevent hospitals from adopting CAM services?

3. Would considerations given to offer CAM services be different from any other type of medical services?

Survey Methods

After the completion of individual in-depth interviews, an e-mail survey with a self-administered questionnaire was conducted among study participants. While individual interviews provided in-depth information and unique insights from interviewees, the survey provided information regarding the similarities and differences in opinions from a broader sample population. Emails and Internet surveys have been commonly utilized in the recent years due to its low cost and time efficiency, comparing to the traditional mail survey (Fontana & Frey, 2000). Schaefer and Dillman (1998) concluded from their study on the response quality of email survey that email surveys achieved
similar response rate to regular mail survey, but with quicker returns and more completed and detailed responses in open-ended questions. Dillman (2000) also reported that the average response rate for surveys of business and organizations usually ranged from 21% to 58%. Methods and procedures used to develop the survey questionnaire, pilot study, and field procedures are discussed in the following section.

Survey Questionnaire

The questionnaire used in the study was developed from four main sources, including findings from in-depth interviews with selected study participants, consultation with an expert panel, related health care management theories, and published previous studies. The expert panel consisted of two CEOs and one VP, all of whom had significant working experiences in the decision-making process on adopting CAM. The expert panel reviewed survey questions and provided their professional judgment in the area whether the questions adequately represented the concepts that they were intended to reflect or measure. Pre-test of the questionnaire through pilot study was also conducted to provide content validity of the survey questionnaire.

The questionnaire included questions regarding the following: (1) the position/title of participants; (2) whether the participating hospital offered any forms of CAM services at the time of this study; (3) what types of CAM
services were offered; (4) why or why not currently offered CAM services; and (5) participants’ assessment on a set of four factors. Some questions were modified from the survey instrument from Health Forum 2005 complementary and alternative medicine survey of hospitals (Health Forum, 2006).

**Pilot Study**

An exploratory pilot study was administered to test the questionnaire and data collection procedures prior to implementing the final survey. Five participants from the individual interview phase of this study also participated in the pilot study. They were asked to answer the questionnaire and debrief about the general readability of the questionnaire, time spent on completing the questionnaire, as well as any questions, suggestions, and comments they had with the survey.

The purpose of conducting the pilot study was to finalize the survey questionnaire and procedures by evaluating the following aspects. First - were the wording and phrases asked in each question clear to all respondents and mean the same thing to the respondents as they were designed to? Second - how much time did it take the respondents to complete the questionnaire? Did the formatting of the questions work properly? Did the skip pattern work properly? Third - were there any problems about receiving and sending the questionnaire through e-mails? Were there any technical difficulties for the
respondents to complete the questionnaire via e-mail reply? Finally - did data collection and coding procedures work properly?

**Final Survey**

The implementation of the final survey questionnaire involved three field procedures, including the initial contact, sending the questionnaire via e-mails, and follow-up contacts. The directories of Oregon Association of Hospitals and Health Systems (OAHHS) and Washington State Hospital Association (WSHA) provided the phone numbers of all the hospitals. The directory was public information available from OAHHS and WSHA websites. The contact information from the directory was kept updated by the OAHHS and WSHA whenever changes occurred. To minimize data bias, participants from the interview and the pilot study phases were excluded from the final survey. Multiple contacts were made to the administrative office of each hospital to ask for participation in the survey. The CEOs or administrators had the discretion to designate a person from their administrative team to complete this survey. The e-mail address of each participant was obtained after the initial contacts. Then a personalized message with the study information letter and the questionnaire was sent to each participant’s e-mail address. Participants were asked to return the completed questionnaire via e-mail at their earliest convenience. One week after the questionnaire being sent, a thank-you note was e-mailed to those who had responded, and a reminder message with a
replacement questionnaire was e-mailed to those who had not yet responded. One final contact was made to non-respondents one week after the first reminder was sent. No further contacts to non-respondents were attempted after this point of time due to time constraint of this study. Respondents were contacted by e-mail or phone for clarification of their answers or comments. No monetary or any other types of financial incentives were provided to study participants.

Data Analysis Methods

This study intended to explore and describe what critical factors and how these factors influence the decision-making of hospitals on the adoption of CAM services through individual interviews. Data collected from the interviews were examined and analyzed by concepts and themes. Each concept and theme was then sorted and coded for systemic similarities and differences among the interviews. Coded data units were compared, refined, and synthesized.

The email survey at the second phase of this study explored the relationship between the set of four independent variables and the outcome variable (whether the hospitals offered CAM services). Two more independent variables (number of staffed beds and operating margin) were also included in the analysis. Number of staffed beds and operating margin data are from Oregon and Washington state department of health and is available for the
public. Questions of interest in the analysis included the following: was the relationship between hospitals’ adoption of CAM services and the set of critical factors identified in the previous interviews generalizable to a larger sample population? If so, what was the strength of the relationship? What were the reasons for hospital to adopt or not to adopt CAM services? What types of CAM services were offered at hospitals?

Initially, given the type of research questions asked, and the number and type of variables - one dichotomous dependent variable, and multiple continuous and binary independent variables, generalized logistic regression was used to estimate the relationship between the adoption of CAM and its predictor variables. Coefficients and odds ratio were obtained to estimate the impact and the direction of impact of each predictor variable. The significance of each predictor variable and possible interaction effect among predictor variables was tested. Secondly, descriptive analysis was performed to illustrate the types of CAM services offered by the surveyed hospitals, as well as the reasons for hospital to offer and not to offer CAM services. Chi-square tests were performed to test whether there was a difference among the categories. Finally, multivariate analysis of variance was performed to test whether there was a difference between respondents and non-respondents in characteristics (number of staffed beds and operating margin) using existing data.
Chapter Summary

The current study employed a mixed methodology of qualitative and quantitative research methods. Study participants included all non-federal acute care hospitals in Oregon and Washington. Because of the exploratory nature of this study, inclusiveness rather than randomness of the sample was emphasized. Individual phone or in-person interviews were conducted to elicit in-depth information and personal experiences related to a hospital's decision-making process of adopting CAM services, as well as how these factors influenced the decision making. A survey questionnaire was developed based on the results of interviews, as well as related literature and health management theories. An e-mail survey was conducted to elicit information from a broader sample population to assess the relationship between the set of predictor variables and the outcome variable (whether hospitals offer CAM services). Data collected from interviews were sorted and synthesized by themes. Survey data analysis was conducted with generalized logistic regression, Chi-square test, multivariate analysis of variance, and descriptive analysis.

In Chapter 4, results from the interview and survey are presented and analyzed. Chapter 5 includes a discussion of the study findings, conclusions that appeared warranted, and recommendations for future research.
The purpose of this study was to identify and examine the critical factors that might promote or hinder the decision-making process of non-
federal acute care hospitals on adopting CAM services. Data collected from the interview and survey phases of this study were presented and analyzed in this chapter.

Survey Results

There were 144 general acute care hospitals in Oregon and Washington at the time of this study. Excluding the 9 hospitals interviewed in the pilot study, 135 hospitals were included in the final survey. After the initial contact, it became clear that 3 of the 135 hospitals were actually under the same administrative management; therefore, in order to avoid redundancy, a total of 132 email surveys were administered. Forty questionnaires were completed and returned. The response rate was approximately 30.3%. One returned questionnaire had a missing answer for one of the predictor variables. The missing value was not included in the logistic regression analysis. No other missing answers were noted. All statistical analyses were performed using the statistical program R.

Participants Characteristics

Because this study requested the person with the most knowledge about the adoption of CAM services to answer the survey, individuals with a variety of job titles participated in the survey. Among them, 40% were chief
executive officers or administrators, 17% were chief nursing officers, 12% were chief operating officers, 8% were vice presidents, and 23% others. The “others” category included medical director, director of patient care services, complementary therapies coordinator, education director, director of oncology services, director of surgical and hospital operations, director of inpatient services, staffing specialist, and supervisor of cancer healing center. The following figure depicted the composition of the participants.

Figure 2. Composition of Survey Participants

CAM Modalities

Among the 40 returned survey questionnaires, 21 (52.5%) of them reported that they offered at least one type of CAM services either at in-patient and/or out-patient settings at the time of the survey. Nineteen (47.5%) hospitals did not offer any CAM services at all. Among hospitals that offered CAM services, massage therapy was the most offered modality (29%), followed by music and art therapy (17%), acupuncture (16%), Yoga/TaiChi
(10%), Reiki (6%), and Chiropractics (4%). It's notable that only 1 (2%) hospital offered naturopathic therapies. Sixteen percent of participants indicated other CAM therapies including the following:

- Dietary and lifestyle counseling
- Aromatherapy
- Drum circles (health rhythms)
- Guided imagery
- Hypnotherapy
- Wellness programs such as cardio health and diabetic programs
- Horticultural therapy/ healing gardens
- Meditation
- Pet therapy

The following chart displays the CAM modalities that were offered by the surveyed hospitals.

![CAM Modalities Chart]

Figure 3. CAM Modalities

Reasons to Offer CAM Services

The main reason to offer CAM services among survey participants was patient and community demand (36%), followed by organizational mission (24%), and having physician champions for CAM services (12%). Fewer participants considered business competition (9%) or financial attractiveness (9%) as the main reasons to offer CAM services. Ten percent of participants also stated other reasons including the following:
- Clinical effectiveness of CAM modalities;
- Improved patient satisfaction;
- Market differentiation;
- Availability of CAM providers (because some existing providers such as physical therapists and medical doctors working at the hospital were also certified/licensed CAM practitioners).

A chi-square test was performed to detect whether there was a difference among the main reasons to offer CAM services. A small p-value of 0.008 suggested that there was a significant difference across the six categories of main reasons (see Table 1).

Table 1. Main Reasons to Offer CAM Services

<table>
<thead>
<tr>
<th>Reason</th>
<th>Patient Demand</th>
<th>Physician Champion</th>
<th>Business Competition</th>
<th>Organizational Mission</th>
<th>Financial Attract</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>X-squared = 15.7273, df = 5, p-value = 0.007667</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Reasons Not to Offer CAM services

The lack of physician support for CAM services was the most cited reason among the survey participants for not offering CAM services. The second most cited reason for not offering CAM was that there were too many other initiatives competing for time and resources, suggesting CAM would rank low on the priority list if its adoption was considered. About 19% of the participants had concerns about the general low reimbursement rate for CAM
services. Twelve percent of the participants believed it would be difficult to have quality control over CAM services if they were to be offered. The downturn of the current economy apparently also played a role. Nine percent of the participants considered the current economic downturn as one of their main reasons to not offer CAM services at this time. Relatively fewer participants thought it would be difficult to credential CAM practitioners (7%) and CAM modalities lacked credibility in general (2%). About 2% of participants suggested other reasons including the following:

- Small rural hospitals in a farming community;
- (The hospital) did not want to compete with providers who already provided CAM services in the community;
- Difficult to recruit qualified CAM practitioners;
- No community demand;
- CAM services generally did not meet medical necessity for hospital inpatient care;

A chi-square test was performed again to detect whether there was a difference among the main reasons to not offer CAM services. A small p-value of less than 0.01 suggested that there was a significant difference across the eight categories of main reasons (See Table 2).

Table 2. Main Reasons Not to Offer CAM Services

<table>
<thead>
<tr>
<th>Low Reim.</th>
<th>Lack of Phy.Suprt.</th>
<th>Econ. downturn</th>
<th>Lack Credibility</th>
<th>Credential difficulty</th>
<th>Quality control difficulty</th>
<th>Many Comp. Initiative</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>19%</td>
<td>28%</td>
<td>9%</td>
<td>2%</td>
<td>7%</td>
<td>12%</td>
<td>21%</td>
<td>2%</td>
</tr>
</tbody>
</table>
The following table summarizes reasons for hospitals to either offer or not offer CAM services:

**Table 3. Summary of Main Reasons to Offer or Not to Offer CAM**

<table>
<thead>
<tr>
<th>Reason to Offer CAM</th>
<th>Percentage</th>
<th>Reasons Not to Offer CAM</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient/Community demand</td>
<td>36%</td>
<td>Lack of physician support</td>
<td>28%</td>
</tr>
<tr>
<td>Organizational mission</td>
<td>24%</td>
<td>Too many other competing initiatives</td>
<td>21%</td>
</tr>
<tr>
<td>Physician champions</td>
<td>12%</td>
<td>Low reimbursement</td>
<td>19%</td>
</tr>
<tr>
<td>Business competition</td>
<td>9%</td>
<td>Difficult to control quality of CAM practices</td>
<td>12%</td>
</tr>
<tr>
<td>Financial attractiveness</td>
<td>9%</td>
<td>Downturn of current economy</td>
<td>9%</td>
</tr>
<tr>
<td>Others</td>
<td>10%</td>
<td>Difficult to credential CAM practitioners</td>
<td>7%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CAM lacks credibility</td>
<td>2%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Others</td>
<td>2%</td>
</tr>
</tbody>
</table>

Logistic Regression Model

Based on the results of individual interviews and the theoretical framework of this study, six predictor variables appeared to influence the general acute care hospitals' decision-making process on adopting CAM services. These six predictors were patients' interests in CAM services,
business competition among hospitals and clinics, physician champions for CAM services, organizational mission and philosophy of providing care, hospital size (measured by the number of staffed beds) and the operating margin of the hospital. Information regarding the number of staffed beds and the operating margins of surveyed hospitals were obtained (via public access) from the state department of health in both Oregon and Washington. Data regarding patient interests, business competition, physician champion, and organizational mission were collected from the email survey of this study. The answer to patient interests and business competition was either high level or low level, while the answer to whether there were physician champions for CAM services and whether providing CAM services aligned with organizational mission was either yes or no. The first regression model included all six predictors with the assumption that the adoption of CAM services was a function of all six predictors. The results were displayed in the following table.

Table 4: Logistic Regression Model with 6 Predictor Variables

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Estimate</th>
<th>Std. Error</th>
<th>P-value</th>
<th>OR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intercept</td>
<td>-1.321</td>
<td>0.884</td>
<td>0.135</td>
<td>N/A</td>
</tr>
<tr>
<td>Patient Interest</td>
<td>2.832</td>
<td>1.346</td>
<td>**0.035</td>
<td>16.980</td>
</tr>
<tr>
<td>Business Competition</td>
<td>-1.603</td>
<td>1.197</td>
<td>0.180</td>
<td>0.201</td>
</tr>
<tr>
<td>Physician Champion</td>
<td>1.776</td>
<td>1.522</td>
<td>0.243</td>
<td>5.905</td>
</tr>
<tr>
<td>Organizational Mission</td>
<td>1.663</td>
<td>0.973</td>
<td>*0.087</td>
<td>5.276</td>
</tr>
<tr>
<td>Operational Margin</td>
<td>4.588</td>
<td>6.691</td>
<td>0.493</td>
<td>98.263</td>
</tr>
</tbody>
</table>
The above regression model suggested that there was a strong relationship between patient interests in CAM services and the adoption of CAM services. This relationship was statistically significant (two-sided $p=0.035$) based on a 5% significance level. Holding all other predictor variables constant, the odds of adopting CAM services when there were high patient interests was approximately 17 times as likely as the odds of adopting CAM services when patient interests were at a low level.

The model also suggested that there was a mild relationship between the organizational mission and philosophy of providing care and the adoption of CAM services. This relationship was slightly significant based on a 10% significance level (two-sided $p=0.087$). Holding all other predictor variables constant, the odds of adopting CAM services when CAM was aligned with a hospital’s organizational mission and philosophy of providing care was approximately 5 times as likely as the odds of adopting CAM when a hospital’s mission and philosophy of providing care did not include CAM.

Based on the above model, the level of business competition among hospitals and clinics in a local area appeared to have a negative relationship with the adoption of CAM services. The odds of adopting CAM services when business competition was at a high level was about 20% as likely as the odds of adopting CAM when business competition was at a low level. However, the effect of the level of business competition on the adoption of CAM services
was not statistically significant (two-sided p=0.18). Similarly, other predictor variables, including physician champions for CAM services, number of staffed beds, and operating margin did not appear to have significant relationship with the adoption of CAM services.

Stepwise logistic regression analysis was also performed, in which the choice of predictor variables was carried out by automatic procedures of the statistical program. The program started with no predictor variables, and then added one variable at a time, including interactions between variables. Only those predictors that were statistically significant were included in the final model. Based on stepwise regression, the patient interests in CAM and the organizational mission were significantly associated with the adoption of CAM services, which confirmed the results from the first regression model. The following table depicts the results of the stepwise regression model.

<table>
<thead>
<tr>
<th></th>
<th>Estimate</th>
<th>Std. Error</th>
<th>P-value</th>
<th>OR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intercept</td>
<td>-1.5002</td>
<td>0.7458</td>
<td>**0.044</td>
<td>N/A</td>
</tr>
<tr>
<td>Patient Interest</td>
<td>1.8559</td>
<td>0.9134</td>
<td>**0.042</td>
<td>6.397</td>
</tr>
<tr>
<td>Organizational Mission</td>
<td>1.6596</td>
<td>0.8355</td>
<td>**0.047</td>
<td>5.257</td>
</tr>
</tbody>
</table>

Significant codes: ** p<0.05;

**Scope of Inference**
The results from the logistic regression model indicated that there was a significant association between the adoption of CAM services and the patients' interests in CAM as well as organizational mission. Because this was not an experimental study and the data were observational, the results from the statistical analysis cannot be used as evidence for supporting causal relationships between the predictors and the adoption of CAM. Furthermore, since the 40 individual hospitals who participated in the survey were not drawn randomly, the statistical inference was limited only to the sample population and these 40 hospitals might not be representative of all general acute care hospitals in the states of Oregon and Washington.

Respondents and Non-respondents Differences

Even though multiple follow-up contact efforts were made in order to obtain as high a response rate as possible, still about 70% of the participants did not respond to the survey. Approximately 58.7% of non-respondents were rural hospitals, while 67% of respondents were rural hospitals. Among non-respondents, 93.5% of them were not-for-profit hospitals and about 6.5% were for-profit hospitals. In contrast, 2.5% of respondent hospitals were for-profit hospitals. The mean number of staffed beds was 127 for non-respondent hospitals and 105 for respondent hospitals. The mean operating margin was 0.03 for non-respondent hospitals and 0.01 for respondent hospitals. The following table displays the differences in characteristics between respondent
hospitals and non-respondent hospitals. In general, there were more urban and for-profit hospitals with larger sizes and operating margins among non-respondents, as compared to respondents.

Table 6. Characteristics of Respondents and Non-respondents

<table>
<thead>
<tr>
<th></th>
<th>Rural location</th>
<th>Urban location</th>
<th>Not-for-profit</th>
<th>Mean # of staffed beds</th>
<th>Mean Operating Margin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respondents</td>
<td>67%</td>
<td>33%</td>
<td>97.5%</td>
<td>2.5%</td>
<td>105</td>
</tr>
<tr>
<td>Mean Operating Margin</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.01</td>
</tr>
<tr>
<td>Non-respondents</td>
<td>58.7%</td>
<td>41.3%</td>
<td>93.5%</td>
<td>6.5%</td>
<td>127</td>
</tr>
<tr>
<td>Mean Operating Margin</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.03</td>
</tr>
</tbody>
</table>

A simple linear regression was performed to assess the relationship between the number of staffed beds and the operating margin of both respondents and non-respondents. The results suggested that the number of staffed beds and the operating margin were significantly correlated (p=0.041). Because of this correlation, multivariate analysis of variance (MANOVA) was performed to determine whether there was a difference between respondents and non-respondents in terms of the number of staffed beds and the operating margins when they were considered at the same time. Table 7 displays the results from the MANOVA test. The results suggested that there was no significant difference between respondents and non-respondents (p=0.1664) when considering the number of staffed beds and operating margins. Therefore, although respondents appeared to be smaller hospitals with lower operating margins in comparison to non-respondents, this difference was not statistically significant.
Table 7. MANOVA Test for Respondents and Non-Respondents

<table>
<thead>
<tr>
<th>Df</th>
<th>Wilks</th>
<th>Approx F</th>
<th>Num Df</th>
<th>Den Df</th>
<th>P (&gt;F)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0.97193</td>
<td>1.8194</td>
<td>2</td>
<td>126</td>
<td>0.1664</td>
</tr>
</tbody>
</table>

Interview Results

The nine hospitals selected for the interviews had a wide range of organizational characteristics, and provided similar and contrasting cases for comparison and analysis. Five of these hospitals offered CAM programs at the time of study and were early adopters of hospital-based CAM services. The other four hospitals did not offer CAM services and were interviewed with the purpose of exploring perceived barriers of adopting CAM services. Multiple contacts to each of the nine hospitals were made prior to the interview to ensure the person who participated in the interview had the most extensive and direct working experience for the interview topics. Of the nine interviews, two were in-person face-to-face interviews, and the others were conducted through teleconference calls. Table 8 depicts the characteristics of the nine hospitals and the titles of the participants.

Table 8. Characteristics of Interview Participants

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Interviewee's Title</th>
<th>CAM services</th>
<th>Location</th>
<th>Staffed-beds (1)</th>
<th>Operating margin (2) (3)</th>
<th>Ownership (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Chief executive officer</td>
<td>Yes</td>
<td>Urban</td>
<td>185</td>
<td>3.5%</td>
<td>not-for-profit</td>
</tr>
<tr>
<td></td>
<td>Name</td>
<td>Position</td>
<td>Rural Urban</td>
<td>10 Year Change</td>
<td>Type of Ownership</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>-------------------------------</td>
<td>-----------------------------------</td>
<td>-------------</td>
<td>----------------</td>
<td>---------------------</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Director</td>
<td>Director of business development</td>
<td>Rural</td>
<td>-4.5%</td>
<td>not-for-profit</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Vice</td>
<td>Yes</td>
<td>Rural</td>
<td>1.4%</td>
<td>not-for-profit</td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>Vice</td>
<td>Yes</td>
<td>Urban</td>
<td>2.9%</td>
<td>not-for-profit</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>Chief executive</td>
<td>Yes</td>
<td>Urban</td>
<td>8.2%</td>
<td>not-for-profit</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>Director</td>
<td>Director of quality improvement</td>
<td>Rural</td>
<td>3.7%</td>
<td>not-for-profit</td>
<td></td>
</tr>
<tr>
<td>G</td>
<td>Director</td>
<td>Director of cancer center</td>
<td>Urban</td>
<td>0.9%</td>
<td>not-for-profit</td>
<td></td>
</tr>
<tr>
<td>H</td>
<td>Administrator</td>
<td>No</td>
<td>Rural</td>
<td>-7.6%</td>
<td>health district</td>
<td></td>
</tr>
<tr>
<td>I</td>
<td>Chief operations</td>
<td>No</td>
<td>Urban</td>
<td>-1.1%</td>
<td>investor-owned</td>
<td></td>
</tr>
</tbody>
</table>


Organizational Mission and Philosophy of Providing Care

One common characteristic shared among participants whose hospital adopted CAM was that CAM services were a good fit with their organizational mission and philosophy of providing care. Two of these hospitals were designated Planetree hospitals, whose philosophy was to provide a patient-centered and holistic approach to health care. One participant described how
her hospital’s mission and philosophy of providing care supported the integration of CAM services and conventional medicine:

Our philosophy is to address the five components of health whenever we provide care to the communities we serve. In other words, we want to address the biological, social, environmental, spiritual, and intellectual needs of the communities we serve. In order to do that, we have to look at providing care to the whole person. In order to provide care to the whole person, you have to address the mind, body, and spirit connection. So it’s a natural fit for our organization to use integrative medicine in our delivery of care.

Another participant stated that the question of whether CAM services were aligned with one’s organizational mission of providing care, would influence not only the organization’s willingness to provide CAM services, but also how well CAM services would be implemented. The participant stressed that hospitals had to ask themselves some important philosophical questions before adopting CAM:

Are you philosophically committed [to] making a program even though it’s not making you millions of dollars a year? … Is it strictly for the finance? … Or are you doing it because it’s the right thing to do, and you believe in your heart that it’s going to boost the wellness of your patient population?

Participants whose hospitals adopted CAM shared a common view that providing CAM services was the “right thing to do”. They believed that:

There were many treatment modalities that could be used in the process of healing. Instead of singling out certain modalities because they were different, these modalities
should be integrated to provide a holistic approach to patient care.

On the contrary, those who did not provide CAM viewed CAM services as “not proper” and were “not generally accepted”, as one participant expressed:

We typically provide services that we think would be beneficial for our patients. … We'll have to do some internal investments to determine if it [CAM] is worth implementing. I’m certain we’re going to have a big hurdle to overcome with in terms of what’s acceptable and what’s not acceptable…. There’re lots of services we can offer, but our patient is [the] number one concern and our organization’s longevity is number two, it goes hand in hand.

Patient/Community Interest in CAM

Patient and community interest in CAM services appeared to be a facilitator for hospitals to offer CAM services. In affluent communities where community members were highly educated and health-conscientious, hospitals were more likely to adopt CAM services to “serve a market niche”. Participants agreed that, even for rural communities, the demand for CAM services could be cultivated through patient education. One participant stated that initially there was no true demand from the majority of the small rural community which his hospital served. “They just don’t know how these services were going to benefit their lives”, he said, “however, the demand grew over time with exposure, experience, and education about CAM practices”.

Another participant gave an example of how her community’s acceptance and demand for CAM services grew over the years:
There wasn’t any demand from the community [initially]. We as an organization and the senior leaders felt that there needed to be more to provide in health care and from there our philosophy grew, after many investigations in the late 1980s, to try better ways to provide meaningful health care. So then we adopted [the] Planetree philosophy and one thing after another. Now our community is asking for it. But we’re in a rural community which is very agricultural-based. So if we can do it, anyone can do it. It’s rewarding for me to walk over our oncology center and see someone is getting a massage. They do expect it now. Our oncology patients from whatever walks of life expect to use acupuncture during their treatment care or after their care. We now use massage, Yoga, Tai Chi, or gentle stretch for patients through our organization.

Physicians’ Attitudes towards CAM

All participants agreed that physicians’ attitudes towards CAM were “mixed”. According to the participants, some physicians opposed CAM in principle because “it’s not evidence-based”. Others had good personal and professional experiences with CAM and therefore they were supportive of it. One participant summarized the full range of attitudes physicians seemed to display towards CAM:

It all depends on who you are speaking with. We have an addiction recovery specialist who is an acupuncturist [who] uses CAM in his practice. We also have physicians [saying] “I want to know about it”, [meaning] they want to have patients’ chart integrated, have the information, and know what patients do. But never in their life are they going to refer patients to that service. …Then we have some people in between. Their first response is that if there is no harm, they probably can live with it. But are they going to promote it? It’s a whole different game.
The overall consensus was that the medical staff in general was becoming more and more open to CAM practices, particularly among the younger generation of physicians. One participant stated:

As experience and education came around, it did change a lot of people’s minds. The trend that is changing [CAM] as far as physicians’ resistance goes is simply attrition. The more young medical staff you have, the more likely they’re going to either embrace or being open-minded towards [CAM]. The younger the medical staff is, the more likely one can have a functioning CAM program… The places that have CAM programs tend to have younger medical staff.

Because physicians were “key referral point” for patients to utilize services, if the majority of physicians held negative attitudes towards CAM, it could be a “big hurdle” to overcome as to initiate and implement CAM services. On the other hand, having strong physician champions was a clear facilitator for CAM adoption. One participant told a story about how one physician champion of CAM in his hospital made a difference:

I have to say one of the biggest reasons why we have been able to do this [providing CAM services] without a lot of push back from the physicians is because of Dr. XXX. She is an extremely well respected mainstream medical doctor. So when she decided to focus on alternative medicine, her colleagues, I’m over simplifying this, would say this is Dr. XXX, and she’s always known for what she is doing. We’re just going to trust she knows what she is doing with these things and we are going to support her. For us, that was a key component of not having a lot of physician pushback. But we do have some physician pushback. Some of the older and more mainstream physicians would only look at evidence-based medicine and that’s how they were trained in dealing with particular issues. They are still questioning of it. We had a question during our physician managing council meeting yesterday about one of the tasks that one patient
was asked to do. And one of the older mainstream physicians was saying “I don’t know what this is and it sounds kind of hokey to me”. Basically, we said: “well, let’s have Dr.XXX come here and talk about it”. And Dr.XXX used to be a member of that group…And she came, made her pitch, explained this, and answered questions. Again, she is very research oriented and is able to answer those questions. But in an environment where you didn’t have a well-respected mainstream physician champion for these services, those could be significant barriers to the acceptance by mainstream medicine.

**Competitive Business Environment**

Some participants expressed that in a competitive business environment, “anything you can provide to make your medical services more attractive to patient population is a big deal”. One of the “differentiating” factors for hospitals to distinguish themselves from competitors was being able to offer adjunctive therapies such as CAM to standard medical treatment. For example, some hospitals devised programs combining massages and acupuncture with cancer treatment services, or nutrition counseling and stress-management in cardiac rehabilitation programs.

Other participants reported that offering CAM services helped them to stay competitive in the business. “We are a customer choice-driven organization”, one participant said, “we need to respond to the desires of our customers to remain competitive in our market. If these are the services customers actually choose to receive, we will offer them to remain their provider of choice.” One hospital did not have CAM services at the time of
interview but was planning to offer CAM in conjunction with their cancer services. When asked why they were considering adopting CAM, the program director answered, “if we are losing market share because people shopping for cancer services in our community use CAM, and they think we don’t have cutting-edge cancer services because we don’t have CAM, then we can make our case from the service standpoint”.

**Financial Viability of Providing CAM Services**

Participants reported that low reimbursement was the main barrier to adopt CAM. Medicare does not provide reimbursement to CAM services at all. Medicaid provided very limited coverage on Chiropractics and no coverage on other CAM services. Although in the state of Washington, the law requires commercial health insurance plans, with the exception of self-insured plans, to reimburse at least one type of CAM services; the payer mix for most hospitals was heavily Medicare. For insurance plans that had CAM coverage, there was usually much limitation on what and on how much the plans would cover. Therefore, CAM services were mostly paid out-of-pocket by patients at the point-of-service. Some participants worried that if CAM services were to be offered, these services would eventually become “write-offs” by the hospitals. One participant stated:

Typically ‘self pay’ is a bad word for hospitals. It’s something we don’t look forward to. If you see a self-pay patient and they are in the hospital and being treated, and the physician ordered CAM services along with the orders of MRI and that’s
already $5000, so what’s going to be the patient’s ability to pay a $20,000 hospital bill?

The current economic downturn also seemed to have an impact on the hospitals’ decisions on adding CAM services. One participant thought the “current economy makes adding any new services with low reimbursement not feasible”. Another participant concurred. “That [cash payment] makes things more difficult”, she said, “I think there are fewer people [who] are using their discretionary dollars. Frankly, that’s why we’ve seen a downturn of our outpatient services because people don’t even want to pay a deductible or a portion of their insurances, so if it’s elective at all, they’re postponing it.”

Participants whose hospitals adopted CAM services also admitted that low reimbursement of CAM services could be an issue to their bottom line. However, there were several solutions to improve the profitability of CAM services. One of the solutions was to identify the segment of the patient population that already utilized CAM services in the communities and market those services to them. “Interestingly enough, because people want it [CAM] enough they’re willing to pay cash for it. They know it can make them [feel] better,” one participant said. “It’s really no different from cosmetic surgery and things like that”, another participant concurred, “people who are focused on this as part of their lifestyle will pay cash for the services.”

Another method to improve the financial viability of CAM programs, as reported by the participants, was to integrate CAM services with other
traditional hospital services. One participant shared his insights on how the integration of CAM and other hospitals services worked for his hospital:

You deal with that in an integrative way by moving patients between practitioners; ... Utilizing [CAM] program as a leader to other settings and programs you have, such as screening programs, membership you may have, health plans, and so on. The best thing about CAM program is when it is integrated with your clinical programs. So you can take advantages of not only people that are approaching the program purely through the CAM therapies, but also the people approach the program through other clinical paths. If you look at [CAM] separately as a clinical service line, it may not be financially viable. But if you look at it as a differentiator towards your cancer or heart programs, or surgery programs, or anything like that, then it starts to make sense because you’re driving additional medical volume as well as getting the volume for CAM.

Other methods hospitals utilized to improve the financial viability of CAM services included: obtaining grants and other funding to operate CAM programs; partnering with CAM schools and local CAM practitioners so that CAM services could be provided at a reduced fee; establishing and expanding volunteer services; and/or selling nutriceuticals/herbal supplements and a variety of other health-related products on a retail basis within the clinic. “This isn’t a real profitable venture as of yet”, one participant expressed his view on the financial outlook of CAM in the future, “who knows. When we go to accountable care organizations, medical homes, where the whole focus of your effort is to get people well, not to treat people who are sick. I think this [CAM] will be a very key component going forward. At least in our system, we are very glad we are in this part of the business.”
Availability of Financial Resources and CAM Practitioners

The size and complexity of an organization might be a factor that influenced hospital’s adoption of CAM services. “For small hospitals it’s a big challenge, because you don’t know if it’s going to alienate your other medical staff and become a financial drain”, one participant said, “but in a big system, it’s much more of an experiment that can be tolerated”. How risky hospitals view CAM services may depend on how much resource the hospitals have available. “If you’re flushed with resources, chances are that where you draw a line for risk is really different”, one participant said, “if we need a new catheter lab, we probably will say okay we’ll go ahead with that catheter lab. [For CAM services] Where the risk is higher, we’ll hesitate longer and try to time the market better.” Another patient explained how resource availability would impact the priority of CAM adoption:

The way hospitals make decisions, a lot of that has to do with resources….What projects within their core business rest in front of CAM decision? If you only have one or two major projects that rest before CAM decision, that CAM decision may just fly right in and be number 3. But if you have to do the renovation on a major part of your hospital, you’re recruiting 25 new docs, or just anything that has large capital implications, CAM decision may move from 3rd on the list down to 15th in a hurry. So it has to do with where the organization sits with their strategic objectives.

In addition to the resource issue, the availability of qualified CAM practitioners also influenced whether a hospital was able to provide CAM services. “We
would like to offer more CAM programs, but finding the right practitioner is the biggest challenge,” one participant explained, “we are rural and small critical access hospital so recruiting has been difficult. We have interviewed at least two physicians with this in mind that have gone elsewhere.”

**Issues of Being “A New Kid on the Block”**

When asked whether starting CAM services was different from starting any other new service lines, the consensus from all participants was “yes and no”. The due process of offering a new service, no matter whether it is a CAM service, a neo-natal unit, or a catheter lab, is essentially the same. The process would include assessing community needs, developing a business plan and budget, gathering financial and human resources, and obtaining approval from the board of directors. As one participant described, “In developing this [CAM] service line or any other, we would look at community needs, the potential financial impact of it, and any political issues might be involved with providing the services. We’d certainly have discussions with our medical providers, with our board, to talk about what benefits this would be and what the downsides would be.”

However, there were several significant issues in the planning of providing CAM services, which apparently made providing CAM more difficult than other hospital service lines. The cause of these issues came from CAM being a novelty in hospital services. It was so new that there was very little
benchmark data about CAM, which in turn made financial planning and budgeting difficult. One participant expressed his frustration and explained how “different” to initiate CAM programs comparing to other hospital services:

There is really no benchmark [for CAM services]. If I want to start a clinical program in allopathic medicine, there is benchmark data you can look for. I can find out how much the practitioners make, how many patients they see, how many RVUs they generate, how much the program is going to provide downstream revenue, how much the procedures are going to be reimbursed, how much volume I can expect to see given a certain population…. [How about] trying to gather that data [for CAM services]. It’s nowhere. How many CAM practitioners do you need for a population of 10,000 people? Who knows? What mixes are going to be perfect for that population? Who knows? How many patients are they going to see? Who knows? How much can you expect to make out referrals? Who knows? You don’t have that benchmark data, so planning is much more complicated for CAM program than it is for allopathic medicine programs. Hospitals are hungry for that data. … Even the general data such as what sort of financial gain we can expect per patient, we don’t have it. And that’s something we should be able to find out. We don’t have that right now because nobody is really gathering that sort of data.

Besides the issue with the lack of benchmark data for planning CAM program, there was also a lack of standard criteria for credentialing CAM practitioners and the quality control of CAM services. “That was one of our biggest questions: how do we do quality control?” one participant asked. “If you look at medical staff and their peer review on the quality control process, what do they know about acupuncture? What do they know about Naturopathy? They would look at it and ask how could we review our peers without knowing what the quality standards are? How could we utilize our medical staff processes to do
that quality control?" Participants whose hospitals provided CAM services concurred that there were no national credentialing standards and criteria for CAM services available at present. Each hospital would establish its own by-laws and procedures and was doing whatever they felt was the best way to handle these issues.

Chapter Summary

The nine individual interviews provided in-depth insights regarding the reasons why hospitals offered or did not offer CAM services, as well as the lessons learned to provide successful CAM programs. Based on the interview results, the facilitators for hospitals to adopt CAM included favorable organizational mission and philosophy of providing care, patient and community interests in CAM, physician champions for CAM services, organizations’ strategic positioning towards a competitive business environment, and the availability of financial and human resources for CAM programs. The barriers for hospitals to adopt CAM services included general low reimbursement of CAM services, lack of physician support, lack of nationally accepted standards and criteria for credentialing CAM practitioners and quality control, and lack of resources and qualified CAM practitioners in certain geographic areas.

One hundred and thirty two email surveys were sent out with an approximately 30% response rate. The survey results confirmed that patient
and community interest in CAM services and the organizational mission and philosophy of providing care were the two factors that significantly differentiated hospitals that offered CAM services from those that didn’t. The statistical inference was only limited to the survey population. Additional analysis was done to assess non-response bias, and the results showed there was no significant difference between responders and non-responders in terms of the size (measured by the number of staffed beds) and the financial condition (measured by operating margins).

Chapter 5 provides the conclusions and limitations of this study, discussion of the study findings, practical implications, and recommendations for future research.

CHAPTER 5

DISCUSSION AND CONCLUSIONS

The current study investigated key facilitators and barriers to the decisions-making process of acute care hospitals on adoption of CAM services in Oregon and Washington. In this chapter, the overall conclusions of the study and a discussion of the main findings are presented. Limitations of this study are discussed. Recommendations for practical applications and future studies are offered.

Conclusions
The main conclusions of this study are the following:

1. Patients’ and community’s interest in CAM services, as well as organizational mission and philosophy of care, which are in favor of CAM services, are major facilitators for hospitals to adopt CAM services. The influence of these two factors on CAM adoption is both practically and statistically significant among study subjects.

2. Other key facilitators for CAM adoption include physician champions for CAM services, an organization's strategic positioning, and availability of financial and human resources.

3. Key barriers to the adoption of CAM include the lack of physician support, low reimbursement, the lack of benchmark data for initial planning, difficulty in credentialing CAM practitioners, the lack of quality control in CAM services, and difficulty in recruiting qualified CAM practitioners due to geographic locations.

Discussion of Major Findings

Survey Response and CAM Adoption

The current study yielded a survey response rate of 30.3% in comparison to the 21% response rate from the 2005 AHA national survey on hospitals’ adoption of CAM services. One reason contributing to the current study’s higher response rate was that the current study made at multiple phone contacts with participants prior to sending out the survey. Other studies
have also shown that making pre-survey phone calls to individual participants can improve survey response rates (Chang, et al., 2006; Cooper & Schindler, 2003).

Nearly 53% of the respondent hospitals in the current study have adopted CAM services at the time of the survey in comparison to 26% in the 2005 national study. The higher CAM adoption rate found in the current study may be due to hospitals that have already adopted CAM tended to respond to this survey. There also may be regional differences in perception and opinions on CAM adoption between Pacific Northwest hospitals and those of the national average, but this comparison is outside the scope of the current study. Future studies may consider further investigation from a multi-regional perspective.

Even though nearly 53% of hospitals in this study reportedly offered CAM services, considering the 30% response rate to the survey and those who did not respond to it most likely did not offer CAM services, it appeared that the majority of acute care hospitals in Oregon and Washington did not adopt CAM services. As institutional theory suggests, organizations have a tendency to respond and conform to external environmental circumstances in order to receive legitimacy and support (DiMaggio & Powell, 1983). With the accreditation agencies’ increasing pressure for hospitals to adopt evidence-based practices, and even though most of CAM modalities have been widely and effectively practiced for centuries, it is not surprising to find hospitals to
shun offering services such as CAM which have not been studied thoroughly using current and standard research methodologies. Therefore, it is arguable that not adopting CAM services may be an isomorphic behavior of hospitals due to their fear of losing their own credibility and legitimacy.

Compatibility Matters

One interesting finding of this study was that hospitals that adopted CAM, and those that did not adopt CAM, agreed on several issues regarding barriers to CAM adoption. However, because CAM services were aligned with their organizations’ mission and philosophy of how care should be provided, hospitals that adopted CAM found ways to overcome the adoption barriers and make their CAM programs work. The diffusion of innovation theory suggests that the characteristics of innovation are related to the propensity of innovation adoption. Innovations with relative advantage, lower risk, lower complexity, higher trialability, and higher compatibility are more likely to be adopted (Rogers, 2003). Furthermore, Rogers particularly pointed out that compatibility referred to being consistent with existing values and the needs of potential adopters. The finding of this study supported Roger’s view, and further suggested that among all the characteristics, compatibility was the most influential factor regarding CAM adoption by acute care hospitals. When a hospital believed providing CAM services was the “right thing to do” and it was
suitable with other services offered by the hospital, the risks and issues associated with adopting CAM became relative.

**Value-Added Services Provide Competitive Advantage**

In addition to compatibility, the other factor that significantly differentiated CAM adopters and non-adopters in this study was the patients’ and community’s interest in CAM services. Strategic management theory suggests that an organization needs to position itself relative to its environment and competitors in order to achieve its objectives and ensure survival (Shortell & Kaluzny, 2006). The current study revealed that one of the main reasons for hospitals to provide CAM services was either to serve the market needs, or to add “value”, or both, to their existing services in order to gain a competitive advantage. This trend was particularly clear in the area of oncology services provided by hospitals in urban locations where the community climate was more open to CAM practices and competition among hospitals was fiercer. As evident from the interviews of this study, one hospital’s oncology department director admitted his concerns about losing patients to other hospitals because his hospital didn’t have CAM integrated with oncology services while his competitors did. In his influential work on competitive advantage, Porter (1985) stated that an organization could gain competitive advantage by delivering superior services whose value exceeded the competitor’s services, and such value-added services would, in turn,
create greater profits for the organization itself. Since CAM modalities are effective and affordable options for complementing traditional oncology services (NIH, 1997), hospitals who add CAM Services can create additional value for those patients seeking comprehensive oncology care, in which the enhanced service would, in turn, attract more patients. Similarly, a study on the integration of CAM with ambulatory care also concluded that offering CAM would add value to the organization’s existing services by differentiating their business from their competitor’s, while increasing their own market recognition (Makowski, 2004).

Limitations of the Study

There were several limitations inherent to the conduct of this study. First, interview participants were selected from a convenient sample with the intention of depicting as much similarity and contrast as possible. Even though the interviewed participants provided a wide range of perspectives, the views expressed from them might not be fully representative of the rest of the study population. Second, some of the survey questions asked for the participant’s assessment using a low/high scoring scale. This method is inherently subjective and difficult to quantify. Therefore, the survey questionnaire was intended to collect information and not to provide measurement. Next, because the study participants were not randomly selected, the
generalizability of this study was limited. The results and conclusions of this study were limited to those hospitals who participated in this study. Finally, because approximately 53% of all participants were those whose hospitals adopted CAM services, the findings of this study might have reflected slightly more of those views that were in favor of CAM adoption.

Implications for Practice

As the U.S. health care reform is taking shape, the two quandaries of the health care delivery system - the quality and the costs of health care services - are at the heart of the challenge. A recent study revealed wide variations in Medicare spending across different regions of the country and the outcome of patient care did not reflect the cost of the care (Fisher, Bynum, & Skinner, 2009). Part of the answer to the problem, as championed by the authors of this study and others, called for Accountable Care Organizations (ACOs) and Patient Centered Medical Homes (PCMH), which are innovative health care delivery and payment structures with the intention of holding health care providers accountable for the quality of care and cost containment (Fisher, Staiger, Bynum, & Gottlieb, 2007; Shortell & Casalino, 2008). Under this new model of health care, health care providers and organizations would have strong financial incentives to utilize cost-effective options to promote well being of their patients. With relatively low costs and proven effectiveness in certain treatment categories, such as chronic pain management, CAM
services may have an advantageous place in this newest and upcoming health care model. For example, the PCMH demonstration project at the Alaska Native Medical Center has already integrated acupuncture and massage into their primary-care medical home model, and its implementation has shown favorable results in a variety of cost-effective measures (Eby, 2010).

Even with the many advances in recent years, integrating CAM into conventional hospital services is still a novelty for most hospitals. As the current study found, there were various concerns and issues raised by hospitals that were unwilling to adopt CAM services. There were also successful examples of CAM adoption as well as valuable lessons learned from going through the nuts and bolts of the adoption process. Based on the insightful input from all participants of this study, the following is a list of practical recommendations for hospitals that are planning or considering adopting CAM services:

1. The first and foremost question to investigate is whether CAM services fit into the organization’s mission and philosophy of care, and whether the organization is open to looking at new services that can be controversial in nature.

2. Start small. Initial large capital investment is apparently unnecessary. This study found that those hospitals with successful adoption of CAM services all started off on a “shoestring” budget with limited clinic space
and a few CAM practitioners. Show the benefits CAM services can offer, and grow the program.

3. Find physician and other clinician champions for CAM services and use them to communicate with other medical providers about CAM services because they’re more likely to speak the same language. A good relationship with clinicians (particularly physicians) is a key in building CAM practices as they are critical referral sources. This relationship is built on effective communication and education to the conventional medical community about CAM.

4. Integrate CAM services with conventional hospital services so that it drives patient volume from both ends. Packaging CAM services with medical testing, screening, or other procedures and treatments for a defined outcome, such as decreased risk for heart diseases, or improved quality of life for cancer patients. The integrated program is likely to provide a competitive edge on business competition.

5. Reach out to local CAM educational institutions and CAM practitioners, if applicable, to consider collaborations on services or volunteer work.

Recommendations for Future Studies

Participants of the current study were from the Pacific Northwest region. Studies at multi-regional or national level would provide a more comprehensive perspective on issues regarding CAM adoption. A couple of
future research directions are of particular interest based on the results of this study. One is the practical need to establish a benchmark database of CAM practices. Unlike other medical modalities, there is very limited financial and utility data available for CAM. Having a comprehensive CAM database, particularly the financial data, would help hospitals plan and budget for CAM programs more effectively. Some examples of such datasets that need to be established include the following: what is the patient volume a CAM practitioner typically sees per work day; how many RVUs are generated; what and how many procedures are generally reimbursed; and how much is the typical compensation for a CAM practitioner. Because CAM includes a variety of individual modalities, these data also need to be collected per modality. The other research area that can be meaningful for future research on CAM adoption is to conduct in-depth case studies of individual hospitals and healthcare delivery systems. The current study mainly focused on the viewpoint of hospital administrators. Case studies of individual hospitals would allow researchers to explore the opinions of other stakeholders, such as physicians and middle-level management, as well as how the dynamics among the groups that may influence the CAM adoption.

Chapter Summary

The current study investigated the key facilitators and barriers for acute care hospitals for adopting CAM services. The compatibility of CAM service
with a hospital's mission and philosophy of care, as well as the patients' and community's interest in CAM services are the differentiators that separate CAM adopters and non-adopters. Major findings of the current study were supportive of the theoretical framework which combined perspectives from the diffusion of innovation theory, strategic management theory, and institutional theory. Even though this study had several inherent limitations, it provided future research directions, as well as practical advice for hospitals that might consider adopting CAM services.

BIBLIOGRAPHY


APPENDICES
APPENDIX A: SURVEY QUESTIONNAIRE

FACTORS INFLUENCING HOSPITALS’ DECISION-MAKING ON ADOPTING CAM SERVICES: A SURVEY OF HOSPITALS

1. Complementary and Alternative Medicine (CAM) services are care or treatments that are not based on conventional allopathic medicine. Some of the examples of CAM services include acupuncture, chiropractic, homeopathy, herbal medicine, music therapy, yoga/meditation therapy, or massage therapy, etc. Does your hospital (at either in-patient or out-patient settings) currently offer any CAM services? [Please place an X to either bracket.]
   [ ] Yes
   [ ] No - - - Skip to question #3

2. What CAM modalities are currently offered at your hospital (either inpatient or out-patient settings)? (Please mark all that apply)
   [ ] a. Acupuncture
   [ ] b. Chiropractic
   [ ] c. Massage therapy
   [ ] d. Music/Art therapy
   [ ] e. Naturopath
   [ ] f. Reiki
   [ ] g. Yoga/Tai Chi
   [ ] h. Others (please specify):

3. Please tell us about your assessment of the following questions. We realize that some questions may be difficult to answer without having actual data on hand, however, please give your best estimation.
A. What is the level of patient interests in CAM services in the communities that your hospital serves?
   [ ] Low level of interest
   [ ] High level of interest

B. What is the level of business competition among the hospitals in your area?
   [ ] Low level of competition
   [ ] High level of competition

C. Are there Physician champions for CAM services at your hospital?
   [ ] Yes
   [ ] No

D. Does the provision of CAM services align with your organizational mission and philosophy of providing care?
   [ ] Yes
   [ ] No

4. If your hospital offers CAM, what are the reasons for your hospital to offer CAM services? Please mark all that apply and use as much space to explain as necessary.
   [ ] a. Patient/community demand
   [ ] b. Physician champion for CAM services
   [ ] c. Business competition
   [ ] d. Organizational mission/philosophy
   [ ] e. Financial attractiveness
   [ ] f. Others (please specify):

5. If your hospital does not offer CAM, what are the reasons for not offering CAM services? Please mark all that apply and use as much space to explain as necessary.
   [ ] a. Low reimbursement
   [ ] b. Lack of physician support
   [ ] c. The downturn of current economy
   [ ] d. Credibility of CAM practice
   [ ] e. Difficulty in credentialing CAM practitioners
   [ ] f. Difficulty in quality control/evaluation of CAM services
   [ ] g. Many competing initiatives on the priority list
6. Please tell us what is your current job title?

THE END! THANK YOU FOR YOUR PARTICIPATION!
PLEASE EMAIL BACK YOUR RESPONSE TO tianx@onid.orst.edu

APPENDIX B: INTERVIEW TRANSCRIPTS

Interview #1
I: First, thank you so much for taking time to speak with me today. The focus of this study is to assess the driving factors and barriers for hospitals to adopt complementary and alternative medicine. As you may know, there are only a handful of hospitals that currently provide CAM services, either in in-patient or out-patient setting. As far as I know, your hospital does not provide such services. Is that correct?
R: Correct. The only thing is that with hospice, they provide some volunteer massage. But that’s not quite the same thing. I don’t know how technical, but if you look at massage as being complementary, the hospice has some ability to provide volunteer massages.
I: In your opinion, what are the barriers that prevent hospitals from offering CAM services?
R: I think one of the barriers would be payment. Because most of CAM services, not so much for Chiropractics, are not paid by Medicare. And the availability for Medicaid is very limited. People into the realm of workmen’s comp and that sort of thing, that’s much more limited. So I think that’s part of it. It’s the payment issue. The private payers, the insurance companies, where the CAM services are part of the benefits package, often times the benefit is very limited. Say, 1500 dollar limit for a year, and that would be encompassing any CAM services. And they include physical therapy frequently in that 1500 dollar limit, which is confusing because most folks don’t think physical therapy being CAM.
I: It shouldn’t be.
R: No, it shouldn’t be. But there are some policies being written. These are the private policies that they bundle physical therapy (with CAM benefits). Often times because patients are not aware of the CAM services that much, they utilize more of the western modalities before they try the CAM. So by the time they get to try acupuncture or massage, even before they try these modalities, they already use up those benefits unknowingly. Also, Chiropractics are
bundled with that. Say, folks having lower back pain. They go to see a Chiropractor for few times, and then maybe the Chiropractor would say how about some acupuncture. And by the time they go to see the acupuncturist, the (benefit) dollars have already dried up. So I think for offering CAM from in-patient perspective, it would end up being in many cases either a write-off or the patient would have to be responsible for payment.

I: Right. Then the patient may not have enough cash resources for the payment.

R: Exactly.

I: How about in an out-patient setting?

R: Out-patient services? The funding is still a large piece of the pie. Because a lot of your CAM services are not covered by the same payers or there’re payer limits. Because of that, the money to pay for the appointments or services come under people’s discretionary spending. Those dollars right now, the way the economy is, is much harder. Discretionary spending is budgeted more closely. So it’s unfortunate. I think payments would rank very high (among barriers to offer CAM services).

I: Right. Besides the payment or reimbursement issue, do you see any other issues? How about credentialing of CAM practitioners?

R: They’ll have to of course apply for (hospital) privileges, like any other allied health professionals. Some hospitals and health systems have easier ways to facilitate that than other facilities do. So it would be definitely hospital or health systems dependant on the ease of doing that.

I: Are there any standards to credential CAM practitioners?

R: The universal credentialing format we use in the state of Oregon for credentialing any type of health care providers, whether it’d be MDs, DOs, Chiropractors, Acupuncturist, massage therapist, or nurse practitioners, you’ll have to jump through a lot of the same hoops. The question to ask is whether the CAM professional has met the standards set by the state of Oregon to be licensed. And if they carry a current license in the state of Oregon, it should be possible for them to go through a credentialing process.

I: So there shouldn’t be much of a concern about the credentialing as long as CAM professionals are licensed.

R: No, technically not. But the process is more has to do with the facility or health system, whether they are interested in credentialing or adding that level to their medical staff. They can still self select out.

I: Right.

R: But if they decide to self select in, there are mechanisms and credentialing tools for them to use.

I: Okay. I got your point. Some CAM practitioners are not licensed by the state.

R: i.e. the energy healers.

I: Right. How do you license them?

R: Exactly. It’s not something you usually see.
I: What do you think about medical staff’s attitudes towards CAM? Is it a barrier?
R: It depends on how you are presenting it and which service you are looking at. I think that over all medical staff in general are becoming more open to what’s out there, as to CAM services. Part of these is because their patients are taking these services, and they’re not afraid to report back to their physicians that they’re doing it. And the practitioners are becoming more informed. Also, as new doctors and practitioners, meaning nurse practitioners or PAs, are going through training now, many of their training programs have information on CAM resources, what various CAM modalities are out there and what they’re used for. As more and more research dollars are allocated towards CAM and looking at actual scientific studies, collecting data in a more statistical manner as it has not been in the past, I think it’ll get better validity from a western medical perspective. Western medicine is very linear. It’s very much from point A to point B and how we get there. They are very science driven and fact oriented. There is a long history of accepted studies (about western medicine) you can go back to the 50’s or even the 30’s. CAM modalities are so far behind the curve. That is because many of these practices, now they’re becoming more studied “scientifically” but they’re more of an art than a science. This is where western medicine runs into a wall.
I: Right. You see there might be a different concept approaching this type of services that is different from standard hospital practices.
R: Exactly. It is so different. Think of western medicine as a jump rope. You have an end of the jump rope and I have an end of a jump rope. And we pull on the jump rope, eventually it’s very straight. And if we’re strong enough, we can hold that taunt enough that somebody can walk on it. Eastern medicine, many of CAM, other than acupuncture, they are like a slinky. When you pull an end and I pull an end, it doesn’t stop moving. It changes. It moves and moves and is constantly changing. You can’t walk on a slinky
I: I love the analogy.
R: It’s a different THING.
I: If we want to get CAM services offered in hospitals, either at in-patient or out-patient setting, what need to be in place for that to happen?
R: I think the best the place to start is to get the teaching facilities on track with it. Because teaching facilities have more access to research dollars, and they can work more co-operatively with CAM training facilities, from the educational point of view, they can also get more CAM practitioners into these teaching facilities and their out-patient program. I think that’s one of the first places. That’s where you can get most exposure. I mean, in a small rural hospital, if I want to get credentialed to practice acupuncture, I could. If they (the physicians) want to refer to me, I could do a few treatments in my house. But is that really making a dent in getting complementary medicine more mainstream in a healthcare system? No. You know it’s a little drop in a bucket. What we have to do, from a CAM perspective, whether it is acupuncture,
naturopathy, massage, or whatever, in order for them to become more mainstream and accepted, you have to look at larger institutions and those associated with teaching programs.

I: It sounds like if CAM is more accepted at institutional level, it'll be easier to get hospitals open to integrate CAM services.

R: Sure.

I: Do you see any demand from your community for CAM services?

R: You know I have access to our patient satisfaction survey. You get suggestions from people everything from things we can put on our menus to whatever. I don't ever remember I've seen any requests that say you should offer massage therapy or acupuncture. We also do patients satisfaction surveys on all the modalities in our out-patient clinics. I haven't seen any comments requesting CAM services.

I: That's interesting.

R: You also have to understand we are in a very small community. Most patients are on Medicare or Medicaid. Those folks already know what Medicare or Medicaid does or doesn't cover.

I: Right.

R: And a lot of those folks are in fixed income or no income. Any discretionary spending is not in their mind-set at all.

I: Yes. It's big. How likely do you think they'll use cash for CAM services?

R: I think if there're payers who would pay at least 80% of the cost of the treatment and patients are only responsible for a small copayment, I think more people would utilize the treatment.

I: What would the decision making-process like if you were to get your hospital offer CAM services?

R: I think a lot of what need to happen is that we have to show there're some interests in the community first of all. It's like any other product line, if there's a big request for it and it's a product line you can break even on, then it's easier to sell to the administration. You know, today in health care, the way the funding is, breaking even on a services is a real accomplishment. So I think you'll have to do a really good strategic plan and community analysis as to what you are looking at. In larger urban area, it would be much easier to sell something like that just from a pure number stand point.

I: I see. Is there anything else you'd like to add?

R: I think over the time we're going to see a lot of integration of CAM services into the health care system. It will be more under the areas like the therapies, such as PT [physical therapy] or OT [occupational therapy]. It'll be handled more like the therapies as long as the CAM practitioners are licensed and their training can be verified;

I: Good. Are there any policies in your hospital that restrain CAM services being offered at your hospital?

R: No. I don't believe there are any policies or our current by-laws that would restrict it.
I: Sounds good. May I follow up with you if new things regarding this study come up later?
R: Yes, absolutely.
I: Thank you so much for your time.
R: You bet.

Interview #2

I: Let me briefly introduce you about our study here today. This study is trying to learn about critical factors that influence hospitals decision making on adopting complementary and alternative medicine, aka CAM, including acupuncture, naturopathy, massage, etc. As far as I know, your hospital offers some types of CAM programs, right?
R: Well, we do. Just for the sake of your research, I don’t know if you segment things out at all, we don’t do a lot of things in the hospitals but I’ll tell you what we do in the hospital. But as part of our hospital and part of our system we do have clinics that offer a variety of alternative medicine kind of things.
I: Great. I’d like to hear about it. So the CAM services are offered at out-patient clinics of your hospital, right?
R: Correct.
I: Nobody is doing in-patient CAM services at this moment?
R: Well, it depends on what components you really define as alternative medicine. A couple of things we do. We do offer massage therapy within the hospital; we do offer music therapy within the hospital. I guess those are probably the two major things that we even offer to patients as part of their stay in the hospital.
I: That’s great. Just to clarify, both in-patient and out-patient CAM services are considered within the scope of my research. Would you tell me what the main reasons for your hospital to offer CAM services are?
R: One of the main reasons is that we are actually seeing more and more what I would call mainstream physicians who are looking at better ways to take care of their patients and get results, rather than just the focused episodic care that’s being offered at the clinics right now. The medical director of our XXX clinic is actually a MD and certified acupuncturist. She has taken a personal interest in doing this because of her personal situation and professionally in looking at ways in bringing other components to patient care. So we got physician interests in being able to do this, and good patient care rationale for doing it from a physician’s stand point. Another couple of reasons for doing that are that a number of therapies have actually become more widely accepted and certainly have been around for a long time, things like yoga and acupuncture have been around for hundreds of years with very good results. Now, there isn’t quite of documentations like what MDs are used to in terms of
effectiveness of their treatments, and it’s more of anecdotal I think, but there is
still a growing body of evidence and certainly a continuing growth of use of
those therapies because they’ve been around and effective for a long time. I
think another reason why we’ve gotten into this that our market research
shows that our patients are very interested in this. They are all looking at more
holistic and comprehensive ways to take care of themselves. You can see that
the proliferation of things like the whole foods, all the organic types of foods
and the health food markets are popping up out there. In our community,
despite of all sorts of the bad things we see about being overweight and
smoking, there is also an increased focus on health and wellness. I think those
are probably the main reasons we thought we should really look into this.
I: Yeah, great. It looks like there has been a patient demand to start the CAM
program.
R: I think there is. I just use Dr. XXX, our medical director, as an example. She
had a really good practice as just a mainstream medical doctor. But when she
converted to the integrative practice by adding alternative medicine, she’s full
immediately. In a short couple of years she’s been doing this, we’ve recruited
two acupuncturists, two more physicians, a naturopath, a dietary counselor,
and a massage therapist. The number of practitioners has grown and their
practice became full immediately.
I: Besides Dr. XXX, what’s your feel of other physician’s attitudes towards
CAM services?
R: That’s one of things that is a barrier, or has been a barrier. I have to say
one of the biggest reasons why we have been able to do this without a lot of
push back from the physicians is because Dr. XXX. She is an extremely well
respected practitioner as a mainstream medical doctor. So when she decided
to focus on the alternative medicine, she would present her case, and her
colleagues, I’m over simplifying this, would say this is Dr. XXX, and she’s
always known for what she is doing. We’re just going to trust she knows what
she is doing with these things and we are going to support her. For us, that
was a key component of not having a lot of physician pushback. But we do
have some physician push back. Some of the older and more mainstream
physicians would only look at evidence based medicine and that’s how they
were trained in dealing with particular issues. They are still questioning of it.
We had a question that came up at our physician managing council yesterday
about one of the tasks that one patient was asked to do. And one of the older
mainstream physicians was saying “well, I don’t know what this is and it
sounds kind of hokey to me”. Basically, we said: “well, let’s have Dr.XXX come
here and talk about it”. And Dr.XXX used to be a member of that group. So
everybody went “well, okay, that’s fine. Let’s have her come and talk about it.”
And she came, made her pitch, explained this, and answered questions. Again,
she is very research oriented and is able to answer those questions. But in an
environment where you didn’t have a well respected mainstream physician
champion for these services, those could be significant barriers to the acceptance by mainstream medicine.

I: Right. Those are expressed concerns from other hospitals as well. I have another question. Do you think CAM services profitable? Is it a booster or barrier to the bottom line?

R: It is a barrier. It is not profitable in itself, unless you get a very comprehensive sector where you can get the economy of scale. What we have done to help with that is: number one you have a variety of practitioners and you are able to refer internally, just like you would in a multi-specialty clinic, for different services like massage therapy, nutritional counseling, and things like these that could be paid for. We have also gotten into the business of compounding pharmaceuticals and nutriceuticals, and selling those on a retail basis within the clinic. We are also doing things like selling yoga mats, DVDs, how to build your metabolism, how to eat gluten-free foods and sugar busters, all these kinds of things that would relate to a healthy lifestyle. We are in a process of adding where we think would be profitable. They are getting us to in a break-even point. This isn’t a real profitable venture as of yet, who knows. When we go to countable care organizations, medical homes, where the whole focus of your effort is to get people well, not to treat people who are sick. I think this will be a very key component going forward. At least in our system, we are very glad we are in this part of business. We already have access to people who are utilizing it, and have pieces in place that I think would be very helpful to managing people’s health not just taking care of their illness.

I: Great. Looks like you’ve got to be creative about this business. Maybe it’s break-even or a little bit short right now, but it sounds like having this type care available to your patients is also important.

R: Right, it is. We work really hard at making sure that we are not too extravagant in the surroundings, although we like to have nice, soothing and healthy kinds of things like music playing in the lobby, comfortable seating, good lighting, and a number of things we want to put in. But we are also careful about not going overboard with those things, because those are the things that can sink you. We’ve seen other programs that have gone so far as purchasing an old department store and remodeling it from healthy restaurants to yoga studios and everything else. Even though that’s all good to have that pulled together, even though there is a big consumer market for that, they’ve never gotten to a point that they would be accepted that like on a membership basis like something you would with a health club. You can go overboard with this stuff. That’s where we were coming from and wanted to get it really close to break-even, and figure out ways to be able to add some value to that without hurting yourself financially.

I: Right. As far as I know, there aren’t many insurances cover CAM services. How does your hospital deal with that?
R: It’s hard. One of the best things we do is that we cover services with our own health plan, and we just recently added acupuncture as a covered service. I think we’ve always had physician services. A good thing is that Dr.XXX works as a medical doctor and we work closely on what she consults on and how the visits are structured. We do get a reasonable reimbursement from most carriers for her services. She’s really good at structuring the service that works and new physicians will do the same thing. As far as other services, they are paid by cash. I mean it’s really no different from cosmetic surgery and things like that. People who are focused on this as part of their lifestyle will pay cash for the services. Again, we are not making lots of money for sure, but even on the cash-only services we do okay with them.

I: That’s great to hear. Some hospitals offer CAM services as a market niche to help themselves stand out from business competition. Is that the case for your hospital?

R: I think to a degree it is. But from competition standpoint, in the xxx [geographic location] we are pretty much it. People can certainly go to xxx [city] or xxx [city] for such services, so it’s a piece of it.

I: But it doesn’t sound like a main reason.

R: I don’t think it’s a main reason. We’ve looked at this in the past and it’s been really focused on serving a market niche, not necessarily doing it to ward off the competition. You’re familiar with xxx [the city where the interviewing hospital is located], right? It certainly has a population that is higher educated, has higher income, is more tuned in the environment and health conscious types of things. With this kind of market, there is a real strong demand for these kinds of services from patients. We felt that we’ve always been focused on making sure as we come together as a system we serve the needs of people within our region, whether it be cardiovascular services, neurosurgery, or wellness services.

I: I see. Is credentialing CAM practitioner a problem or a barrier in your hospital?

R: Well, I go back to my initial comment. We have acupuncturists in our clinics but they don’t have privileges within our hospital. They haven’t asked for it. We haven’t felt there’s a need for that. Who knows, maybe at some point there will. To me the issue of credentialing is the acceptance as an appropriate medical modality. Doing the research about what it takes to be proficient and accomplish what we want to accomplish medically, our medical staff has always been good with that. I know as a graduate student you’re probably very young and I’m much older than you, I can recall back years ago when podiatrists rarely had hospital privileges. Overtime they evolved to where they serve specific niche, and they are trained in a specific modality. When you have patients who are utilizing them and they’re providing a solid medical service, you can work through a process of identifying what their skills are, what skills are needed, how they’re trained, and grant them privileges. We certainly have podiatrists on our staff here, as probably most hospitals at these
days do. But in my career I recall a time when it was a very controversial thing. I’m sure we’ll involve some of these alternative medicine practitioners as well overtime. When? I don’t know. At this point, we don’t really credential them and nobody has asked to do it at this point.
I: Maybe it’s just my ignorance about this subject. It looks like credentialing is different for a practitioner who works at in-patient settings versus out-patient clinic, right?
R: The physician who does acupuncture is a medical staff and she has medical privileges here [at the hospital] but she does not have medical privileges to do acupuncture [at in-patient setting]. But at clinic, it’s perfectly appropriate.
I: Why is that? Why there’s a difference?
R: That’s the way medical practice typically is. There’re certain things you typically do in a hospital, and there’re other things you do at the clinic. You might do osteopathic manipulation at the clinic setting, but… I think the bottom line is that whatever you want to do at a hospital, you do have to get credentialed for and get privileges to do it. There are just a number of those things that the practitioners haven’t desired to do in the hospital and so there isn’t really anybody with medical privilege for those. Acupuncture is a perfect example. I have had acupuncture myself. I have it done in a clinic. I go to the clinic just like I would for a regular doctor’s appointment. I received the acupuncture treatment and I walk right back to work. That’s all there is to it. Like I said, at some point in time, somebody is going to do enough research and say, you know this is something I’d like to do it in a hospital and I’d like to do for these kinds of diagnosis or procedures or those sorts of things. But as of right now, there isn’t that. Those kinds of things are done in an out-patient clinic setting. We own the clinics and they are employees of our system, and those things are done in a clinic setting.
I: I see. Do you think the considerations given to start CAM services different from starting any new service line?
R: No, I really don’t think so. The way we look at a new service line is that we try to identify from our market research what are the things we can do to better serve the needs of community that we’re representing. In fact under the new health perform law the IRS is actually going to require hospitals in particular that have 501 C3 statuses to do the community needs assessment every 3 years, and then develop plans on how to address those needs. There’s never been requirement to do that before, but we’ve always done something like that. So in developing this service line or any other, we would look at community needs, the potential financial impact of it, and any political issues might involve with providing the service. We’d certainly have discussions with our medical providers, with our board, to talk about what benefits this would be and what downsides would be. It’s really going to be the same kind of thing your discussion with me. What makes you to go this way? What are the barriers?
What are the pluses? We would do any service line, enhancement, or additions pretty much the same way.  
I: All right. It sounds like there’s really no difference in starting CAM services versus any other mainstream medical services.  
R: No, not in my way of thinking. It was a potential area that wasn’t served within our market. It made sense for us to look at it, do a financial Performa, have an identification of what the staffing would look like, and have the discussions pretty much the same.  
I: Great. That’s all my questions. I appreciate your time. Is there anything else you’d like to add?  
R: No. I wish you good luck with your study. If you have more questions later on, do give me a call or email.  
I: Will do. Thank you very much.
Interview #3

I: First of all, thank you so much for taking time to speak with me today. The focus of this study is to learn about the reasons hospital do or do not offer CAM services. As far as I know, your hospital offers some CAM services. Could you share what are primary reasons for your hospital to offer such programs?

R: First of all, I dislike greatly or our organization dislike greatly about using the term complementary and alternative medicine. We’d like to look at it as integrative medicine. Alternative gives me an impression that you have to use one – either allopathic or the other and it’s not used hand in hand. So we’d like to use integrative medicine instead of alternative or complementary. We feel it’s very important to integrate both types of medicine into the practice of medicine.

I: I see. Integrative medicine emphasizes the importance of both types of medical practice. What are the primary reasons for your hospital to offer integrative medicine?

R: Our philosophy is to address the five components of health whenever we provide care to the communities we serve. In other words, we want to address the biological, social, environmental, spiritual, and intellectual needs of the communities we serve. In order to do that, we have to look at providing care to the whole person. In order to provide care to the whole person, you have to address the mind, body, and spirit connection. So it’s a natural fit for our organization to use integrative medicine in our delivery of care.

I: It makes sense. I’ve noticed your hospital utilizes Planetree philosophy.

R: Right. We are the first facility to adopt Planetree facility-wide in 1991 and 1992. It stared in San Francisco in a unit. But we are the first one facility wide.

I: Wonderful. When your hospital started integrative medicine, was there a demand of such services in the community?

R: No, there wasn’t any demand from the community. We as an organization and its senior leaders felt that there needed to be more to provide in healthcare and from there our philosophy grew, after many investigations in the late1980s, to try better ways to provide meaningful health care. So then we adopted Planetree philosophy and one thing after another. Now our community is asking for it. But we’re in a rural community which is very agricultural-based. So if we can do it, anyone can do it. It’s pretty rewarding for me to walk over our oncology center and see someone is getting a massage. They do expect it now. Our oncology patients from whatever walks of life expect to use acupuncture during their treatment care or after their care. We use massage, Yoga, Tai Chi, or gentle stretch for patients through our organization. That’s what we usually do for our patients. And we provide for
their care givers as well. Access to information is very important to our philosophy. Whether it’s our Plantree resource center or open medical chart where we encourage patients to chart their own chart. All of these are components and just as important as the integrative medical therapies that we offer.

I: It sounds like it is really the philosophy of how your hospital is providing care that is the main guiding principle for offering integrative medicine programs.
R: I think that’s a fair statement.
I: Are there many competitions from other hospitals or clinics in your area?
R: In our community of 13,000 people, we are the sole community provider as far as hospitals. Now, 20 miles west there’s a hospital. Just immediately across the river 20 miles north there’s also a hospital. 35 miles northeast of us there is also a hospital.
I: But your hospital is the only one providing integrative medicine, correct?
R: I’m not sure if they have some sort of program. We certainly are much further along than they are. But I can’t tell you if they have provided any other things or not.
I: As far as I know, there’s not much insurance coverage for integrative therapies, such as Tai Chi, massage, Yoga, etc. Do you think that lack of insurance coverage is an obstacle for your hospital to provide integrative medicine?
R: Many of our classes are self paid. We constantly search for grant. A year ago, we entered a 3-year grant for Tai Chi. It’s Train the trainer (program), which will go into even more rural communities to train the trainers there so they have access to Tai Chi. So some of them we absorbed as the cost doing business, and some of them are cash paid.
I: What do hospitals need to consider when they plan to offer integrative medicine?
R: You start small. You find your champions. You find your physician champions. Sometimes it’s their significant others have experienced acupuncture or something else. So you find your informal leaders and use them as your champions and as a key. However, you also have to have a philosophy and climate that’s open to looking at the mind-body connection and the role it’s playing. It’s hard for me to believe that young medical graduates nowadays who isn’t aware of that. You need to play upon that. Start small and show the benefits it has to offer. Whenever you communicate with a provider if you’re providing the [integrative medical] services and you get back to the provider, make sure you include that in a letter. So that when they open that chart again, they see those comments that will refresh their memories once again. So next time when they see their patients, maybe they’ll think, oh, I’ll recommend this again. It’s a slow and steady process and journey. I don’t think you’ll be successful walking in starting from nothing and say all right I’ll start this I’ll start that. You’ll overextend yourself that way. You won’t be able to pay for it. Your community won’t be ready for it. Getting out to your community,
reach out to service group, church group, anything like that, offering education about it, taking believers with you, taking former patients who were successfully treated and helped; including successful stories in your annual magazines that are sent out to the community. It’s just a journey.

I: What were the physicians’ attitudes in the beginning?
R: You know, I had someone said “yeah, we can try it”. One of our champions’ wife went to Portland and had acupuncture. And when it came time to credential our acupuncturists, it’s a pretty smooth sailing because he went by our side telling the benefits.

I: Great. That worked out really well. Do you think staring integrative medicine similar to the starting of any other new medical services?
R: I think it is. Say, if I wanted to do Physiatry service and we didn’t have Physiatry. That’s not the best example because people know the benefits of Physiaty. Say they didn’t. I’ll start with doing my research, finding out some really reputable studies that show it really can improved care. And I find myself a group of champions, and started asking about, you know, what do you think if we were to offer this service at a very minimal basis, would you be willing to try a pilot with it. Yeah, yeah, yeah. No, no, no. Okay let’s just do it. We try a pilot. You know behind the scene, I also have to do a business plan and figure out where I am. Am I going to be able to absorb it as a cost? Because many times when you just start doing this, you’ll have to throw it as a cost, but maybe I might recoup 10% of my expenses or whatever it is. So behind the scene, I’m sharing with my CEO. I’m talking about how it will support our mission and values. I may need to give a presentation to our board and get them on board. Depending on what the program is, may be now or further down the line, but usually starting with a pilot project, then taunting on those benefits of the pilot project, and slowly growing it and growing it. And the journey continues, after several years, it’s like how we are able to do without it.

I: That’s great. Is there anything else you’d like to share about integrative medicine?
R: I guess I’m just disappointed about American health care for viewing that it’s such a monumental task or such a way far out philosophy to provide mind-body care. I have trouble understanding why people think we [the hospital] are so unique. What we do here should be what everyone is doing.

I: I agree. I hope my study will able provide some answer to this question
R: I do too!

I: All right. As we are almost done with our interview, may I ask what your position at your organization is?
R: Sure. My name is XXX. I’m a vice president at XXX medical center. I actually started my career as a clinical pharmacist. So, along those years, I realized that while drugs are good, it’s not all there is. We won’t be able to live without them, but there are also things we can do besides drugs. I guess it’s a very simplistic way to explain it. That’s why we’re so committed to have
integrative therapy, and not wanting to give up the traditional medicine, but we can help traditional medicine so much if we use integrative therapy whether it’d be stress management, nutrition, or whatever it is.

I: Do you see any barriers that preventing hospitals from offering CAM?
R: One of the things that continue to be the barriers is medical reimbursement. How do you continue to offer the service when the reimbursement is decreasing instead of increasing and expenses are going up? Traditionally integrative medicine is provided at a cash pay basis. Interestingly though, because people want it enough they’re willing to pay cash for it. They know it can make them better. So, those are huge barriers. With decreasing reimbursement, I know some hospitals are resistant to try because of it. I’m also not sure about how current curriculums at medical or pharmacy schools are addressing the mind-body connection and the five component of health. I don’t know any of those curriculums have made that jump.

I: I think it’s getting there. I really appreciate your time and insights. May I follow up with you if I need to?
R: Absolutely. Good luck.
I: Would you tell me what CAM services do your hospital offer?
R: We have acupuncture, massage, and naturopathic medicine. Those are the most popular services we have, and we do have music therapy as well.
I: Do you offer these services at an in-patient or out-patient setting?
R: We offer them at out-patient setting as well as in-patient setting, depending on what the services are. Aroma therapy is mostly used as in-patient services. Reiki is at both in-patient and out-patient services. Then the acupuncture and naturopath are out-patient services currently.
I: What are the main reasons for your hospital to offer CAM services?
R: Our hospital is a Planetree hospital. Are you familiar with Planetree?
I: I’m somewhat familiar with it.
R: Okay. Planetree is patient-centered and patient-focused philosophy of care. It actually has components around the environment, healing arts therapy, and information. It really tries to humanize, demystify, and personalize patient care. That is the philosophy the organization as a whole. It is who we are. It is part of our mission.
I: I see. That makes it natural for your hospital to incorporate some CAM therapies, right?
R: Correct. That was one thing that drew me here. I came here specifically for the cancer center and to develop the wellness center with the cancer center. The wellness center where we hold acupuncture and naturopathic services also offer yoga and meditation classes as well. That was just part of the philosophy behind building the center. As part of a hospice care for many years, they already have had healing art therapies, which included healing touch therapy, massage, Reiki, and a whole variety of healing arts therapies. At our family child birth center, Aroma therapy is especially a part of the nursing practice.
I: Very nice. Is there much patient demand for such type of services?
R: I think the patient demand is something you have to define it. When patients say they want these services, they certainly want the choice of having these services. Have they always utilized these services? It’s a different question.
I: Okay. It sounds like the program is there, and it’s about generating the demand, correct?
R: It is about creating that customer base for these services. Patients absolutely want to have choice and access to these things. We have patients come and say “well, I come here because you offer these things”, then you go “can I send you there?” “Nope, I wanted to know it’s there and available, and when I’m ready I’ll take part.” They don’t necessarily access those services. Physicians are the key referral point. They’re what drive people to those services as well. Creating a relationship between CAM practitioners and physicians are really a key in building those CAM practices.
I: What are the physicians’ attitudes towards CAM?
R: Well, it all depends on who you are speaking with. We have an addiction recovery specialist who is an acupuncturist uses CAM in his practice. We also have physicians go "I want to know about it", so they want to have the chart integrated, have the information, and know what patients do. But never in their life are they going to refer patients to that service. It has to be expected as self-referral [by patients themselves]. Then you have some people in between. Their first response is that if there is no harm, they probably can live with it. But are they going to promote it? It’s a whole different game. You have to find those individuals and educate them. Then it’s all about relationships.

I: Right. Do you know how long has your hospital been offering CAM services?
R: You know what, I have to go back and look. I wasn’t here when it started. But I want to say it’s been here as long as we’ve been a Plane Tree hospital since the 80s.

I: As far as I know, there isn’t much insurance coverage for CAM Services, how do you deal with that?
R: In the state of Washington, unless the company is self-insured, they are required to have at least one CAM therapy covered. So for commercial payers, there’s a fair amount of coverage for individuals. However, our patient population is about 62% Medicare, and there’s no coverage for those patients. We designed our wellness center around this process. We partnered with CAM schools so we can provide these services at a reduced rate of fee for service. And a lot of services are volunteer services. Providers for our Reiki services are volunteers.

I: yeah, you know, when I talked to other hospitals, the reimbursement issue is their main concern. Your hospital seems to be very creative in coming up reimbursement methods.
R: Yeah, we’ve been very fortunate. Team Survivor Northwest is an organization that supports women out from cancer. We partner with them for some of our fitness classes. We have a wonderful volunteer base. We’ve got certified Yoga teachers provide classes at very nominal instructor fees, so we can cover cost by charging individuals $5 per class or $30 per series. It’s very nominal fee. The volunteers for healing arts have been very nice. They come to us.

I: yeah, very nice. It seems like the CAM services aren’t very profitable.
R: No, they aren’t now. Ultimately it’s about building a relationship to form a referral base. We have made strides and we have been able to break even. Our issue is working on that sustainability, that referral base, and constantly replenishing it. You have to have physician buy-in and relationships to help to drive that. We haven’t always had that.

I: It sounds like as the program grows, it might become profitable sometime in the future.
R: Yes, I think there’s definitely possibility for that from fee for service. Have you talked to XXX from XXX hospital in Colorado?
I: No, I have not.
R: Well, they have a very successful model on integrating CAM services. They employ all of their CAM practitioners. We don’t. We contract our practitioners.
I: Do you still have to credential them, even they’re contractors?
R: Yeah, for out-patient services we credential them. For in-patient, the majority of those services are volunteer-based. Most of our Reiki practitioners are credentialed through our hospice program and our hospice program has a credentialing process for their contract providers. And our cancer center has credentialing process for acupuncturists and naturopath physicians.
I: Is getting people credentialed an issue?
R: You know they come to us already credentialed or licensed generally. They have to meet our evaluation and criteria before we even talk to them. To get CAM practitioner credentialed for in-patient services is really the next big leap that needs to be made. The barrier to that is really about getting around medical staff. Credentialing goes through medical staffing. It’s about getting physician support for credentialing anybody from nurse practitioners to acupuncturists to provide those services. That won’t fix the problem for reimbursement because it’ll just get added as a cost to your DRGs. So it’ll continue to be a problem unless we offer it as a cafeteria service for people.
I: What does cafeteria service mean?
R: Meaning that your services are provided at a fee-for-service basis. For example, some hospitals have beauty shops. Patients can have the beauticians come to see them and have their hair done, but they pay for them separately from their hospital stays.
I: I see. You know, when I talked some people in other hospitals, because of business competition, they started to offer CAM services as a business strategy to gain a market niche. Is that the case for your hospital?
R: I think the primary driver is really our Planetree philosophy. We provide wellness and integrative services from that perspective. Having said that, when you evaluate any addition of a program, “is it a differentiator” is always a question asked. I think from a patient choice perspective, they want to know if it’s available. So, did we ask the question? Yes. Did we think about how we could leverage it? Sure. We have leveraged it in some ways to garner recognition and support. Several other cancer centers have looked to our cancer center about how we have modeled it and what it looks like, what some of the integrations are. XXX hospital has an integrative therapy program, and they have talked to us several times. They have similar challenges as we do around referral base and getting providers to feed the program.
I: I see, that’s what you see as the main barrier is about getting the referrals and physician buy-in to the services.
R: Yeah. I wouldn’t say just getting the physicians to buy in. I would say all clinicians. I mean everybody needs to be educated about it. There are small pockets of populations that both know and utilize it, but then there are others who just don’t know. Unless they utilize it themselves they just don’t know. They are like “What? You’re going to stick needles in me?” there’s this whole
thing associated with some of the therapies you need some education around. One of the largest aspects we noticed is from naturopathic medicine. We have all kinds of questions the clinicians asked around the interactions among nutrients, supplements, and the care and treatments of individuals. We were very thoughtful about bringing that service into the cancer center, because of the potential impact. I would say one other driver from clinician perspective is that clinicians want their hands around something that is going to work for their treatment. We partnered with individuals that shared our philosophy about the types of care provided to oncology patients during their treatments to really integrate what we do, and not to create more barriers to them.

I: Right. Do you think the considerations given to start the CAM program are any different from starting any other new service line?
R: I don't think it's different. I think you need the same thing. You need base support. You need to understand the market implications. You also need to understand, and some of these are learning for us, the needs for the services you're going to provide in your area, so you have the right facilities and right tools that works along the way. So I really don't think it's any different from, say, adding a rheumatologist when you never had one before. You need same kind of support because if he or she doesn't have the support from the medical staff, he or she isn't going to do well either. So the short answer is no. It's not a problem. It's the same.

I: Good. How supportive the senior management of your hospital has been for the CAM program?
R: They're totally supportive. I mean you always have to answer the questions: is it going to make money? What should we do if it doesn't? I mean it's the same thing you do in any business decision. But they're totally supportive from the patients' perspective and the needs from the patients.

I: Great. Is there anything else you'd like to add? Or any question for me?
R: I don't think so. If I could be any help further let me know. Email me or call me back!
I: Will do. Thank you so much. I really appreciate your expertise and time today.

Interview #5

I: Your hospital has an integrative medicine program for a while now. What were the primary reasons for your hospital to offer integrative medicine in the beginning?
R: As for the primary reason that we decided to offer integrative medicine program, really there were four that I can remember. Not necessarily in order. One was financial attractiveness. In health care, in general we don't deal with
patients themselves as far as reimbursement goes. We deal with third-party payers. So, government is about half of what a hospital’s business portfolio, and then commercial payers, and that kind of stuff. You know, a lot of hospitals are looking at ways they can go into a retail environment, and get some of the cash that is spent out of pocket by patients receiving alternative therapies. To be very honest, that was and is a major factor for hospitals to adopt alternative therapies.

I: Because it’s more of cash based (business), right?
R: Yeah, it’s cash based. For the same reasons, a lot of hospitals have gone into cosmetic surgery and things like that. There’s a financial part to it for sure. The second reason, and also the one that is very closely in lined with that whole financial picture was differentiation. As hospitals look at that competitive environment, say, gosh, what makes our clinical program different from anybody else’ programs. One of the differentiating factors was being able to offer adjunctive therapies to standard medical treatment. We really learned a lot from XXX medical center who had adopted a planetree philosophy which was a method of running a hospital to make it more patient friendly and more open minded towards different sorts of therapies. They didn’t use integrative medicine and their mind body program as necessarily a focal point, but they adopt it into all their clinical programs, especially in cancer. They use it as a differentiator pretty effectively. That’s probably the second big reason. We utilized, for example, pre-op massages to decrease the amount of anesthesia, and we used massage for laboring mothers. That was really our first forayer into integrative medicine. It was really through massage. Because it’s kind of the thing everybody accepts. Everybody loves massages. Our patient population actually started it. Even they didn’t get their massages, they let us know. It was a big deal to our patients. Umm, third big reason that we looked at for starting (integrative medicine) was community. The community talked about why we didn’t have acupuncture? Why didn’t we have naturopath? Why didn’t we have alternative therapies? The community was really asking for integrative medicine. And then, forth reason was because of our board. One of our board members has a sister who teaches at Harvard in their mind-body program. She would come out and talk about it. So John came to our board meeting and say, hay, why don’t we do the mind-body thing? Look at the XXX [hospital], they’re doing the mind-body thing. So the board really started getting active. One of our other board members was a cardiac nurse, and she has seen big changes (of her patients) through meditation and yoga, and things like that. So a lot of board members started to say, you know, as long as we are doing all these neat and innovative stuff, why don’t we do integrative medicine program. Those were the four factors really influenced the starting (of our program).

I: Well, the differentiation part you talked about earlier… was it because there is strong market competition over there?
R: Yes. There’s a lot of competition. In SSS [city], we’re competing with XXX hospital, with YYY hospital from the [inaudible] area, with ZZZ from the [omission] area, even with ABC hospital. We’re a small hospital, but it’s really a bigger hospital as far as what it offers. We have one of the best Urologists around, we have a really phenomenal general surgery program, and the cardiac program, and we can go on and on and on. So we’re competing on kind of a peer basis with these larger hospitals. But the question was why anybody would want to drive out to SSS [city], or to where ever we’re serving the community. Why would they come there as oppose to our much larger competitors? You know, it was like if we adopt this high-touch type of process with our focal programs, then we’re going be more successful drawing patients to our clinical programs. That was a big deal for us. We really want differentiation.

I: Right, it makes sense to pick a niche and sell it to a segment of population who are attracted by it. Is the integrative medicine program more of a primary care mode?

R: It has evolved over time. We started up with a consultative program approach. What we’ve learned fairly quickly was that consultative programs that were successful were very few and far between. Most programs that are financially viable are actually operated at more of a primary care model. I think many people are realizing that instead of integrative medicine as a specialty, we should be thinking at it in terms of how medical care is supposed to work in general. Instead of looking at it as, ok I’ll go to my primary care doctor for the medicine and everything else, and I’ll go to this other person if I wan to use acupuncture. No, not really. The physician you see should be versed in all aspects of health care, whether it’s allopathic or naturopathic. I see that as a real trend.

I: That’s really neat.

R: Yeah, and now it’s much more of primary care model.

I: Okay, interesting. Do you see physician’s resistance against that (alternative medicine)? Or in other words, how physician’s attitudes towards CAM would affect the adoption (of your integrative medicine program)?

R: That has also changed over time. When we first to look at integrative medicine in 1998 or 1999, we had a whole chunk of medical staff was like, “no, you don’t”, “don’t you dare”… [laugh]. Umm, in fact this is an interesting story. We had a Reiki practitioner come to a nurse managers’ exhibit we had and I was involved in that. This Reiki practitioner was actually teaching us Reiki techniques to use with patients. And She was so good and so vibrant; we had her come in and give a talk at our hospital about Reiki. We had a bunch of people showed up. When this kind of chunk of medical staff found out about that, I mean, they were really up in arms. “How dare you”? “This is our hospital, how dare you pollute it with this garbage”? What we saw over time was that as the knowledge about the therapy spread out and about how they could incorporate it into their medical care, we saw a gradual shift. In fact, one of the
biggest opponents about that Reiki therapy was a husband-wife physician team, who was very fundamentalist Christian, and did not like the whole thing. Well, the wife ended up going through some tough health issues, and finding out about Reiki on her own, and then ended up being a (Reiki) practitioner.

I: Wow, interesting story.

R: So, as experience and education came around, it did change a lot of people's minds. The trend that is changing the integrative medicine as far as physicians' resistance goes is simply attrition. The more young medical staff you have, the more likely they're going to either embrace or being open-minded towards integrative medicine. So, the younger your medical staff gets, the more likely you can have a functioning integrative medicine program. We've seen that all over. The places that have integrative medicine programs tend to have younger medical staff.

I: Interesting. Maybe they have more exposure to alternative medicine. You know, many medical schools have started to offer introductory CAM courses.

R: We were actually getting a lot of CVs for our medical jobs with people who have gone through UCLA's “acupuncture for physicians” course, or have done some naturopath training. There're a lot of people, especially people migrated to the Northwest, who are much more open-minded towards integrative medicine and try to incorporate at least parts of that into their own medical care.

I: Do you think if consumer demand is a big factor to affect your hospital's decision on offering CAM? Or do you think you can cultivate that demand?

R: I think you can cultivate it. I wouldn't say that it's huge. One of the things we got caught by was that we thought we were going to get a lot bigger initial demand (for integrative medicine) than there actually was. There was a very vocal minority of local people asking for integrative medicine in the beginning. You know, there were all these town hall meetings and so on. We found out later these weren't a true demand from the majority of our communities we serve. Part of that goes to the same thing as medical staff, was education. What can these things do for you? If people don't understand how these therapies can benefit them, even though a lot of mainstream people have heard of them, they may be okay with it but they're not demanding it because they don't know how they're going to impact their lives. You know, if you can decrease nausea with acupuncture or with visualization, then that's something going to have an impact in your lives. Demand was really that vocal minority that was initially using the services and everything, but really it was an education processes. We're still doing it at XXX. We have community forums where we talk about different alternative therapies and how they can benefit people. So, much like Chiropractic, which was once considered as an alternative therapy, has gained mainstream acceptance because of exposure, experience, and education. Now I would say probably the majority of the Americans have visited or heard of Chiropractors.

I: You seem to know a lot about alternative therapies.
R: [Laugh]. I have to be educated about it too. It’s something that I had four years of research into about the programs, the practitioners, the therapies themselves, what they did and how they worked, so that we can build a decent business that would actually make sense. It took a long time. It took a long time to gain medical staff’s acceptance; it took a long time to find the right practitioners; it took a long time to put all pieces together.

I: Do you think it’s financially risky to start offering CAM services?
R: Yeah.

I: How much of a risk would that be?
R: Well, the risk is small, depending on how you do it. You know, if you’re not building buildings, then the financial risk is small. I don’t believe that any hospital should go into integrative medicine program thinking it’s a separate service line. I don’t think they should do that. (Generally) we divide our businesses as service lines. You know, you got urology; you got your general survey; you got your primary care, and all these buckets you throw your medical services into. And that should not be the mindset for hospitals trying to get into integrative medicine programs.

I: Why not?
R: Because if you are going to build a successful program, you need to take the word “integrative” into account. If you run it as a separate division, it will be like employing medical staff. Historically employing medical staff has been a financial drain. It’s a financial drain hospitals are willing to go through, because it provides some other benefits. It provides downstream revenue; it provides referrals; it provides control. So we’re enthusiastically going to employ physicians because we know there’s benefit to it. Similarly, integrative medicine programs can be a financial drain. When you think about it, to just look at breakeven with a primary care doc, they’ve got to see about 16 to 20 patients a day. When it comes to integrative medicine, you ask, gosh, what is the greatest thing about an integrative medicine practitioner? Well, they spend more time with their patients. And as a result of that, they see fewer patients. Even if you get cash upfront for that patient’s payment, you’re not going to be able to increase your prices dramatically because that kills your demand. But you want to have the ability to have that practitioner to spend time with patients, which is a great thing about integrative medicine, and that’s going to result in negative financial. So how do you deal with that? Well, you deal with that in an integrative way by moving patients between practitioners; you deal with that by retail sales; you deal with that by utilizing integrative program as a leader to other settings and programs you have, such as screening programs, membership you may have, health plans, and so on. The best thing about integrative medicine program is when it is integrated with your clinical programs. So again you can take advantage of not only people that are approaching the program purely through the CAM therapies, but also the people approach the program through other clinical paths. If you look at integrative medicine separately as a clinical service line, you say, gosh, it’s not
going to be financially viable. But if you look at it as a differentiator toward your
cancer or heart programs, or surgery programs, or anything like that, then it
starts to make sense because you’re driving additional medical volume as well
as getting the volume for integrative medicine.
I: Yeah, it really makes sense. It generates referrals back and forth between
integrative medicine and other clinical programs.
R: Really philosophically when you look at integrative medicine, it comes from
a philosophy that there are many modalities that can be used in the healing
process. Instead of continuing to separate out certain modalities because
there’re different, we should incorporate them so that we have a holistic view
of health care.
I: Besides that, adding integrative medicine program seems to strengthen the
hospital’s reputation in the communities it serves.
R: Yeah. From the other perspective, when an integrative medicine program is
associated with a hospital, it brings credibility. You know, if you just go down to
your local acupuncturist, what confidence do you have in the fact that they’re
quality practitioners and they’re utilizing the best practices for their modalities.
What kind of seal of the approval is there for that acupuncturist? Whenever
you’re aligning alternative medicine practitioners with a hospital it brings them
credibility. They are XXX [hospital] practitioners so that they have the seal of
the approval of XXX [hospital]. And it’s a two-way benefit. It’s not only a benefit
to alternative medicine practitioners, but also the hospitals.
I: You’re right. There are practitioners out there need to do a better job in their
practices.
R: This is an area that still needs work. You hope there is the ability by
medical institution to verify this matter and has some quality control. That’s still
an area in integrative medicine that is evolving. How do we credential these
practitioners? How do we verify their quality? How do we review them? How
do we do peer review? How do we ask routinely whether the treatments are
actually beneficial for any given medical condition? So that’s still evolving.
I: That could make a hospital shy away from offering CAM. Don’t they?
R: Lots of them do. That was one of our big questions: how do we do quality
control. I don’t know. You know, it’s like if you look at medical staff and their
peer review on quality control process, what do they know about acupuncture?
What do they know about Naturopathy? They look at it and saying, oh gosh,
how can we review our peers without knowing what quality standards are and
being able to utilize our medical staff processes to do that quality control.
That’s something that a lot of hospitals are struggling with. I know at least a
couple of institutions that have basically said we’re not going to aligned with
integrative medicine programs because we don’t know.
I: Hospitals are under pressure about (the regulation regarding) practices of
evidence-based medicine. There’re all these government agencies watching
over you…
R: Right, absolutely. You got JACHO, and all of this stuff. You’re like, okay, how does integrative medicine fit with all of this?
I: So how do they do it then? How does XXX [hospital] deal with it?
R: You know, Umm [silence]… We did a lot of work with our medical staff by-laws and how different types of practitioners are treated. Because it wasn’t just… I mean, you know, XXX [hospital] had never had a Chiropractor on staff. And it was similar, this is kind of funny, but this was similar to Podiatry. Podiatry was one of those things that were out of the medical mainstream. If you never had a podiatrist on your medical staff, how do you go about finding out? The big question was in Naturopathy; the range of (Naturopathic) training that people get is all over the board. I mean, you got programs like Bastyr (University) widely hailed as excellent programs. Then you got, you know, “Any town Naturopathic School incorporated” that you don’t know anything about. [Laugh]. It’s a struggle. And I think that’s an evolution we’re going through.
I: Even though these practitioners are licensed, that still doesn’t say a whole lot about their skills…
R: Yeah, technically practitioners are responsible for the quality of care of the medical institution. That’s a hope that I have for integrative medicine as a whole is that medical communities will come together, and say, this is how we’re going to do it; this is how we’re going to credential these practitioners; this is how we are going to allow these modalities to be integrated in clinical practices. That hasn’t happened yet but it will someday.
I: Interesting. Let’s see, you mentioned about there’s not a whole lot of insurance coverage for alternative medicine. Do you think it’s an advantage or disadvantage to hospitals that are thinking about offering CAM?
R: That’s a good question. This is a difference between allopathic medical care and integrative care. The payment packages out there from insurance companies for integrative medicines aren’t extremely bad in many cases. They’re very narrow as far as the scope it will cover, and the people will kick in a lot of money before it starts to cover. So it’s kind of like, why bother. But you know, the deal with integrative medicine, more for allopathic medicine but you can make a case even with allopathic medicine, is that insurance is an event based financial tool. So for example, you buy car insurance for that day you get in a car wreck but you hope you never use it. But you buy medical insurance knowing for sure you’re going to use it and it’s just a matter of how many times. So, can I scale back the package for how many times you can use it? For integrative medicine, the idea is that it should not only be used when you’re acutely ill, it should be used to promote your wellness. Okay, if my insurance package only pays one massage every three months, will I really get any benefit out having integrative medicine coverage, or should I really should forgo that integrative medicine coverage and pay that out of pockets. I think we’re still on that … nobody really has come up a perfect (insurance) package. As a result of that, we’ve got to be very price conscience. How much
you charge? What’s the patient is getting for? What’re other sorts of things can be offered? I know a lot of integrative medicine practitioners are really lobbying for insurance coverage, but it ends up being not a lot different from paying out of pockets. So I don’t know if it’s a good or bad thing. We’ll see.

I: Doesn’t a hospital wish integrative medicine service being paid by patients out of pockets?

R: You know, there’re some good parts about integrative medicine in that some of the programs deal only with cash and then they devise many payment methods consumers can use to access the service. You know, revolving credit accounts and stuff like that, or packages. Packages have blossomed in integrative medicine. You have a “heart” package where they [patients] go in and they learn bio-feedback they learn yoga for heart health they get massages they do a life-style modification class with a Naturopath. So the patient is paying for a preferred outcome. Will it make a huge difference acutely? Who knows. But what they’re doing is buying something that is articulated positive outcome. If I’m at risk for heart attack and I have some objective measurements that I’m at risk, (such as) my lipid profile and that sort of stuff. Then I can go through this package, modify my life style, and at the end I can decrease my risk by having a better lipid profile, decreasing the reactive protein, and you know all these sort of stuff. The more hospitals do that; they package their integrative medicine services for a defined outcome, the more willing consumers are to pay for these services. That’s the trend I see among integrative programs where it’s not allied with pure medical procedure, but allied with medical testing or something like the “Heart Strong” program at XXX [hospital] which is a good example, they actually do coronary CT and they do your lipid profile and other sorts of tests, and then they send you through this package and at the end you repeat all the tests and tell you how much you reduced your risk. And that’s huge. That’s the trend we’re seeing and it’s exiting.

I: Let’s talk about what are the factors your hospital looked at when you’re deciding to offer CAM-integrative services?

R: We looked at the successes of other programs. That was big, because we want to be able to not have to reinvent the wheel. So if somebody else had a good formula and they’re doing okay with it, and that was important to us. Financial viability is always going to be a primary consideration for any hospital administrator looking at a program of any type. So, it doesn’t matter if it’s medical or integrative, it doesn’t matter. It’s got to be financially viable, or it needs to lead to a defined benefit where they’re going to be able to measure and see. Measuring success is a huge issue. The fit with medical staff was a big issue that we’re already talked about that. You know, when we decided to move from a consultative model to a primary care model, a lot of our medical staff were a little kicked off about that. Because they thought, well, you’re going into competition with primary care docs, and why would you want to take away patients from me. So a lot of physicians don’t want it to be a primary
care model but would they want it to be a consultative model? No. It’s weird. So have a guy from XXX clinic and they had a consultative program at the time when we were setting up ours. They had a huge medical staff that was not willing to refer to this program. They hardly saw any volume because their primary care docs didn’t want to send any patients to the program. So then they shifted to primary care approach. They built the volume they needed but alienated a bunch of their medical staff that felt they were competing. So it’s a fine line you walk and how you structure your program. The fit with medical staff is a key because it will determine the success of integrating those modalities within your clinical practice. Also, the expertise of the (integrative) practitioners is big. We needed and wanted people that understood integrative medicine. We looked out for a medical director for our integrative medicine program; you don’t know what the heck you’re going to get. We were looking specifically for someone who was a practitioner, had lead a program, and had experience with integrative medicine programs within a medical setting. They’re very difficult to find. That’s why training programs for allopathic practitioners to get them involved in the integrative side is paramount. Things like the UCLA’s acupuncture program, the energy medicine course, the massage therapy course, and anything these practitioners can do to increase their knowledge of integrative modalities are really important.

I: Are considerations are given offering CAM services different from offering any other type medical services?

R: Yes. There’s really no benchmark (for integrative medicine program). If I want to start a clinical program in allopathic medicine, there is benchmark data you can look for. I can find out how much the practitioners make, how many patients they see, how many RVUs they generate, how much the program is going to provide downstream revenue, how much the procedures are going to be reimbursed, how much volume I can expect to see given a certain population. I mean, I got so much data. Go to the integrative side and try to gather that data. It’s like nowhere. How many integrative practitioners do you need for a population of 10,000 people? Who knows. What mixes are going to be perfect for that population? Who knows. How many patients are they going to see? Who knows. How much can you expect to make out referrals? Who knows. You don’t have that benchmark data, so planning is much more complicated for integrative medicine program than it is for allopathic medicine programs. So the different reimbursement structure is huge. I know that if I’m going to get an orthopedic surgeon and they are going to do total joints, I know exactly within 100 dollars how much of the each of those procedures is going to cost me and how much I’m going to get reimbursed for. I can’t do that with integrative medicine. I can’t say that, gosh you know, we’re getting an acupuncturist, and I know there’re going to be a 20% discount for Blue Cross so we’re going to be reimbursed this much. Payers are all different in what they will allow and what they’ll accept (in terms of different modalities of CAM). Even the difference in patients, how do you know how many times the patients
need to see you [the CAM practitioner]. Well, if it’s the orthopedic surgeon doing the procedure I know they’re going to see that surgeon once. It depends on the patients. [In integrative medicine procedures] one patient may require three treatments and the next patient may require ten. So figuring out reimbursement is just a nightmare in integrative medicine services.

I: It sounds really hard for the people doing the planning.
R: It’s incredibly hard. And hospitals are hungry for that data. They look at it and say, gosh, how can we figure out... Even the general data like what sort of financial gain we can expect per patient, we don’t have it. And that’s something we should be able to find out. We don’t have that right now because nobody is really gathering that sort of data. How much we’re getting from each patient in XXX hospital is going to be completely different from YYY hospital, because different programs offer different arrays of services and different packages.

I: Different levels of skills the practitioners have may also create variations in different programs.
R: There’re so many factors. With allopathic medicine, it’s cut and dry. You got some factors in allopathic medical practice, like you got a not-so-productive practitioner, instead of seeing 25 patients a day they see 20. Well, there’re ways to get around that. With integrative medicine, it’s a whole different ball game. It’s very complicated to play.

I: Despite all this, what make hospitals want to offer integrative medicine then? You mentioned earlier that one benefit is to diversify hospital services.
R: It’s the fact that what can we utilize to make our medical services more attractive to our patient population. Down there in YYY hospital, it’s not such of a big deal, because the competition is limited. But, if you get to a competitive environment like the XXX area, or the ZZZ area, it becomes a much bigger deal. Anything you can provide to make your program more attractive and outstanding to people, it’s going to be a big deal. That’s a huge reason why hospitals do it. But there’s also that, gosh, we see tens of billions of dollars being spent by people out of pocket for these services, how we cash in on them. People call me from other hospitals asking how you would structure… whatever. They’re still in the thought process that if we start integrative medicine program, all these people are going to come and dish out lots of money in cash and we won’t have to deal with insurance companies, and we’ll take all that cash we’ll do great.

I: That would be an ideal situation, right? But reality may be…
R: Right. For the majority of hospitals that have committed philosophically to integrative medicine, they’ll figure out a way to make it work even though it’s not a cash cow they thought it would be when they were going into. If they are not philosophically committed, if they’re only into it because of the finance, they’ll shut down the program. The Medical director we got at XXX hospital came from an integrative medicine program that has been shut down. It was in Illinois. It was within a large medical center. They started this integrative
medicine program, appointed her as medical director. It was going [inaudible], I think, for a year, and then they say we’re not making any money and they shut it down. Are you philosophically committed making a program even though it’s not making you millions of dollars a year? That’s an important question hospitals have to ask for themselves. Is it strictly for the finance? Are you doing it to differentiate your services? Or are you doing it because it’s the right thing to do, and you believe in your heart that it’s going to boost the wellness of your patient population? The last thing that is different from other medical programs is the credentialing. The whole issue around credentialing [CAM] practitioners and quality control is a lot different from an allopathic medical program.

I: And we still don’t have a good way to solve that problem.
R: No. I think each institution is doing whatever they feel the best way to handle it. But somebody needs to come out with some sort of criteria for credentialing practitioners.
I: What’s your pick of the top three factors that most influence hospitals’ decision on offering integrative medicine?
R: Besides that whole philosophical question, you know, what are we doing this for? Are we doing it for our patients, are we doing it to differentiate our program, or are we doing it because it’s attractive financially. They need to answer that philosophical question. Other than that, demand, they need to understand the demand of their patient population, because for some patient populations, it’s not a good thing to do. If you go into a small town in Idaho, and try to do an integrative medicine program to a group of people that are manic about their religion or lifestyle … it will not work out well. Simply you got to understand your patient population. Are they open to this? Are they able to be educated about it? Financial viability is important here too. It doesn’t need to be a cash cow, but it needs to be able to support itself.
I: What does financial viability mean here?
R: It can’t be something that takes away from your mission. Our mission is to provide health care for our patient population. If running an integrative medicine program means that we have to shut down an ER, that’s not going to work. It’s got to be self-sustained.
I: Right.
R: And then leadership [of the integrative medical program]. A huge deal. It needs to have somebody running that center who is enthusiastic, who can educate people, who is a practitioner, and who can relate to your medical staff and relate to you administration. If they can’t go, talk to another doc and explain in an elevator speech why integrative medicine is great, don’t start the program. You need to have effective leadership. Just like (allopathic) medical programs, there’re practitioners who are the face of the program and make it all rainbows and puppy dogs. And there’re other practitioners who are meant to go into a room and see patients all day long. They have no gift for
presenting the program; they have no gift inspiring people who are in the program. That’s a huge deal for sure.

I: Is it scary for hospitals to even think about providing CAM services?
R: [Laugh]. Of cause it depends on how big the wound would be. At small hospitals, integrative medicine programs could be a big screw up, because it could alienate your medical staff, it could be of a huge financial drain, you know, your community could involve. So for small hospitals it’s a big challenge. In a big system, it’s much more of an experiment that can be tolerated. You know, you’re not going to kill your business by starting integrative medicine, and you’re not going to alienate all of your docs. So it depends on the size and complexity of the organization. But it’s scary. It’s scary for any organization to start a new clinical program period. And integrative medicine is something we don’t know very well. It was like (that) you didn’t have a good sense of what these things actually were and how are they supposed to work. I didn’t know one could use acupuncture to treat addiction, or Chiropractic manipulations to release headache and tension.

I: It’s a learning and educational process…
R: On the other hand, I can tell you everything you ever want to know about cardiac catheterization because it’s something we’re familiar with. Yeah, entering into the unknown is scary. The more practitioners can come up viable models and methods, the more accepted these programs would be because then they’ll be a known entity.

I: Great. Thank you very much for your time today.
R: You’re very welcome.

Interview #6

I: Hello! How are you doing today?
R: I’m fine. Thank you.
I: Let me give you a little background about what we’ll do here. I’m currently doing a research assessing the factors that influence hospitals decision making to offer complementary and alternative medicine or CAM services. Does your hospital offer such services?
R: Yeah, one time we did offer massage therapy, but mostly for employee wellness. I’m not sure if it’s offered as a service for patients.
I: Yeah, I know some hospitals previously offered such programs but discontinued and some others don’t have them at all. I wonder why your hospital is not interested in providing CAM services.
R: The thing is the reimbursement that hospitals are going to look at. I doubt Medicare/Medicaid would pay any of that. It’s pretty much going to be what’s recognized there.
I: I see. If it’s not covered, then the profit is not going to be there.
R: Exactly.
I: Although some commercial insurance, like BlueCross, cover some CAM services.
R: Yeah, Chiropractic medicine may be covered, but that wouldn’t be something we would use in house, because we tend to treat patients with acute conditions. CAM is more for treating chronic, not acute, type of diseases.
I: right, so CAM may not be proper for in-patient use?
R: Not proper for the kind of patients we get.
I: right, I got it. Are there any other barriers preventing your hospital from offer CAM?
R: I’m sure you have to look at demographics and types of people are requesting these services. Certainly not all treatments are available in all areas. So you look at what’s generally accepted versus what’s generally provided. That would be another barrier.
I: So the low level of demand in your community would be a factor?
R: Right. Also, before we bring a practitioner on staff, they’re going to go through quite a bit of credentialing, verification of competencies, and that sort of things. Who would say one physician is competent in acupuncture, when it’s not generally accepted as medical treatment. How do we determine their competencies? It’s a very difficult thing to do.
I: Right. Only a few CAM modalities require licensure to practice, like massage or acupuncture. Many other modalities don’t. I understand why it’s hard to credential practitioners when there’s no licensing or other governing board overseeing their professions.
R: Right, exactly.
I: What are the barriers specific for your hospital?
R: The reimbursement is number one. And the credentialing issue. It’s very difficult to determine the ability and competency of a CAM practitioner.
I: Is there demand in your community for such services?
R: I’m not sure. I’m new to the community. I just moved here a year ago.
I: Well, when I interview some other hospitals, some of them face strong business competition in their area, and they mentioned that they would provide CAM as a differentiating niche service. What do you think about that?
R: We typically provide services that we think would be beneficial for our patients. For example, we just started a wound care therapy program with Huckleberry chambers. You know that’s a widely acceptable treatment. It’s a proven treatment that we actually have physicians oversee. We’re going to look at all aspects of programs before we implement it.
I: Something safe to start with.
R: Right. We’ll have to do some internal investments to determine if it’s worth implementing. I’m certain we’re going to have a big hurdle right there to overcome with in terms of what’s acceptable and what’s not acceptable, what’s going to be reimbursed and what’s not going to be reimbursed. There’re lots of services we can offer, but our patient is number one concern and our organization’s longevity is number two, it goes hand in hand.
I: Sure. Do you think CAM would be profitable to some degree?
R: I really doubt it. I don’t know how much about medicine you understand. We have primary care physician to refer patients to the hospital. It is the physicians who are going to order these services. It’s going to have to be marketed in the physician community before it would be profitable for the hospital. Physicians put patients to the hospital, but we don’t just start treating them – we would go by physician orders.
I: I see. That makes sense. If physician don’t prescribe such services, then you wouldn’t be able to offer such services to patients.
R: Exactly.
I: What do you think physicians’ attitudes towards CAM in your hospital?
R: I really can’t say. You would get different opinions speaking with different physicians. Some physicians may have been a patient of CAM services. It’s really hard to say. There’s probably a mixed response.
I: If for some reason your hospital decide to start a CAM program, do you think starting a CAM program would be different from starting any other type of new medical service line?
R: I don’t think it would be. I think typically if there’s a need for the service, physician would be first ordering. Of course we would look at the return on investment numbers and that sort of things. I don’t think we would look at it any differently.
I: So what would you look at?
R: The number of procedures that would be ordered in a month, then the cost of bringing in a therapist, any equipment needed for the procedures and so on. It would be a typical return on investment analysis.
I: I see. My guess is that it might be hard to get the estimates of all the numbers though.
R: Sure. What we would do is to speak with the physicians on staff to find out. You admit X amount of patients a month to the hospital, and you order Y amount of services. That’s typically how we get number, the volume is there.
I: Then you calculate the reimbursement of such services, and then determine what profit margin would be. Is that right?
R: Exactly.
I: I see. But the reimbursement rate for CAM services is not great. Many services have to be self paid for patients out of pocket. Is that something interesting?
R: You know, typically “Self Pay” is a bad word for hospitals. It’s something we don’t look forward to.
I: Why is that?
R: If you see a self-pay patient and they are in the hospital and being treated, and the physician ordered CAM services along with the orders of MRI and that’s already 5000 dollars, so what’s going to be the patient’s ability to pay a 20,000 dollar hospital bill.
I: Right. It seems like it’s really difficult to offer CAM services at in-patient setting at least financially speaking.
R: Yeah, exactly.
I: By the way, how do hospitals operate out-patient services?
R: Out-patient services again come from physicians’ order. When patients present to the hospital, we get their demographic information, and their financial information, then we have an order from the doctor to do whatever the test is or whatever the out-patient service is, and then we’ll perform that. But again, the ordering physician has to be on staff and credentialed. We don’t typically just do any treatment. Say, a patient from Dallas was here in Oregon on vacation or something and he came to the hospital needed a respiratory treatment. If the order was from his physician in Dallas, we wouldn’t do the treatment because that physician is not credentialed by our hospital.
I: I see. Besides a licensure to practice, what else are needed to be credentialed?
R: Typically the patient services need to be approved by the board of directors first. Once it’s approved by the board of directors, we would send it through the medical staff of services, the chief of staff and those sit on that board to approve it.
I: How would decision-making process be like for your hospital to start a new line of service?
R: We’ll have to first create an evaluation to decide if it’s profitable. If it’s profitable, then we would go through the governing boards.
I: Great. Is there anything else you’d like to add before we wrap this up?
R: Not Really. Good luck with your study!
I: Thank you very much!
Interview #7

I: Hello! Thank you for taking time to speak with me today. The focus of my study is to learn about the factors that influence hospital’s decision making on providing CAM services? CAM services referred to non-allopathic medicine, such as acupuncture, massage, naturopathy, and so on. Does your hospital offer any of these kinds of services?
R: No, not really.
I: Would you tell me why?
R: Primarily reimbursement issue. What’s paid for is driving by Medicare. Most rural place has over 50% Medicare patients, and the community our hospital serves isn’t any better.
I: Some commercial insurance, such as BlueCross BlueShield covers some CAM services.
R: Our payer mix is about 20% commercial, which actually has been dropping with the current economic downturn. So I think it’s more challenging now than it would’ve been 5 years ago for this type of services, because of the change of economy.
I: Most CAM services are cash paying services.
R: That makes things more difficult, because I think there are fewer people are using their discretionary dollars. Frankly, that’s why we’ve seen a downturn of our out-patient services because people don’t even want to pay deductible or a portion of their insurances, so if it’s elective at all, they’re postponing it. I don’t know if our area may be a little bit more economically depressed than
other areas, but I think in a lot of the rural areas you see a rest of discretionary fund. I think people now are just holding off on their medicine.

I: That would make hospital operation harder, huh?
R: Correct.
I: Besides reimbursement, are there any other hurdles preventing your hospital from binging on CAM services?
R: No, I think that’s primarily it. You do business plans like every hospital does and assess how well these services would perform financially so they can survive. I think our hospital like to develop new services, keep them fresh, and offer the public the newest and latest kinds of services. But they have to be self-sustaining.
I: Sure. Would the considerations given to start a CAM services be different from any other new service line?
R: No. It would be the same process you go through.
I: What would the process be like?
R: You do a cost-benefit analysis.
I: Okay. Could you go into more details?
R: First, who do you think your patient population would be? How many of them are there? If it needs referral, how many doctors would refer the services? If it doesn’t need referral, how many candidates you think you would serve? Then, from there you price how many treatment you would do and what the cost of doing those treatment would be, and you decide within 3 years if it would be viable.
I: Great. Are there any other barriers specific to you hospital?
R: No.
I: Mostly the funding issue, right?
R: Yeah. I think that’s also why most of other places that aren’t doing it.
I: Right, especially during this kind of economy.
R: the economy, really. Everybody is hunkering down a little bit, I think.
I: Do you think credentialing CAM practitioners would be a concern to your hospital?
R: Well, yeah. If the person providing the CAM services wants to become medical staff, then credentialing is an issue. You have to tell me specifically what the service is, because the credentialing depends on what the service is. If the person applies for medical staff, you’ll have to have him credentialed. What the criteria for credentialing are and what’s acceptable throughout the country is something we’ll have to look into and figure out how to set up the credentialing criteria for specific service like that. If the person doesn’t need to be part of medical staff, then it’s not as big of an issue. Just like massage. I don’t think massage therapists have to be part of medical staff. You know what I mean? For acupuncture, if you want to do it independently and just have referrals, then you wouldn’t have to have the credentialing. So it depends on the service. Credentialing is an issue though if you want to become part of the medical staff at the hospital.
I: Right. So if CAM practitioners do out-patient contracting work, then they don't need to be credentialed. Is that what you're saying?
R: Yeah, it all depends on the service. If you have to part of the medical staff, then it creates an issue. Because I'm not sure if there's much credentialing history about how these services providers are credentialed as part of medical staff. If I were to set it up, I would try to avoid going through credentialing process because it is easier without it.
I: How do you avoid that?
R: It depends on the services. It's hard to answer. If it's massage therapy, you don't have to be a physician or PA to do that. It's sort of like a physical therapist. If I had a therapist here providing physical therapy services, I don't need that person to be part of medical staff.
I: Or if a physician performing acupuncture and the physician is already credentialed as medical staff, then it wouldn't be a problem?
R: Yeah, if the physician's license allows the practice.
I: What do you think of your physician's attitudes towards CAM?
R: I think our doctors are pretty open-minded. It's not preferences. It's about nationally what criteria has been set up for different specialties and how do you go by it. We want to be consistent and have standards that match other hospitals. We'll have to do research if CAM practitioners want to get credentialed in certain area.
I: Okay. Do you see any patient demand for CAM services in your community?
R: We have a physician here who manipulations. We have several people here who do massages but I don't know if they're licensed in any way in town. I think we have enough to meet our needs, frankly. I don't think there's population here right now that has a lot of discretionary money. I just don't think it's a good time to develop such type of services.
I: I see. Is there anything else you'd like to discuss today?
R: No.
I: All right. Thank you very much for your time today.
R: Okay. Good luck with your study.
Interview #8

I: What was the primary reason for your hospital to consider offer the program?
R: I think we are always looking to different ways to grow the business. You reach plateaus in your revenue growth, and if you are not looking to add different or new services, you're never going to add additional revenue over above what you get out of your services. Your volume increases, and your rate increases; there are years when your expenses will exceed what you are able to do just from those two items, and when revenue line is going like that, it’s kind of flat, and you got expense line going like that, very steeply. You'll get into red when those two cross. So, you always need to be looking to different ways to grow your revenues in addition to volume and rate increases. So, this was fairly low capital investment alternative to look at, to start the program. Its risk rests, I think, in its credibility.
I: I understand what you’re talking about. It's still fairly new. There’s some research supporting that, but not a lot.
R: You are right. There’s quite a bit of research out there that supports it. But at same time, it’s a little bit more on the fringe. So you take a look at that. In addition you take a look at your market. Now if I was out in the eastern Oregon, I don’t know I would’ve done this, because eastern Oregon has a much more conservative market. Where this market here is much more interested, I think, in the alternative medicine. We had Dr. XXX who’s had acupuncture practice in this community for years, and was able to make a very good living of it. We’ve had other different types of alternative therapists (in this community). So, you know, it seems to fit the market. Then it’s just bringing all the elements together in one spot, and looking to start it.
I: So, it seems to me that consumer demand or patient demand could be also the reason to start the program?
R: I think that’s fundamental. If you don’t think there’s consumer demand to start a program, you can invest in it, but is not necessarily going to be successful. In terms of two stereotypical American acts. One was that, on that negative side, you can bring a horse to water, but you can’t make him drink. So you built it, and they may not like the idea. Or the other one is, if you built it, they will come. So you have to decide which of those camps you are in, and which one is your community. If you built it, they are going to come? Or you built it, and they’re not going look at the horse and say I don’t want to have anything to do with it.
I: Is market competition a factor when we decide to bring out this program?
R: ZZZ [city] is so unique in that. The fact is XXX [hospital] is rather dominant in this area. But I would think that if you are in a very competitive market, say like YYY [city] market or any other major metropolitan market, this would be a service you could use to differentiate yourself from your competitors.
I: Do you think (having the service) would improve the public image of a hospital?
R: I think so. It shows the hospital is open to different styles and different ideas. And not one method of primary care needs to fit all of us. I mean, when it’s come to primary care, we’ve not been given too many choices. You kind of having a typical model that is: you’ve got 5 or 6 either internists or pediatricians in a box. And you come to them. This is really quite a bit different from that. You got a couple of primary care docs, acupuncturists, naturopath docs, psychologists, and a whole platter of other individuals. It was, I think, on NBC or CBS news that some major clinics just started a program kind of like ours. (Patients) have opportunity to see a wide variety of practitioners, both conventional and alternative providers.
I: You talked about credibility issues earlier. Was it a concern for you when you started the program?
R: I think it is a huge concern. It's extremely difficult to gain trust and loyalty within a community. It is altogether too easy to lose it. You can lose it over night by making one misstep and putting doubts in some individuals. You’re dealing people’s lives. If they don’t think you have their interest at heart, and you are not capable of doing a good job, no amount of marketing is going to help you. So it is that basic underline senses of confidence that the employees (of the organization) and the public need to have in your organization to make it successful. So you don’t ever want to jeopardize that. This is probably the greatest good will business successful factor that any community hospitals, regional hospitals, or trauma center. It’s that aura of what it is and what it provides to patients who come there. So you want to make sure you guard that trust really religiously. You hire good people. Whatever you do, you do well. You don’t have to do it in exorbitant standards, but you do it well. You need to be able to balance what the community’s expectations are to you as
an organization and what you provide. You certainly don’t ever want to come short of their expectations, but you don’t also want to go over the top. The example I can give you is the R [hospital]. There’s some criticism within the communities of greater XXX area and XXX County that the hospital is extremely ostentatious. You know, in today’s market, all the things happening to the price of health care. People have said that when they walked in there and their comment was “I have not stayed in as nice of a hotel as this place is.” They don’t see that as equating to good quality of care. So if you have that doubt that place in the back of somebody’s mind that if they spent money that way, what else would they be willing to do that may not be quite right? I don’t blame XXX [hospital] to create a very rich environment. It’s a very delicate balance the community’s expectation with what you provide. Probably over time as people adjust and get used to it, they won’t think too much about it. You just don’t know what this is going to end up with. It could end up to the point where health care rates in that market would become extremely high because they have to pay for the debt. And then XXX hospital probably would be paying for that on the public relation side for maybe the next 10 to 15 years.

I: When you first decide to offer the service, did you look at if the service fit in the mission or style of our organization?
R: It’s part of the evaluation that we go through. When we start a program, we do give the program some consideration whether the program fits in the mission. If it does, how do you see it fit in the mission? Then we look at from performance standpoint. What is the revenue and expenses associate with it. We think it’s a go or no go. If that looks to be positive in both of those aspects, then next thing we’ll do is to start taking the concept to the board and ask them what do they think about it. They are eyes and ears in our community. They have a good feel of the pulse of what happens (in the community). Sometimes they say yes, sometimes they say no. Sometimes they say well maybe if you did this way. So we’ll have that conversation. Then we’ll come back, re-tool it, really put a lot of meet on the bone relative to the performance, and bring it back to them for consideration. And then ultimately it will probably end up in the budget. Now there have been some programs where we have gone in and said it certainly meets the mission, it looks like it’s going to perform out for us, but we don’t think it’s going to have enough volume so the organization is going to be able stay (profitable), and it’s kind of marginal volume program and so it’s probably it’s the best we don’t do that.

I: So basically the board makes the final decision?
R: The board will make the final decision. But we’ll make our recommendation.

I: From what I know of other similar programs, the alternative medicine services have not yet to generate big revenue. Was small start-up cost of this kind of program a factor to consider when we decide to start our program?
R: It’s one of the factors. It doesn’t require the same level of capital investment that most hospital programs require. We kind of started off on a shoestring budget. A little bit of space, a few practitioners, and the business grew to the
point where the space is no longer adequate. So we had to make a decision on whether to continue to grow the program or stay where it is. We took a look at it, and asked what some of the things we could add that would make it more financially profitable, met the needs of the community, and took that next step. So it was the addition of more practitioners that people are calling for, and a retail space. But in order to do that, it really requires the space. That was why we got the new building. It’s a service that we think the community appreciates and a program we think we’ll grow. It will probably never be like radiology which is a major profit center, or surgery, or anything else like that, but it extends the reach of the organization into another area where the community is underserved or they are going other places for their care.

I: how important do you think the support of physician for alternative medicine plays in the decision to offer the program?
R: Well, again it’s to some extent market dependent. If we were starting this program and the market is over saturated with physicians, they’re going to pull some patients away from us. Our physicians are paid on productivity basis. They would be upset with us, because regardless it was integrative medicine practice, which is boutique type of practice, or not. They would’ve been upset about it because we would’ve hitting them financially. But since the market is not over saturated, there’s under supply of physicians. We don’t have that issue to worry about. The next thing that you have to worry about, as I said before, is the trust issue and whether they will do a good job. We rely on Dr.XXX and Dr.YYY to recruit good practitioners that have good clinical skills. There’s nothing that can get in the way of our relationship with physicians but to have somebody that has marginal clinical skills. Physicians are trained first and foremost to do their best for their patients. If they don’t think somebody that is doing the best for their patients, they’re going to react in some way. They’re either going to let you know, let the patients know, or let the community know. They’re going to do something.

I: Do you find it difficult to get traditional trained docs to accept alternative medicine practiced in a hospital setting?
R: I don’t think it’s as tough as it used to be. Like I said, we had Dr.XXX, and Dr. YYY. Dr.YYY is an anesthesiologist. He’s done acupuncture for more than 15 years. The general exposure fosters the acceptance to it. As long as you can assure you can do a really good job, I don’t think it’s a big issue now.

I: You know, many health insurance plans do not cover a whole lot of alternative medicine practice. Was it an issue when we first consider starting the program?
R: You do take that into consideration. That probably throws hospitals into more of a loop than trying to decide to add some other programs, such as a catheter lab. Because you know what your reimbursement is, you know what your deductions are and revenues are. You know your revenue stream pretty well. Integrative medicine is more of a retail model; that’s stretching us. It’s an area of business that we don’t have as much experience with. Because it’s
more of retail model, the cash concept, the limited reimbursement. So we just can’t apply our formula and say here’s a million dollars worth of revenue, you’re going to have 40% worth of deductions, and here’s your growth for revenue. You can’t apply that. It doesn’t work that way. You might have a million dollars worth of revenue, but you don’t know what those deductions are going to be. Are they going to be 20%, which will be huge difference from the bottom line? Or will it be 50%?

I: Every insurance plan is so different.
R: Yeah. That’s the area XXX might be able to help you. He’s familiar with all those reimbursement models and how they’ve been put together, and what’s research showing on the reimbursement side.
I: Do you think more research evidence showing the efficacy and safety of alternative medicine will help more?
R: I think so. Yeah. I think the more people know about it as an alternative, (the better the business will grow). Again, it’s not that one-size-fits-all model in health care anymore.
I: Is the existence of research evidence in alternative medicine a factor we considered when we first decided to start the program?
R: Yeah. It’s one of the reasons you can use to justify doing this.
I: Do you see any difference in the process of decision making between adding any type of conventional service lines and adding integrative medicine program?
R: I think the only difference that you would have would be “is this something that the community wants, is this something that going to be accepted, and is this something we’re going to do well.” Now, we ask that question to our entire program, “Can we do it well?” But you’re asking it a little differently with integrative medicine because the question in order to do well a little bit different. Everything from the types of people you recruit, business model is different, and so the outcomes in terms of quality of care could be impacted because of that. I think first and foremost, you need to have a good solid understanding about if we build it, will they come? If we build it, is it something the community going to accept or reject.
I: So market assessment is important.
R: yeah, you want to do a survey on what the community is saying. Say, we’re thinking about development of integrative medicine as a local business. These are the services we’re going to provide, this is the costs, and would you be interested in something like that? Will your insurance reimburse for it? You can find a lot of information from the survey.
I: So those are the differences.
R: I think so. You wouldn’t need to do that type of community survey for a neonatal unit, or a catheter lab, or a heart program, because you know what your market is, you know where your cases are going. The clinical natures of them, and their business models are much more defined and development. This is more of a risk. When you get into the retail side, it’s much more of a risk.
I: this is different from what we usually do to run a hospital business.
R: (The way of hospital operations) it’s pretty defined. I agree. It’s a cookie cutter. I won’t say it’s easy, and I don’t mean to imply that by saying cookie cutter. It is a known set of variables for the most part. Anytime you get into more of a consumer retail model, even an urgent care center borders on the same thing. Do you put it in the right location, are the staff right, or are the hours right? Urgent care centers are kind of on the same line. Maybe it’s not quite as a new territory, but it’s somewhat similar.
I: We talked about all the factors, like market demand, credibility, insurance and so on. If you have to rank them, what are the top 3 factors that influence the decision-making to start a program?
R: The top 3? Can you do a quality?
I: Quality of the program? Okay.
R: [Silent. Thinking]
I: In terms of the factors affecting the decision making mostly…um…
R: Can you do it from a quality standpoint? Is the community willing to accept it? And then can we deliver that financially? I think the answers to the first 2 questions are yes, and the answer to 3rd question is going to be a yes also. I guess, just talking about this, (and) one area you might want to look at is that some organizations may think the development of integrative medicine program is too risky. So you may want to assess how risk adverse some organizations are. Some organizations may say that it’s way outside of what we see our mission to be, it’s too risky, and it’s not something we want to do. Other organizations may say this is really part of our core competency. In terms of risk, we’re willing to go outside and … um…let’s see what would be an example of extreme risk that would be related to health care… run a series of chiropractic offices. That would be very risky and not traditional. But some organization may say, look, we wanna have chiropractic, we wanna have Naturopath, we wanna have dentist, we wanna have acupuncturist, we wanna have psychologist, you know, all that planter of providers that are kind of outside the walls of a hospital, and in addition, oh yeah, we’re gonna have an integrative medicine program. If you’re going to have a line of risk, chiropractic office would be most risky, integrative medicine would be in the middle, and the hospital might be the least risky item here at the right hand side.
I: Sounds like it’s also related to how much resources a hospital has and willing to put into new programs.
R: Yeah! If you are really flushed with resources, chances are that where you draw a line for risk is really different. Don’t get me wrong with XXX [hospital], we’re not really flushed with resources. [Laugh] We just take a risk every now and then. Say, if we need a new catheter lab, we probably will say ok we’ll go ahead with that catheter lab.
I: I see. For those uncertain things, we’ll be more hesitating to …
R: Yeah, more hesitations. Where that risk is higher, we’ll hesitate longer and try to time the market better.
I: [Laugh] it’s hard to get a loan these days.
R: [Laugh] it’s hard to get cash.
I: Is anything else you would like to add to this topic?
R: So your research question is gonna be what prompts hospitals to develop integrative medicine program?
I: Yeah, along that line.
R: You know, the way hospitals make decisions, a lot of that has to do with resources, going back to the issue we just talked about. What projects within their core business rest in front of CAM decision? If you only have one or two major projects that rest before CAM decision, that CAM decision may just fly right in and be number 3. But if you have to do the renovation on a major part of your hospital, you’re recruiting 25 new docs, or just anything that has large capital implications, CAM decision may move from 3rd on the list down to 15th in a hurry. So it has to do with where the organization sits with their strategic objectives.
I: That makes sense.
R: And, you may have somebody on the board, or on your management team that says, CAM may look like it’s the 15th, but I see it and for this and that reason we need to bring it up to, say the 7th. You know, good organizations will have that discussion. It will frequently come and go, and priorities will change based upon the environment [inaudible] I think you have that given or taken.
I: Sounds great. Is there anything else you’d like to add?
R: Not really.
I: Well, thank you very much for your time. I so appreciate you sharing your perspectives on this topic today.
R: You’re very welcome. Good luck with your study.
Interview #9

I: I’m so excited to have this opportunity to speak with you. I’m doing a study assessing hospital’s opinions on adopting complementary and alternative medicine, mostly to look at what are the driving forces for hospitals to adopt CAM and what are the barriers that prevent them from offering CAM services. It looks like that your hospital currently does not offer CAM services, but I heard it’s planning to do so. Correct?
R: Yes.
I: Is it going to be offered at the Cancer center?
R: Yes.
I: Okay. Would you tell me what stage are you currently at in the planning process?
R: Well, we’re at very preliminary stage. At the same time there are some already existing aspects of complementary medicine that are already being offered. For example, in relation to our cancer patients, there are yoga classes, many classes for nutrition, etc. But in a general definition of CAM services, having acupuncture, massage, naturopathic and alike, those are only in a very early stage. They [the CAM services] are mentioned in our longer-term business plan, but they need to be analyzed and discussed with physicians and other providers in our communities, and determine if we should proceed ahead with that. So it’s definitely on our tar map, if you will, but in line behind a number of other planes waiting to take off.
I: Yes, I see. What is your assessment on why XXX hospital is willing to offer CAM services?
R: Well, if you look at patients’ experiences across healthcare system through their journey. Let’s say it’s a cancer journey. I think everyone recognizes the holistic approach. I shouldn’t say everyone, but most of providers recognize the holistic approach. The complementary services have been ever improving their reputation and have been effective, even though there’re not a lot of scientific based studies. That’s why many physicians tend to shy away from these services. As consumer demand for these services rises, as the popularity of these services increases, as more studies have been done to show their at least the symptom management effects, more physicians are willing to consider them. So, I would say XXX [hospital] is not the bash of liberalism. It tends to be more conservative from a provider’s standpoint and as a community. Therefore it’s not surprising we lag behind other market when starts such service because they are cutting edge in a way.
I: Right. It is. In Oregon there are only few hospitals that have CAM fully integrated with allopathic medicine.
R: Right. We will analyze that. I know they have such services at XXX [health system] and some at YYY [hospital] and alike. We are a like-size hospital as those larger hospitals. So we'll be analyzing those programs in detail as to why they exist and how they impact the patients as we present the analysis to physicians and decision makers.
I: Who are the decision makers, beside the physicians?
R: Well, the way cancer services are organized here there’s something called cancer service line. The service line has a director. I’m the director of the cancer services here. And then there’s physician counterpart as the medical director, Dr. XXX, who is actually seeing a patient I just checked on her. She is taking away by a busy case loads today. She and I share the management responsibility. We have a steering committee of physicians and other management people that guide cancer services decision-makings. But it tends to be collaborative. Of course the senior management of the hospital would be involved, certainly if you’re requesting capital funds, re-modeling fund, or operating fund to start a new program that is not projected to be immediately profitable in the beginning. If you have to look at program subsidy and the alike, you go to senior management of the hospital for those decisions. But the business plan comes from us. We would be the one that ask for it.
I: Interesting.
R: Yeah, decisions for capital or operating funding come from the hospital, but the business plans are done at this level.
I: So what factors are you looking at during the planning stage?
R: Well, we generally start at market analysis, the size of our cancer service market penetration, then do a market share and data analysis. Then that moves to draft a plan, meaning what’s financially responsible if we were to have complementary medicine services under our existing management structure or you hire a new management person and then what services would be offered. So, you have to project demand, the financial piece. It’s tough for hospitals manage to support new services unless they’re contributing towards a financial basis. So the financial piece is big for most hospitals and certainly is here.
I: Do you think CAM service is going to be profitable?
R: I don’t know. My guess is not very. Let’s say, my inclination about it is marginally. I would say maybe you could make it break even.
I: Is there already a high demand for CAM services in your community?
R: I think we'll have to cultivate the demand. I certainly don’t know anyone asking for it. Now, there’re such providers in XXX [city], so undoubtedly cancer patients are getting such treatments on their own. But I don’t really know how penetrated those services are in our cancer community. Like I said, when we get there our first step is to analyze the demand.
I: Right. How would you analyze that, I’m just curious. Where do you find the data?
R: You can find it from databases; also you can do survey or focus groups. It’ll be a combination of those things. There’re also advisory services. Our hospital is a member of the advisory board. They have over 2000 hospital clients and they share experiences from other places. We’ll send queries to them asking about what is the average volume of complementary medicine programs for a community of our size and so on. They can provide you the starting information.
I: How competitive of cancer services in your community?
R: Somewhat. You know, with life-threatening disease, some people are thinking the best place is the closest to home; many others are thinking we want the best services. If people don’t believe they can get the best service here, they would readily travel to YYY [city] or other places in the country depending on their financial status. We know we keep something like 75% of the market for cancer here. It might get as high as 90% if you add ZZZ [area] into that. So I’d say somewhere between a low of 60% and a high of 85% of market share if you add ZZZ [area], because we have a relationship with ZZZ [area]. The ZZZ [area] physicians use our facility to do their surgeries and typical our-patient cancer services. Anyway, we have a fairly high market share. We’re also in a process of analyzing that.
I: Do you think by adding CAM services will make your cancer center more attractive to patients?
R: Yes, I think so.
I: Will the CAM service be a differentiating point for your center?
R: Yes!
I: Are you aware how the insurance coverage for CAM services is?
R: No. It’s usually not great. I know some insurance covers some of the CAM services, but you have to count on patients to pay most of it out of pocket.
I: Will that be an issue?
R: Absolutely. It’s a huge issue.
I: How do you deal with that?
R: It’s going to be factored in the analysis. Let’s say, if you project $300,000 in revenue but only $100,000 of that is collectable. Then that will impact your bottom line. As I said early on, financial analysis of starting these services is a key factor. If you project you’re going to lose $200,000, then the hospital has to decide to subsidize it for other reasons, other than financially profitable business. There are many competing initiatives for that type of funding.
I: Okay. So, how do you make your case strong enough to compete for the funding?
R: Well, cases are made from the standpoint of clinical effectiveness, services excellence, and financial performance. Most organizations will have some forms of “the big three”. So you make your case, if it’s not a financial winner, then the clinical effectiveness has to be so strong that “someone must have”. If
we are losing market share because people shopping for cancer services in our community use CAM, and they think we don’t have cutting edge cancer services because we don’t have CAM, then we can make our case from the service standpoint.

I: Good. That’s very interesting. So it’s not all about profit.

R: No.

I: Have you thought about the credentialing process? Are you going to hire CAM practitioners as part of your medical staff, or just use contractors?

R: I don’t know. We’re not that far enough in our planning. We’re looking for undoubtedly the highest credentials possible, because that’s the way how things are done here at XXX hospital. But in this particular instance, I don’t know what that means.

I: Okay. Will CAM offered at in-patient settings, or outpatient settings?

R: For CAM services, mostly out patient. That doesn’t mean they can’t do consultations for in-patients. They might. But that would be a small piece I’d imagine.

I: You know, XXX medical center has acupuncturists on their medical staff for in-patient cancer services.

R: Yeah, they’ve been working on this for about 20 years though. Their history of how they put all that together goes way back. They’ve been integrating this type of thinking with their medical staff for many, many years.

I: What do you think your medical staff’s attitudes towards CAM?

R: I’ve heard some commentaries that some people oppose it in principle because it’s not evidence-based, in their opinion. Some people are supportive, like “why not, it can’t hurt”. And some others are saying “we will support it if it doesn’t conflict with patients getting their proper treatments” in their mind, their definition of being “proper”, or “as long as it doesn’t create false hope”. It’s a very controversial area. You know, there’re a lot of “Charlottes” out there in the world, and there’re certain programs people fly up to and do all kinds of things and spend thousands and thousands of dollars that doesn’t prolong their lives at all. Sometimes you hear one-in-a-million miracle cure, but…. There’s that whole range of thinking around this. And that’s all opinions expressed about this from our medical staff.

I: Will it be a hurdle for you if you want to bring in more CAM services?

R: oh, yeah. Definitely.

I: Are there any other barriers you can foresee as to start the CAM program?

R: Oh, just the competing initiatives. It’s a big one.

I: what does “competing initiatives” mean?

R: Oh, recruiting a next physician, adding the next cancer dietary program, adding the next piece of equipment, re-modeling our lobby, it goes on and on and on. For such an initiative to land on the priority list, you have to have a really effective organization that would view it as a high priority. I’ve been here for a year. Complementary medicine program is definitely on the list, but has
not made to the top-10 list yet. I'm guessing at least another year before it would.
I: Who is pushing on this?
R: I don't think anybody is pushing. It's more like the key decision makers are aware that the complementary medicine is out there and it's popular in certain patient segments, and should look into it.
I: So the competing initiatives are competing for funding?
R: No, competing for time. For example, if you are my advisor who says we should stop doing but start planning for complementary medicine programs, it will be competing for executive planning time. That's what I'm saying about competing initiatives.
I: Okay, that's the main issue right now.
R: For us, it is the main issue. It hasn't risen high enough on our priority list for us to pull an analysis.
I: Right. Is there anything else you'd like to add?
R: No. I think I have told you about everything I know. I hope it's helpful for you.
I: It's very helpful. It's interesting and a rare opportunity for me to talk to someone whose hospital is in the initial planning stage of start a CAM program.
R: Good. I'm glad it's helpful. I wish you a good luck in finishing your project, and calling back if you have more questions.
I: Thank you so much.