PEER REVIEW HISTORY

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ARTICLE DETAILS

TITLE (PROVISIONAL)	Referrals to Integrative Medicine in a Tertiary Hospital: Findings from Electronic Health Record Data and Qualitative Interviews
AUTHORS	Griffin, Kristen; Nate, Kent; Rivard, Rachael; Christianson, Jon; Dusek, Jeffery

VERSION 1 - REVIEW

REVIEWER	Benjamin Kligler Mount Sinai Beth Israel USA
REVIEW RETURNED	03-Apr-2016

GENERAL COMMENTS	This is an informative and interesting paper on an important topic. Page 6 line 29. This is confusing re referral process—first states that these were done via calling, then via HER, and then there was a transition to all EHR-based? Need to clarify. Page 6, line 39 Triaged based on what criteria? Page 8, line 42. This is confusing because you state that data saturation was reached when no new codes emerged—you mean no new themes I think, need to clarify this. You do explain in the Methods Appendix but should be clearer in the paper itself. In the Methods Appendix you also explain that the reason you stopped before reaching your target of physician interviews was because you were coding and doing preliminary analysis of the data while the interview process was ongoing and you concluded that you had reached data saturation regarding the physician interviews—this should also be clearer in the body or people will ask why you had a goal of 24 docs and stopped at 15. These are important enough issues to be at least briefly mentioned in the main paper as opposed to only in the Appendix in my opinion. I would include the interview guide as a Figure in the main article; it is helpful to readers to see what the questions were that subjects were responding to. Table 3: please clarify what the p-values refer to here—significant differences between what and what exactly? Table 4—I find it confusing having numbers representing only half of 2012 and then all of 2013 and 2014—makes it look like referral numbers increased dramatically when in fact they were pretty stable.

	I would either include all of 2012 or omit that year. Also since you provide p-value in Table 3 maybe need to comment on whether any of the differences in Table 4 reach significance? Another option is to omit p-values from Table 3 in my opinion. Methods—I believe a brief mention of the analysis strategy in the Methods section is appropriate. You do describe this in the Appendix but I feel it should be at least mentioned in the paper. Also in the Appendix you describe inductive analysis and grounded theory strategies as having been used—it seems to me like it was just the former. Would either omit reference to grounded theory or elaborate on how this approach was included in the analytic strategy. Page 14 line 36 The statement starting “It is also possible that…” seems to be to be author’s conjecture rather than based n data. If this is the case this statement belongs in Discussion rather than Results section. In my opinion in reporting qualitative results it is crucial to only include in the Results section statements which can be explicitly backed up by actual quotes. Page 15 line 46 The comment preceding the quote here regarding decisions being “nuanced” is too vague and not really related to the quote. The quote has important information re the importance of complex patients and polypharmacy as motivators in referral—I would specifically mention these issues rather than the more general introduction to this quote currently provided which does not do justice to the content of this quote. I wonder if other participants referred at all to the value of the IM therapies as reducing the need for medications, which might be an important specific point to call out as a reason for referral if that is supported by the data. Page 17 line 20 Need to clarify whether the statement “(who typically did not know about the referral)” came from the data or this is conjecture. If the latter this should go in Discussion, Page 18 line 35. Would be useful to offer a quote to support this statement if possible. As this is an important point regarding inpatient referrals—how often do docs concern about medications or other medical issues come into play? Page 24 line 30 This sentence is unclear in my opinion—what are you saying here? “The finding that projected or actual length of stay has a bearing on whether a patient is referred for IM may not be useful for a facility with a greater ratio of IM practitioners to patients, but it is likely to be a common challenge in programs similar to this one. “ Discussion: I would be interested in seeing a comment somewhere about your opinion on the use of standing orders vs. active referral based on your data. Also without wanting to be too self-promoting you may want to consider including the following reference in your discussion of previous literature Kielczynska BB, Kligler B,^ Specchio E. Integrating acupuncture in

	an inpatient setting. Qual Health Res. 2014 Sep;24(9):1242-52. PMID: 25079502

REVIEWER	Malcolm B. Taw, MD, FACP Director, UCLA Center for East-West Medicine - Westlake Village Associate Clinical Professor UCLA Department of Medicine David Geffen School of Medicine, UCLA USA Several years ago, I had been invited by the former Executive Director of the Penny George Institute for Health and Healing at Allina Health to speak at a conference organized by them. As such, I have some familiarity with the inpatient integrative medicine program and have met several of the staff, including Jeffery Dusek.
REVIEW RETURNED	20-Apr-2016

GENERAL COMMENTS	This study by Griffin and colleagues investigates referral patterns for integrative medicine services within an inpatient setting using structured qualitative interviews and reveals driving factors that influence the process. The study is rigorous in that it reports several of the necessary items as delineated by the Standards for Reporting Qualitative Research (SRQR) and Consolidated Criteria for Reporting Qualitative Research (COREQ). Grounded theory using an inductive approach from electronic medical records data is appropriate. The emerging themes as supported by interview findings are of interest given the dearth of research in this area. However, there are some areas where the manuscript can be strengthened. Definitions: Suggest defining “general IM consult” vs. “acupuncture consult”: The difference between general IM consult and acupuncture consult may seem obvious, but should be briefly described to clarify. Can general IM consult include acupuncture? Please define “IM services” as some readers may not know what this specifically entails. Tables: For Table 3 – it is unclear what ‘Referral for IM services’ describes. I assume this describes the total of both “general IM consults” and “acupuncture consults.” If so, please make explicit. Please briefly describe how you reached your ‘p-values’ as I do not see any description of statistical analyses in the body of the paper. Though there is a section on qualitative data analysis in the appendix, it would also be good to have a brief explanation in the main manuscript. Table 4 states frequency of ‘integrative medicine referrals’ – again, is this a combination of both “general IM consults” and “acupuncture consults”? Table 5 is a little confusing. The title is “Median time from first referral until contact with an IM practitioner” but all the subsections

	do not seem to apply to 'contact' with an IM practitioner. Does 'time until first acupuncture referral' and 'time until first general IM consult referral' describe the time from hospital admission to actual placement of the referrals or contact with a practitioner? Also, it is not clear what 'Time until first referral' means – I assume that this is the time until either 'first acupuncture referral' or 'first general IM consult referral.' If so, please explicitly define. Would suggest perhaps separating out into 2 tables for clarity (the first table as "Median time until placement of referral for IM services" and another table on "Median time until first contact with IM practitioner"). Please also define Q1 and Q3. Per SRQR/COREQ checklist items: Please identify the research paradigm used (e.g., postpositivist, constructivist/interpretivist) Would suggest including a diagram or schematic showing intention to interview and dropouts/reasons (I see there is a description of this in the appendix, but it would be good to briefly describe this in the main manuscript). Please briefly discuss other 'salient contextual factors' that can potentially influence referral patterns as well as affect generalizability and transferability, such as: 1) Amount of prior education for referring providers about IM and role of IM services. I know that there was some discussion about this under the section "Desire for better education and information about IM." However, was there ever any prior "in-servicing" sessions, presentations or annual conferences offered to inpatient clinicians, staff or administrators? Could this affect referral patterns? 2) Executive leadership involvement. How does this potentially affect administrative and hospitalist 'buy-in' and hence referral patterns? The previous Executive Director of the Penny George Institute had training in holistic nursing – was this a factor in getting "buy in' among nurses, given that much of the referral process seemed to be "nursing driven"? Would this affect referral patterns? 3) Impact of the lack of physician involvement as part of the IM team. Are there any implications, whether positive or negative? Could this be a factor that can affect the referral process, given that many of the interviewees were physicians? Could this be a reason why much of the referral process seems to be "nursing driven" and less "physician driven"? 4) IM services at no cost. In the Methods section, under "Study Setting" the authors state that IM services are "available to all inpatients without cost." Can this affect referral patterns? Also one of the exemplar physician quotes states "And so, after the acute phase, there's this other phase where it [IM service] is particularly necessary and that's where it becomes a resistance, is that you can offer something in the hospital, but then, because of financial issues, the patients can't keep it up." Please briefly discuss the implications of inpatient IM referral patterns for services that are free. Please also include a copy of the qualitative interview template as a supplementary file.

REVIEWER	Suzanne Grant Western Sydney University, Australia
REVIEW RETURNED	01-May-2016

GENERAL COMMENTS	The paper is an excellent report on the referral process for integrative medicine services in a large hospital. Although this is an area of specialist interest, there are a growing number of hospitals now offering or considering such a service. Perhaps a little context on where this hospital sits with similar international undertakings in this area would be useful (prevalence). The paper provides appropriate context for studies of referral processes. Well written and engaging paper.

VERSION 1 – AUTHOR RESPONSE

Reviewer: 1
Reviewer Name: Benjamin Kligler
Institution and Country: Mount Sinai Beth Israel, USA Competing Interests: None

This is an informative and interesting paper on an important topic.

1) Page 6 line 29.
This is confusing re referral process—first states that these were done via calling, then via HER, and then there was a transition to all EHR-based? Need to clarify.

This paragraph on page 6 has been revised in several places to clarify the timeline of changes to the program.

2) Page 6, line 39
Triaged based on what criteria?

The triage process has been described in more detail, including a reference to a 2015 publication that details the experiences and perspectives of the IM practitioners (in which they describe triage, among other features of the program): “The triage process happens daily at a morning staff meeting before patient visits begin and is based on a system of flags from the patient’s EHR for symptoms such as pain, anxiety, nausea, or bowel dysfunction. Notes from referring providers are also considered in decisions about which patients will be seen, and by which practitioners. The triage process and decision-making factors affecting it are described in more detail elsewhere from the perspective of IM practitioners at ANW.10”

3) Page 8, line 42.
This is confusing because you state that data saturation was reached when no new codes emerged—you mean no new themes I think, need to clarify this. You do explain in the Methods Appendix but should be clearer in the paper itself.
In the Methods Appendix you also explain that the reason you stopped before reaching your target of physician interviews was because you were coding and doing preliminary analysis of the data while the interview process was ongoing and you concluded that you had reached data saturation regarding the physician interviews—this should also be clearer in the body or people will ask why you had a goal of 24 docs and stopped at 15. These are important enough issues to be at least briefly mentioned in the main paper as opposed to only in the Appendix in my opinion.

We agree with the need for more clarity on our methods. “Codes” has been corrected to “themes.”

This section has been augmented with material from the appendix in order to be more specific about intended recruitment and final numbers of interviews.

4) I would include the interview guide as a Figure in the main article; it is helpful to readers to see what the questions were that subjects were responding to.

We agree with the reviewer that the interview guide should be included. Due to the length and to there being multiple interview guides for multiple interviewee types (one for physicians/nurses and one for administrators), we are taking the suggestion of Reviewer 2, comment 9, and including the interview guides(s) as a supplementary file.

5) Table 3: please clarify what the p-values refer to here—significant differences between what and what exactly?

Per this and the following comments, we have removed p-values from this table (now Table 2).

6) Table 4—I find it confusing having numbers representing only half of 2012 and then all of 2013 and 2014—makes it look like referral numbers increased dramatically when in fact they were pretty stable. I would either include all of 2012 or omit that year. Also since you provide p-value in Table 3 maybe need to comment on whether any of the differences in Table 4 reach significance? Another option is to omit p-values from Table 3 in my opinion.

We have decided to omit this table, as well as what was Table 2 in the original submission. We agree with the reviewer that the tables including half-years were confusing in the context of this paper.

7) Methods—I believe a brief mention of the analysis strategy in the Methods section is appropriate. You do describe this in the Appendix but I feel it should be at least mentioned in the paper. Also in the Appendix you describe inductive analysis and grounded theory strategies as having been used—it seems to me like it was just the former. Would either omit reference to grounded theory or elaborate on how this approach was included in the analytic strategy.

We agree with the reviewer and have added material from the appendix to the section and have omitted the reference to grounded theory.

8) Page 14 line 36
The statement starting “It is also possible that…” seems to be to be author’s conjecture rather than based n data. If this is the case this statement belongs in Discussion rather than Results section. In my opinion in reporting qualitative results it is crucial to only include in the Results section statements which can be explicitly backed up by actual quotes.

We agree with the reviewer on this point and have moved a version of this statement into the third paragraph of the discussion (page 27) with more clarifying language: “We found that projected or actual length of stay can have a bearing on whether a patient is referred for IM; however, we must interpret this theme cautiously. While the tendency to refer longer-stay patients may be related to an operational delay in service delivery that would make short-stay patients less likely to be seen, it also is possible that chronically ill patients with longer stays may be referred commonly for IM simply because providers work with these patients longer and have more time to consider what combination of conventional and IM approaches may help them.”

9) Page 15 line 46
The comment preceding the quote here regarding decisions being “nuanced” is too vague and not really related to the quote. The quote has important information re the importance of complex patients

and polypharmacy as motivators in referral—I would specifically mention these issues rather than the more general introduction to this quote currently provided which does not do justice to the content of this quote. I wonder if other participants referred at all to the value of the IM therapies as reducing the need for medications, which might be an important specific point to call out as a reason for referral if that is supported by the data.

The reviewer's point is well taken here about the questionable connection between comment and quotation.
We have replaced the overly vague lead-in text with the following text, on page 17, to highlight the importance of complex patients: "Patients with complex sets of circumstances and conditions were frequently mentioned as those whom providers might refer. For example, one physician described working with complex patients who are being treated with multiple medications, and the hope that non-pharmacologic IM treatment might provide additional relief without drugs:"
We revisited our data and found more instances of this theme; thus we added the following text after the quotation: "Several respondents from each of the three provider groups mentioned the value of IM as an alternative to medications, whether because a patient was already on the maximum amount of medication he or she could be given, or because the patient expressed an interest in trying a nonpharmacological approach to manage his or her symptoms."

10) Page 17 line 20
Need to clarify whether the statement "(who typically did not know about the referral)" came from the data or this is conjecture. If the latter this should go in Discussion,

We have added the phrase "according to the physician" to the parenthetical statement noted above, to clarify that that information did come from the interview and not from conjecture.

11) Page 18 line 35.
Would be useful to offer a quote to support this statement if possible. As this is an important point regarding inpatient referrals—how often do docs concern about medications or other medical issues come into play?

This information came from a handful of nurses in response to a specific interview question about whether physicians might ever disagree with a suggestion to refer a patient. The responses where contraindications were mentioned at all were very infrequent. We have added the phrase, "although these exceptions were mentioned infrequently by interviewees," to this statement.

12) Page 24 line 30
This sentence is unclear in my opinion—what are you saying here? "The finding that projected or actual length of stay has a bearing on whether a patient is referred for IM may not be useful for a facility with a greater ratio of IM practitioners to patients, but it is likely to be a common challenge in programs similar to this one. "

Upon revisiting this statement, we agree with the reviewer that it is unclear. The attempted meaning—to project how useful this finding may or may not be to facilities with similar or different staff and operational makeups—is not a necessary point and explaining it further would likely result in an overwrought sentence or section. Instead, we have combined a revision of this point with a clarification requested in comment 8 above, where we offer caveats to the interpretation of our length-of-stay finding.

13) Discussion: I would be interested in seeing a comment somewhere about your opinion on the use of standing orders vs. active referral based on your data.

We have added the following text to the discussion, page 29: “Another operational feature potentially unique to ANW’s IM service is the nature of how standing orders for IM services are implemented. At present, all instances of standing orders for IM are very specific (e.g., the order in joint replacement program is for group acupuncture, the order in the spine service line was related to a temporary and now-completed quality improvement project). It may be of interest in future analyses to examine the influence of standing orders more closely.”

14) Also without wanting to be too self-promoting you may want to consider including the following reference in your discussion of previous literature

Kielczynska BB, Kligler B,^ Specchio E. Integrating acupuncture in an inpatient setting. Qual Health Res. 2014 Sep;24(9):1242-52. PMID: 25079502

This article contributes valuable background and a nice complement to our previous article on IM practitioner perspectives and experiences (Nate et al., 2015). We appreciate the suggestion and have added this reference to page 30 of our discussion section.

Reviewer: 2
Reviewer Name: Malcolm B. Taw, MD, FACP
Institution and Country: Director, UCLA Center for East-West Medicine - Westlake Village; Associate Clinical Professor UCLA Department of Medicine David Geffen School of Medicine, UCLA, USA
Competing Interests: Several years ago, I had been invited by the former Executive Director of the Penny George Institute for Health and Healing at Allina Health to speak at a conference organized by them. As such, I have some familiarity with the inpatient integrative medicine program and have met several of the staff, including Jeffery Dusek.

This study by Griffin and colleagues investigates referral patterns for integrative medicine services within an inpatient setting using structured qualitative interviews and reveals driving factors that influence the process. The study is rigorous in that it reports several of the necessary items as delineated by the Standards for Reporting Qualitative Research (SRQR) and Consolidated Criteria for Reporting Qualitative Research (COREQ). Grounded theory using an inductive approach from electronic medical records data is appropriate. The emerging themes as supported by interview findings are of interest given the dearth of research in this area. However, there are some areas where the manuscript can be strengthened.

Definitions:

1) Suggest defining “general IM consult” vs. “acupuncture consult”: The difference between general IM consult and acupuncture consult may seem obvious, but should be briefly described to clarify. Can general IM consult include acupuncture?

We have added a clarifying paragraph on page 7 (last paragraph of Study Setting): “There are two major categories of referrals for IM: acupuncture and general IM consults; the latter can encompass any of the IM services available. Acupuncture orders can also result in an acupuncturist delivering a service other than acupuncture (e.g., acupressure, aromatherapy, mind-body therapy). Acupuncture referrals require authorization by a physician or mid-level provider, while general IM referrals can be placed by nurses and other providers. General IM referrals can be fulfilled by acupuncturists as well as other IM practitioners, but only acupuncturists can respond to acupuncture referrals.”

2) Please define “IM services” as some readers may not know what this specifically entails.

We have added the phrase “which encompass visits to patients from practitioners offering a range of IM modalities and/or education,” to the top of page 6, where we first mention the phrase “IM services.”

Tables:

3) For Table 3 – it is unclear what ‘Referral for IM services’ describes. I assume this describes the total of both “general IM consults” and “acupuncture consults.” If so, please make explicit. Please briefly describe how you reached your ‘p-values’ as I do not see any description of statistical analyses in the body of the paper. Though there is a section on qualitative data analysis in the appendix, it would also be good to have a brief explanation in the main manuscript.

A footnote has been added to this table to define the IM services label more clearly. Regarding p-values, per this comment and Reviewer 1’s comments #5 and #6, we have omitted the p-values.

4) Table 4 states frequency of ‘integrative medicine referrals’ – again, is this a combination of both “general IM consults” and “acupuncture consults”?

We decided to omit this table, due to another reviewer’s concern over showing a half-year for 2012. The total number of referrals by service line are still represented in what are now Tables 2 and 3.

5) Table 5 is a little confusing. The title is “Median time from first referral until contact with an IM practitioner” but all the subsections do not seem to apply to 'contact' with an IM practitioner. Does 'time until first acupuncture referral' and 'time until first general IM consult referral' describe the time from hospital admission to actual placement of the referrals or contact with a practitioner? Also, it is not clear what ‘Time until first referral’ means – I assume that this is the time until either ‘first acupuncture referral’ or ‘first general IM consult referral.’ If so, please explicitly define. Would suggest perhaps separating out into 2 tables for clarity (the first table as “Median time until placement of referral for IM services” and another table on “Median time until first contact with IM practitioner”). Please also define Q1 and Q3.

We have retitled this table to “Length of stay and median time outcomes for IM referrals and fulfillment, by clinical service line” and we have moved the fulfillment rows to the end. We have also relabeled row titles in column 1 to provide better clarity.

Per SRQR/COREQ checklist items:

6) Please identify the research paradigm used (e.g., postpositivist, constructivist/interpretivist)

On pages 8-9, we have added the sentence, “An interpretivist paradigm was used in creating the interview guides and subsequently in analyzing the data.”

7) Would suggest including a diagram or schematic showing intention to interview and dropouts/reasons (I see there is a description of this in the appendix, but it would be good to briefly describe this in the main manuscript).

A figure has been added to the methods to illustrate invitations, declines, and participation.

8) Please briefly discuss other 'salient contextual factors' that can potentially influence referral patterns as well as affect generalizability and transferability, such as:

8a) 1) Amount of prior education for referring providers about IM and role of IM services. I know that

there was some discussion about this under the section "Desire for better education and information about IM." However, was there ever any prior “in-servicing” sessions, presentations or annual conferences offered to inpatient clinicians, staff or administrators? Could this affect referral patterns?

More uniform education may have affected referral patterns, but we cannot know to what extent. We have added the following sentences to the second paragraph of the discussion on page 27: “Neither physicians nor nurses described training on the referral process that was systematic or driven by the IM program. Some respondents were better informed than others, but knowledge was uneven among staff in all service lines, depending on interest level, work hours, time in the position, and team dynamics.”
We also added some clarifying details in the results on how nurses and physicians recalled being trained on the IM referral process (see pages 23-24).

8b) 2) Executive leadership involvement. How does this potentially affect administrative and hospitalist ‘buy-in’ and hence referral patterns? The previous Executive Director of the Penny George Institute had training in holistic nursing – was this a factor in getting “buy in’ among nurses, given that much of the referral process seemed to be “nursing driven”? Would this affect referral patterns?

We have added a sentence to the discussion section on page 27 addressing the role of a nurse leader in affecting the nurse-driven nature of the program: “Since a nurse was the key developer of the IM service,10 the link to nursing is understandable.”

8c) 3) Impact of the lack of physician involvement as part of the IM team. Are there any implications, whether positive or negative? Could this be a factor that can affect the referral process, given that many of the interviewees were physicians? Could this be a reason why much of the referral process seems to be "nursing driven" and less "physician driven"?

It is true that there are no physicians on the inpatient IM team. There are physician providers in the PGIHH outpatient clinic, but the inpatient and outpatient services have separate operations. Physician providers might influence physician referrals differently, but we have no way of knowing, and because our interviews did not touch on this topic, we do not have data here to reflect upon. However, we have added the following text to the discussion to address the presence of nurses on the IM team: “The presence of nurses on the IM team may be a factor in the acceptance by nurses of the service. In a separate set of interviews with the IM practitioners at ANW, those who had nursing backgrounds described their experiences of feeling accepted by nurses on the floor, due to being well-versed in the language, culture, and workflow of conventional medicine and nursing practice.10”

8d) 4) IM services at no cost. In the Methods section, under “Study Setting” the authors state that IM services are “available to all inpatients without cost.” Can this affect referral patterns? Also one of the exemplar physician quotes states “And so, after the acute phase, there’s this other phase where it [IM service] is particularly necessary and that’s where it becomes a resistance, is that you can offer something in the hospital, but then, because of financial issues, the patients can’t keep it up.” Please briefly discuss the implications of inpatient IM referral patterns for services that are free.

This is an important point, and we appreciate the reviewer raising it. We have added an acknowledgment of the free nature of IM services to page 29: “The tendency for the demand for IM services to exceed supply likely contributes to the delay in service delivery, and the high demand may be related to the service being offered at no cost to patients. We previously addressed this challenge in an analysis of IM practitioner views of providing inpatient services.11 However, we did not gather from our interviews that concerns about the service being free deterred providers from referring for the service in general.”
Perhaps because our interview questions did not overtly address this topic, it did not emerge in our

interviews. In previous paper (Nate et al.), now referenced, we did touch on the service being free in our discussion, because it has a bearing on the workload of the small IM team (a free service creates high demand which cannot always be met by a team of this size). But for the referring providers, it does not seem to factor into their decision-making process, based at least on the present interviews. Even in the quotation mentioned above, the concern is related to the broader experience of patients who receive this free service but then cannot access it once they leave the hospital.

9) Please also include a copy of the qualitative interview template as a supplementary file.

We agree with reviewers 1 and 2 that it would be beneficial to show the interview questions. We have added the interview guides as a supplementary file, as requested.

Reviewer: 3
Reviewer Name: Suzanne Grant
Institution and Country: Western Sydney University, Australia Competing Interests: None declared

1) The paper is an excellent report on the referral process for integrative medicine services in a large hospital. Although this is an area of specialist interest, there are a growing number of hospitals now offering or considering such a service. Perhaps a little context on where this hospital sits with similar international undertakings in this area would be useful (prevalence). The paper provides appropriate context for studies of referral processes. Well written and engaging paper.

We agree with the value of providing international context for our findings. We have added the following text (with references) to the discussion on page 30: “Our study addresses several gaps in the literature with regard to the provision of IM in U.S. hospitals, as IM referral processes within an inpatient setting have not been studied previously. Although IM is increasingly being provided to U.S. inpatients in areas such as oncology13, 14 and pediatrics,15, 21 hospitals with well-established integrative medicine offerings for inpatients are more prevalent internationally (e.g., in Israel,16, 17 Germany,19, 20 and China18). However, operational processes and cultural contexts surrounding acceptance of IM are substantially different internationally in comparison with the U.S., where IM offerings are less widespread and assimilated.4 Furthermore, international studies have examined feasibility and outcomes of inpatient IM, but inpatient IM referral patterns have not been described. IM referral patterns have been explored within a U.S. health network5 and in an Australian primary care setting,6 but not, to our knowledge, within a single inpatient facility offering IM as ANW does.”

VERSION 2 – REVIEW

REVIEWER	Malcolm Taw, MD, FACP UCLA Center for East-West Medicine UCLA Department of Medicine David Geffen School of Medicine, UCLA Ronald Reagan UCLA Medical Center USA Several years ago, I had been invited by the former Executive Director of the Penny George Institute for Health and Healing at Allina Health to speak at a conference organized by them. As such, I have some familiarity with the inpatient integrative medicine program and have met several of the staff, including Jeffery Dusek.
REVIEW RETURNED	23-Jun-2016

GENERAL COMMENTS	The authors have done an excellent job in addressing all concerns. The manuscript is complete in its incorporation of all the items outlined by the Standards for Reporting Qualitative Research and Consolidated Criteria for Reporting Qualitative Research guidelines. It is much improved in its discussion of salient contextual factors.