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Divider Title: Kelly

John Kelly, M.D.

Aetna/U.S. Healthcare

DRAFT

I am John T. Kelly, MD, PhD, Director of Physician Relations for Aetna, Inc.

On behalf of Aetna I would like to commend the Commission on Complementary and Alternative Medicine Policy for its important work.

I am pleased to be here to discuss health plan issues related to complementary and alternative medicine.

Aetna, the largest health benefits company in the United States, provides health benefits and other health-related services, such as pharmacy and dental insurance, to approximately 19 million members

Aetna offers a wide variety of health insurance products, including Traditional, PPO, HMO, pharmacy, and dental, to meet the diverse needs and preferences of consumers and the employers who provide access to health care coverage to their employees. Most Aetna members receive health care coverage through their employers or as a family member of an employee.

Insurance benefits, and the cost of health insurance, vary by product type (e.g., Traditional, PPO, HMO), benefit design (e.g., inclusions, exclusions), administrative requirements (e.g., referral, pre-certification), financial mechanisms (e.g., charges, co-payments, deductibles, limitations), other factors such as state-specific requirements, and individual contract design.

Members receive a "Certificate of Coverage" that specifies what benefits are covered and what services are excluded. A typical "Certificate of Coverage" might specify outpatient benefits, inpatient benefits, optional benefits (e.g., routine eye exams, durable medical equipment), other riders (e.g., prescription plan, dental plan), eligibility requirements, pre-certification requirements, deductible amounts, co-insurance and co-payment requirements, and exclusions.

Typically, unless specifically stated otherwise in the "Certificate of Coverage", services must be "medically necessary" for services to be covered.

The "Certificate of Coverage" would include information regarding how medical necessity is determined. For example, a typical "Certificate of Coverage" might specify that "medically necessary" services are services that are appropriate and consistent with the diagnosis in accordance with accepted medical standards.

A typical "Certificate of Coverage" might also state that in determining if a service is "medically necessary", Aetna considers:

- Information on the member' health status;
- Reports in peer reviewed medical literature;
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;

- Professional standards of safety and effectiveness which are generally recognized in the United Stated States for diagnosis, care or treatment;
- The opinion of health professionals in the generally recognized health specialty involved;
- The opinion of the attending physicians, which have credence but do not overrule contrary opinions; and
- Any other relevant information.

A typical "Certificate of Coverage" might also specify specific exclusions. For example, a "Certificate of Coverage" might state that charges and expenses are not covered for:

- Services or supplies not medically necessary for the diagnosis or treatment of an illness or injury;
- Certain convenience items or services
- Services or supplies of an educational, experimental or investigatory nature.

Aetna would generally not provide coverage for complementary and alternative medical services, as these services would typically not meet Aetna's definition of medically necessity.

I will repeat, Aetna would generally not provide coverage for complementary and alternative medical services, as these services would typically not meet Aetna's definition of medically necessity.

I will add that members have not typically sought to purchase and employers have not typically sought to provide access to coverage for complementary and alternative medical services.

However, if a "Certificate of Coverage" explicitly states that coverage for specific complementary and alternative medical services is included, coverage for these services would be provided according to the terms of the "Certificate of Coverage."

Aetna's Coverage Policy Bulletins are used as a guide when determining health care coverage for our members. Coverage Policy Bulletins are written on selected clinical issues, especially addressing new technologies, new treatment approaches, and procedures. Aetna's Coverage Policy Bulletins are available through the Internet at www.Aetna.com.

Actual coverage decisions are made on a case-by-case basis. The Coverage Policy Bulletin is used as a tool to be interpreted in conjunction with the member's specific benefit plan and after consultation with the treating physician.

In the event that a member disagrees with a coverage determination, Aetna provides its members with the right to appeal the decision; in addition, a member may have an opportunity for an independent external review of coverage denials based on medical necessity when the service/treatment in question costs more than $500.

Although insurance coverage for complementary and alternative medical services is not generally provided to Aetna members, Aetna offers our members reduced rates on alternative therapies and products, including visits to acupuncturists, massage therapists and nutritional counselors, through a program named Natural Alternatives™ . Natural Alternatives™ program participants can also save on vitamins, herbal supplements, books and other health related products.

Aetna has not evaluated, and makes no guarantee, regarding the quality of Natural Alternatives providers or vendors. Providers or vendors offering reduced rates under Natural Alternatives have not been credentialed or reviewed for quality.

Aetna has no responsibility to pay or reimburse participants for reduced rate services received through this program.

Aetna provides educational information on the subject of complementary and alternative medicine through the Internet to Aetna members and to everyone else who has access to the Internet. This information is available at www.InteliHealth.com. InteliHealth includes articles on alternative medicine and alternative medical therapies as well as commentaries on complementary and alternative medicine from physicians and other experts from the Harvard Medical School. InteliHealth's "Ask the Doc" provides questions and answers on the topic of alternative health. InteliHealth provides access to literature searches on complementary and alternative medicine. InteliHealth also provides information on related resources such as the National Institute of Health's National Center for Complementary & Alternative Medicine and the Alternative Medicine Foundation.

Aetna does not promote or discourage specific forms of therapy. Aetna encourages member to consult their physician for the advice and care appropriate for their specific medical needs.

Because of the many important and complex issues related to complementary and alternative medicine, Aetna strongly encourages research, especially outcome research, regarding complementary and alternative medicine.

Such research will increase our knowledge regarding what works and what doesn't, and assist our efforts to identify optimal ways to provide access to heath care services, improve quality, and use resources efficiently. Such research will assist health plan efforts to develop and implement effective insurance mechanisms.

I would like to thank you again for the opportunity to meet with you. I wish you success in your important work.

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Weeks

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Biographical sketch

John Weeks

Principal, Integration Strategies for Natural Healthcare
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John Weeks has been called an "expert in alternative medicine" by *Medical Economics* and an "alternative care (integration) guru" by *Modern Healthcare*. Harvard's David Eisenberg, MD, has called his work both "a reality check" and "an enormous contribution to this entire field of inquiry." Weeks writes and speaks widely on integration topics and is a frequently cited source in the industry, medical, and popular media on business of integration topics. Since 1996, he has produced the journal of record for the evolving industry, THE INTEGRATOR *for the Business of Alternative Medicine*. The newsletter's pioneering information sharing reports include the ongoing INTEGRATOR *Integrative Clinic Benchmarking Survey* and the annual INTEGRATOR *CAM Network Executive Survey*. Recognizing the need in the industry for a forum to explore the challenges, opportunities and collaborative possibilities, Weeks convened an invitational Integrative Medicine Industry Leadership Summit in May 2000. The gathering brought together active participants from 75 organizations representing all the leading stakeholders under one roof – HMOs, employers, hospitals and health systems, government, CAM professions, academic medicine, public health, venture capital – for an interactive, cross-fertilizing exchange. A second gathering of 105 leading individuals will be held May 3-5, 2001.

The Summits, THE INTEGRATOR and Weeks' consulting and writing are informed by his long-time, hands-on experience in the field. From 1983-1993, Weeks served a decade in the maturation of the alternative medicine movement. He held positions as vice president for Bastyr University and as board member for the American Herbal Products Association. Since 1993, when he formed Integration Strategies for Natural Healthcare, Weeks has worked full-time as a bridge-builder, consulting, writing and speaking on CAM integration. His early clients included HMOs (Group Health Cooperative, PacificCare of WA, Providence Healthplans/Medalia Healthcare, First Choice), which he has assisted with credentialing, provider selection, network building and product development. Between 1997 and 2000, Weeks worked with the National Managed Health Care Congress, including chairing their CAM track. He was a repeat presenter in diverse forums for the American Association of Health Plans. Since 1996, Weeks' consulting on integration branched out to included service for most of the other leading stakeholders, including government agencies at all levels (Washington State Office of the Insurance Commissioner, US AHCPR, US NIH, Seattle-King County Department of Public Health, Arizona Department of Health), and hospitals and health systems (Health Forum/American Hospital Association, St. Joseph Health System (CA), Deaconess (IN), Sisters of Providence (OR), Catholic Health Initiatives (CO), Baptist-St. Vincent (FL)). His clients have also included alternative provider network services organizations, venture-backed firms, and numerous CAM professional associations. His INDUSTRY/HEALTH information-consultation service, a joint project with Integrative Medicine Communications is subscribed by 35 leading organizations.

Weeks' writing appears in diverse publications, both peer-reviewed and industry, including *Health Forum Journal, Medical Economics, Physician Executive, Drug Benefit Trends,* and the first issue of Andrew Weil's *Integrative Medicine*. Among the books for which Weeks has contributed chapters are The Managed Health Care Handbook (4th Edition -- Peter R. Kongstvedt, editor, Aspen Publishing)), Best Practices in Medical Management and Current Medicine (Mark Micozzi, MD, PhD, editor). His prior professional experience was in journalism, politics and organizing. Weeks attended Stanford University for three years, studying history.

White House Commission on CAM Policy

James Gordon, MD, Chair

Reimbursement: Panel on Health Plan Perspectives

Testimony of

John Weeks

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May 14, 2001

Thank you, Chairman Gordon, Commissioners, and staff, for the honor of appearing before you to share some perspective, ideas and recommendations regarding the current state of CAM reimbursement. We are here to "follow the money" in health care. We need your vision and insight to make certain that resources are sent down the appropriate chutes.

Professional Background

My name is John Weeks. I have been involved in this field for 18 years, for the past eight as a principal with Integration Strategies for Natural Healthcare and the past five as publisher-editor of THE INTEGRATOR *for the Business of Alternative Medicine* (Integrative Medicine Communications, Newton, MA). Under my consulting hat, I have had an opportunity, in the past eight years, to consult with over four dozen organizations on CAM issues. Most CAM integration stakeholders have been represented in the mix -- HMOs, an Insurance Commissioner, managed care educators, hospitals, academic medicine, employers, CAM networks, health systems, government agencies at all levels, and the CAM professions. A significant early engagement was a contract with what were then the NIH Office of Alternative Medicine and the Agency for Health Care Policy and Research to provide a report on operational issues in reimbursement as part of an October 1996 workshop on CAM coverage. (Weeks/ NIH OAM-AHCPR, October 8, 1996) In

1997-1998 I began, at the invitation of the Washington State Insurance Commissioner, to serve an 18 month stint as co-founder and then co-facilitator of the Clinician Workgroup on the Integration of CAM. This multi-stakeholder examination of coverage implementation under Washington's unique "every category of provider" mandate included most of the state's leading health plans, networks and CAM provider organizations.

In partnership with Integrative Medicine Communications, I have had the professional pleasure, and challenge, over the last two years of expanding such a multi-stakeholder roundtable nationally. In consecutive, interactive meetings which we dubbed the Integrative Medicine Industry Leadership Summit(s), I have invited, then co-hosted and facilitated, the cross-fertilizing of first 75, then 105, leaders of diverse stakeholder organizations. Reimbursement issues are never far from the center of the Summit conversation, regardless of the stakeholder.

In my capacity with THE INTEGRATOR, I have closely followed, reported, analyzed and commented on CAM reimbursement issues nationwide for the past five years. My writing has also appeared in numerous other industry publications, including a column in *Medical Economics*, repeat articles in *Health Forum*, and numerous book chapters.

My testimony attempts to synthesize for you the collective understanding gained as consultant, observer-analyst-journalist and as a convenor and listener at multi-stakeholder CAM industry gatherings.

Basic Observations

1. ***Third party payment of CAM, by private and public agencies, is critical to finding CAM's optimal role in our system's payment and delivery.*** CAM can not appropriately reach the underserved or the middle class as a cash-only proposition. Nor can CAM find its optimal role in the referral pattern of mainstream delivery and physician practices if it only operates in a parallel, secondary economy.

2. ***In most reimbursement models, CAM is in quarantine.*** Our reimbursement structures typically poorly integrate CAM clinically, economically and administratively.

3. ***Evidence is mounting that CAM has significant potential for creating more cost-effective care***. Diverse surveys, measuring especially the perceptions of

members/employees/users and employer-purchasers, but also conventional physicians, suggest that healthcare will be more cost-effective from expanded, appropriate CAM reimbursement.

4. ***Information to support more appropriate and intelligent payment is not presently being produced by either third-party stakeholders or the research establishment.*** Neither current research priorities nor third parties involved in CAM reimbursement are yielding the critically needed experience data and outcomes which will help us maximize CAM's potential.

5. ***Reimbursement of CAM can be explored with limited financial risk.*** Early experience with CAM reimbursement offers the paradox of very high member perception of helpfulness and satisfaction, plus significant perception from diverse parties of cost-offsets, combined with very low utilization. Many strategies to limit utilization, and cost, are effectively employed.

6. ***CAM is optimally explored through demonstration projects in a context shaped by continuous quality improvement.*** Wedging CAM into present reimbursement models, which many on the mainstream and CAM worlds believe are less than optimal, may miss the value CAM has to offer US healthcare, third-party payers and individual consumers. The CAM reimbursement question is needs to be positioned near the center of our culture's broader efforts to create a system than is not merely reactive to disease but also wishes to create health.

Introduction: What is the Question?

Question

"If a healthplan which is determining whether to introduce a covered CAM benefit has a choice between excellent efficacy data and no utilization data, or poor efficacy data and very good utilization data, which will the plan prefer?"

Answer

(from Thomas Snook, consulting actuary, Milliman and Robertson)
"The latter, no question."

Source: National Managed Health Care Congress, April 2000

The subject of this panel is reimbursement, specifically from a health plan perspective. The focus is on identifying the present models and examining the challenges and opportunities presented by the current environment. It is the nature of the integration beast, however, that an exploration of third-party payment must also question whether the current paradigm(s) for third-party payment are optimal models for capturing the CAM's value for the public health. We have widespread agreement -- in the conventional medical world and in CAM -- that we have problems with our current payment system. Therefore to ask "how is CAM doing" from inside the box of current reimbursement practices misses a larger opportunity which may better reflect CAM's potential.

So let us look at CAM's role in reimbursement from three, more fundamental, perspectives.

- Is CAM an add-on or a replacement for conventional care? Put differently, can CAM interventions create medical cost-offsets?

- Does CAM have a role not just in lowering "medical" costs but also in lower the global costs of health to government and employers -- with cost issues such as functionality, disability, productivity, absenteeism, "presenteeism" and satisfaction thrown into the mix?

- Most important, are we paying for CAM therapies, providers and approaches at the optimal time and optimal level to maximize the health and well-being of the human beings we are all here to serve?

We must wed ourselves to these larger questions, rather than to the intramural concerns of the presently constituted third-party payment system. Behind these questions lingers the critical corollary: *Are we gathering the data which will help us find answers to these questions?*

1. Historic CAM Reimbursement: Fear-based Models for CAM Coverage

CAM coverage falls into two general categories. The first, which receives most of the media attention, is the inclusion of distinctly educated and/or licensed CAM providers as credentialed providers by healthcare plans. The second is the inclusion of CAM modalities in the "integrative" practices of conventionally trained medical doctors, osteopathic doctors and nurses – an emerging field which will be, and is, raising a separate set of challenges and opportunities. My comments will focus on the inclusion of the distinctly educated and licensed CAM providers – with coverage typically extended to chiropractors, acupuncturists, naturopathic physicians (in states where they are licensed) and massage therapists. Amidst the global diversity of CAM services, these four professions, each of which has achieved significant levels of internal self-regulation and standard setting, represent the "low hanging fruit" of CAM reimbursement.

Characteristics of the leading inclusion models

The leading models for inclusion have these characteristics:

- ***Carved out/sub-contracted rather than built internally*** The relationships (credentialing, management, payment) are "carved out" to a CAM network firm. Most are historic chiropractic firms which have added additional modalities and services.

- ***Paid through an additional "rider" instead of core premium*** If reimbursed, the pot of premium is typically an additional per employer per month (PEPM) or per member per month (PMPM) amount which varies based in benefit design, but is typically $1.00-$2.50 PMPM.

- ***Most non-chiro inclusion is via "discounts" – not covered*** In CAM discount products, the credentialed networks agrees to 15-30% discounts off usual and customary fees. The member/employee still pays cash, but now at a discount. The plan, meantime, typically gets "something for nothing" – or next to it. The CAM network typically views the discount as a foot in the door or a loss leader and charges a little as nothing ($0.00 PMPM) or up to $0.03 PMPM for the product, sometimes even cutting the HMO in on the back-end of natural product sales to members through a website. While over 50% of industry leaders in a recent poll believe that these are a reasonable starting place for HMO involvement with CAM, a significant minority disagree. (Pre-Summit survey, Integrative Medicine Industry Leadership Summit 2001) Some evidence has recently emerged of some plans moving from discounts to offering covered models. Given the HMO's historic resistance to CAM, I have suggested

elsewhere that the discount is a kind of Trojan Horse for entry into third-party payer organizations.

- ***Directly accessed – little communication with conventional providers*** The member or employee is typically allowed to directly access the CAM provider without going through a conventional referral or even communicating with their conventional providers. Data suggests that referral limits use of chiropractic by 75-90%. (Snook/Milliman & Robertson, HCFA) Communication with conventional providers is not typically required.

- ***Management of economic risk rather than clinical-economic opportunity*** A number of strategies are used, including: pre-authorization, visit limits, dollar limits, higher co-payments, and, in some models, referral requirements. Each of these can substantially limit care, and financial risk.

"Quarantine" characteristics of the typical CAM coverage models

Notably, these models are, by definition, not integrated. While a user may be pleased to see that the use is "integrated" into coverage, in truth, medical management, financial management and clinical relationships are not directly part of conventional payment or delivery. The model is one of "quarantine:" the services are nominally part of operations, but in reality, financial, clinical and human "firewalls" have been erected around the CAM benefit which is not allowed to "infect" conventional treatment. *The CAM reimbursement and integration zone may be visualized as a kind of restricted homeland inside a larger, more powerful system in which providers and users have more freedom.*

The historic basis of this approach is noteworthy. The immediate predecessor to the dominant present model of CAM reimbursement is chiropractic, which began fighting its way, with consumer support, into third-party inclusion via federal and state mandates, over the last 30 years. Conventional medical providers were typically not knowledgeable about chiropractic, nor did they value the care. The business model was established at a time of mutual antagonism and disrespect between the conventional and chiropractic providers. Meantime, third-party organization (government, insurer, managed care) had little or no internal competency in working with or managing these new sets of distinctly licensed and educated providers. Interestingly, a similar parallel exists with mental health services which were also not well understood, valued or utilized by conventional physicians, stimulating the development of the behavioral health carve-out networks. So the business model for CAM inclusion was a fear-based model, developed to

sidestep the core human, economic, managerial and quality issues of actual integration. The CAM networks developed to meet the opportunity this fear created. Unfortunately, the incentive structure in this environment, as well be seen in more detail below, is antagonistic to even exploring integration.

- The HMO or insurer has little or no direct financial incentive to explore cost offsets, or clinical incentive to explore appropriate, pro-active referral to CAM providers.

- Once the CAM network accepts a PMPM or PEPM, as in all managed care, profitability is tied to limiting use and therefore pay-outs to providers. This is problematic in an environment of initial inclusion, if we assume that more CAM use and coverage optimizes healthcare expenses.

- Unfortunately, the CAM network, as the source of the HMO's knowledge on CAM, may be assumed to have some investment in keeping the "internal competence" of the HMO or employer at a minimum. If the larger entity gets smart and pursues more integration, the need for the network may shift and eventually decline.

The consumer can be served, in the short term, in this model. But can optimal healthcare -- optimal inclusion and coverage -- be created? As will be seen, the barriers to even beginning to understand a pro-active role for CAM are significant.

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2. Potential in Expanding CAM Reimbursement: An Emerging Picture

But before the obstacles, the opportunity. Our coverage and inclusion experience to date creates an impression that we have a good deal to gain in moving CAM out of quarantine into a more active exploration of value.

High member/employee satisfaction and perception of functional value from CAM

The decade of the 1990s is the decade in which "patient-centered" -- or perhaps more appropriately, "market-centered" -- strategies have begun to have a more important role in payment. Numerous surveys have found high experience of value with CAM among HMO members and particularly those who are users of covered benefits. Three surveys which looked at users of covered CAM services found that between 92-97% found massage, acupuncture, naturopathy and chiropractic to be "helpful." (Alternare Health Services, Portland, Oregon, 1997, 1998, 1999; INTEGRATOR May 2001) Other reports, including those using tested functional outcomes instrument such as the SF 36, find positive change through CAM interventions. (Tzu Chi Institute, Vancouver, B.C., and ChiroAlliance, Jacksonville, Florida; INTEGRATOR January - February 2001).

High perception of value of covered CAM from conventional physicians

A survey by staff and network model HMO Group Health Cooperative found that 65-75% of these providers believed that the services of the covered massage practitioners, acupuncturists and chiropractors were "usually" or "always" beneficial.(Group Health Cooperative, Seattle, WA; INTEGRATOR April 2001) Use and perception of value of CAM are also high in a published survey of staff model HMO physicians in Northern California. (Gordon, Nancy; Kaiser Permanente Northern California; INTEGRATOR November 1998) In three separate reports, between 24-55% of physicians believe better CAM integration can lead to more cost-effective care -- and 40-74% believe better integration will lead to more effective care. (Medalia Healthcare (Sisters of Providence), Seattle, WA, 1997; Baptist St. Vincent Healthcare, Jacksonville, Florida, 1998; and Group Health Cooperative, 2000; INTEGRATOR November 1998)

One unproven observation: proximity to CAM seems to make the conventional physician's heart grow fonder. We would expect the positive views of CAM to be higher with increased experience and understanding among conventional providers. (Note that a similar phenomenon appears to hold true among administrators and executives.)

Significant perception of potential cost-savings among stakeholders

A series of patient surveys find that typically between 50-65% of users of distinctly licensed CAM providers believe that the care is diminishing use of conventional services and, when asked, of prescription drugs. (American Specialty Health/Health Net/Stanford University, 1998; Tapestry Group/Marino Centers, Newton, MA, 2000, INTEGRATOR Jan-Feb 2001; Alternare Health Services, 1997, 1999, 2000, INTEGRATOR January 1998, May 2001) Over 50% of HMO executives in another survey stated they believe that CAM is at least cost-neutral. (Landmark Healthcare, 1999; INTEGRATOR April 1999) Some 30% of large employers state that cost-effectiveness is a part of their motivation, and 63% believe that CAM can be cost-effectively integrated. (PricewaterhouseCoopers, 2000; INTEGRATOR December 2000) As noted in Table 2 in the Appendix, some 55% of a set of employee benefits professionals noted a "potential" for some kind of cost savings as the chief factor for inclusion of CAM in their benefits package. (American Compensation Association, 2000; INTEGRATOR July-August 2000) While the interest of the consumer or member is the top motivation for CAM inclusion in benefits packages, perception of economic value from CAM coverage is a significant sub-theme and motivator for coverage.

An additional note on potential cost-savings through the role of CAM providers in primary prevention: according to a CAM network executive, when medical directors of HMOs found that CAM providers scored highly on HEDIS-like surveys which quantify CAM provider participation in stimulating health promoting behaviors among patients, the pro-active interest of many in CAM services was stimulated for the first time. (Complementary Healthcare Plans, Portland, Oregon; INTEGRATOR May 2001)

Potential for cost savings expand when measured against global costs of health

The perceptions of potential value of covered CAM to stakeholders is beginning to produce some limited evidence of potential savings. An informal report of a managed CAM firm which offers a "non-pharmacological" model of primary care suggests that such care may be linked to lower hospitalization and drug costs. (Alternative Medicine, Inc., Chicago, Illinois; INTEGRATOR Jan-Feb 2000, May 2001) The value may be most evident in areas such as productivity, satisfaction, disability cost-offsets, long-term savings, functionality, presenteeism and absenteeism. (Husky Injection Molding, Ontario, Canada, INTEGRATOR November 2000; employer panel, Stanford/Harvard meeting on *Practical Applications*, October 2000; Report, Integrative Medicine Industry Leadership Summit 2000, Integrative Medicine Communications, Newton, MA)

CAM providers -- do we value their claims?

The popular literature from the CAM professions is strewn with assertions that one or more CAM interventions can be more cost effective, or create cost-savings, relative to conventional treatment. The claims relate to supporting self-efficacy in patients who uses fewer unnecessary services; lower pharmacy costs; cost-offsets from fewer surgeries and procedures; increased functionality, productivity and satisfaction; fewer adverse effects; a specialty in influencing the course of chronic diseases which consume the major part of the healthcare dollar; and a philosophical approach which aims to focus on primary prevention. Most of this assertion has not yet been analyzed. Yet providers of CAM services nearly unanimously share this view, which is presumably based in their primary data collection of observation of their own practice. While a weak form of evidence, worth noting – particularly since 10 years ago the claims of these same providers as to the *effectiveness* of their care (some of which has since been affirmed and accepted) was widely derided as quackery and fraud. Utter dismissal in the first instance, as the historian put it, is a tragedy; to dismiss out of hand the experience of these providers on potential cost savings a second time may be a farce.

From the "demand side" -- alignment of purchaser and consumer interests?

The grassroots CAM movement, and even the clientele in hospital based integrative clinics, tends to grow most from the word-of-mouth of CAM users. (Integrative Clinic Benchmarking Follow-up Report, INTEGRATOR April 2001) The user "feels better," "gets along better," "likes the treatment," "felt heard by their doctor," can "do more things," can "go back to work," etc. (Claire Cassidy, Traditional Acupuncture Institute, Columbia, Maryland, 1997; INTEGRATOR, November 1996) Notably, these perceived outcomes are closely aligned with the set of health and productivity economic outcomes of interest to employers. Yet these are not often the priority interests of the CAM research community.

A growing consensus appears to be emerging in the CAM integration industry that comparative benefits from CAM's multi-factorial approaches are most likely to emerge the broader the outcomes measures in capturing the whole effect of the interventions. Among a multi-stakeholder set of leaders of organizations involved with payment and delivery of integrative medicine, 93% expressed agreement that CAM will tend to look best "in research designs which reflect broad outcomes." (Pre-Summit survey, Integrative Medicine Industry Leadership Summit 2001, April 2000) The group supports a radical shift of research funding priorities toward such outcomes-based health services explorations: over-half felt the current focus on efficacy studies should represent 40% or less of the research dollar. Notably, the employer is viewed, behind the

stakeholder, as the stakeholder group with the strongest interest alignment with integrative medicine.

Consolidated, emerging picture

The consolidated picture that is emerging has these characteristics.

- High member satisfaction with CAM services.
- High member perception of usefulness/helpfulness of CAM among users.
- High perception of CAM's value among referring conventional practitioners.
- Significant perception that CAM produces at least some cost offsets.
- Early utilization data which suggests that financial risk from offering CAM benefits is limited.
- Indications that the broad set of cost-oriented, functional outcomes of interest to a typical consumer/patient/member, may be reflected in the outcomes of interest to a healthcare purchaser.

This picture amounts to an intriguing postulate of a direction toward more cost-effective care. Given the general upheaval in health care, the interest in patient-centered approaches, and the significant, unmanaged cost pressures in conventional payment and delivery, one might assume that we would be pouring significant resources into CAM exploration. Yet, under our current healthcare purchasing and third party reimbursement structures, and CAM research priorities, we have barely begun to explore this potential.

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3. Forces Keeping CAM in Quarantine: Understanding the Barriers

Introduction: same as it ever was

A January-February article in *Healthplan* magazine, a publication of the American Association of Health Plans, makes the case bluntly: we lack good utilization, cost and cost-offset data to make good, informed decisions about coverage. (*Healthplan*, Jan-Feb 2001) The statement is particularly interesting in that it directly echoes statements in articles from the same industry publication back in 1996 when the exploration of CAM by HMOs and managed care organizations began in earnest. In fact, a year 2000 systematic review of cost and economics in CAM yielded little more than 30 studies of any kind which met selection criteria and none of them were on cost in a reimbursed benefit in the United States. (Ernst & White) An effort begun by the Society of Actuaries in 1996-1997 to accumulate cost data from the industry was largely abandoned when little that was conducive to actuarial analysis. (Lee Launer, PricewaterhouseCoopers) Similarly, a report on CAM by a consulting actuary with Milliman and Robertson in 1999 which attempted to provide actuarial perspectives is singularly thin on actual cost and utilization information. (Thomas Snook, Milliman & Robertson, Scottsdale, Arizona)

Surveys suggest that we can expect little new data from employers. One study of employee benefits professionals found that none (0) were exploring whether or not CAM was additive or had cost offsets.(International Foundation of Employee Benefit Plans, 2000) A survey of large employers found that, while 83% of the executives believe CAM "has value" and 63% believe CAM "is cost effective," very few offered useful analysis of experience data. (PricewaterhouseCoopers, 2000).

For those of us interested in the core questions regarding the economics of CAM coverage are a collective Rip Van Winkle, waking up after five years of sleep and found that the world had not, in fact, changed at all. *How is it that so little headway has been made on the core issue in third party payment for CAM?* This section explores the real challenges and barriers to optimal exploration, if not yet inclusion, which need to be addressed through policy.

Challenges in generating data by the CAM network industry

One would hope that some of the gap in published experience might be at least partially filled by data from inside the managed care industry. However, many CAM networks report – typically on a "not-for-attribution" basis -- challenges in getting their health plan clients to provide the necessary comparative data which allows an initial, speculative understanding of potential cost offsets. Some have spoken out on the challenges on the record. (Alternative Medicine, Inc.,

Chicago, Illinois; ChiroAlliance, Jacksonville, Florida) The networks will report their costs, and data from member surveys. In one notable presentation, a CAM network executive shared detailed experience-based analysis of the cost of chiropractic care, including incidence of referral for conventional treatment. He concluded with a challenge to conventional back pain specialists and managers, paraphrased as: *Show me your data which shows that your care can top this.* (Tom Allenburg, DC, CEO, American Chiropractic Networks, National Managed Health Care Congress, 1999.) As intriguing as these data may be, they tend to be dismissed by medical directors. What is needed is actual data on utilization of all medical services of the individual members pre-CAM and post-CAM, or analysis of use from matched pairs.

The problems in generating the data are many and include:

- Utilization and other data from managed care plans are viewed as proprietary.

- More immediate and costly issues are viewed as more pressing and a better use of plan resources than an exploration of CAM. One bottleneck frequently noted is the pressure on data managers and information officers.

- Unwieldy information systems do not readily yield comparison data.

- Data that is collected by the networks or plans may not be what is needed. In addition, some mainstream payment strategies, such as capitation, either do not capture encounter data or the data may be captured by yet a third party, the capitated medical group.

- With CAM-discount products, the lack of an economic exchange between the plan and the CAM provider means that not even basic encounter data is captured. In addition, asking CAM providers to participate in data collection on services which are not reimbursed is to ask them to first, take a discount on pay, and second, add to their time. This is not a scenario that is friendly to data collection.

- The non-integrated business and clinical structure of the typical carved-out, rider-paid, direct access CAM benefit creates disincentives to exploration at every level. The premium is from a separate pot and management from an outside firm. In addition, CAM provider-conventional provider communication, as well as CAM user-conventional provider communication, are limited or non-existent.

- In addition, under some rider-driven business models, the HMO reaps easy profits by simply marking up by 50%-200% and "retailing" the CAM product which the CAM network has "wholesaled" to the plan at a much lower rate. (THE INTEGRATOR, November 1999) The immediate effect exploring change in the premium structure is to cut out a certain profit line for an uncertain future.

- Even when CAM services are part of a managed care firm's "core benefit" which all members receive, the management of the CAM services, and the CAM dollar, may still be contracted-out to a CAM network based on an agreed-upon PMPM rate. CAM still operates in a non-integrated manner.

- With a few exceptions, public and private funders of CAM research presently provide little or no support for research into the economics of CAM. Significant explorations will be costly.

- Methodologies for evaluating cost-offsets are viewed by some researchers as challenging. (Daniel Cherkin, Group Health Cooperative, at Stanford/Harvard *Practical Applications* conference, 2000).

- The assertion of CAM providers that the cost-savings will be felt long-term suggest to many the need for a major, multi-year study.

- Most plans have a fundamental lack of commitment to developing internal CAM competency.

- The multiple troubles between physicians and managed care firms, based on diverse changes in the third-party payment environment over the past decade, create an environment in which asking conventional MDs to take CAM more seriously is viewed by some as the straw that will break the camel's back.

- Finally, anti-CAM biases, or at least a lack of education and experience of CAM among most conventional medical directors, for both insurers/HMOs and the mainstream delivery systems with which they typically work.

In addition, privacy requirements in HIPAA are expected by many to clamp a deep freeze on this already chilled environment.

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4. Some Possible Directions out of the Reimbursement Quarantine

The emerging experience with CAM has led to some clear suggestions about how to move out of the present quarantine. Some strategies are emerging in conventional models. Others are best viewed as pilot or demonstration projects.

Strategies in the dominant model of network-based CAM reimbursement

In May 2001, executives with top CAM networks, pro-active health plans (Oxford, Group Health Cooperative, Highmark) and employers met in three break-out sessions at Integrative Medicine Industry Leadership Summit 2001 with the charge of breaking out of the box of the currently limited inclusion in reimbursement. (Ira Zunin, MD, MPH, Hawaii State Integrative Medicine Consortium, managed care break-out co-facilitator, end of Summit oral report; THE INTEGRATOR and Integrative Medicine Communications, Newton, MA) The reported consensus of the group was as follows:

- For the near future, CAM benefits will continue to be a consumer-drive, "value added" proposition.
- Creating a "qualitative shift" in the way CAM treatments are valued requires solid cost-offset data.

The group recommended: setting consensus standards for the data set which should be collected; promulgation of this standard throughout the industry; and reporting of outcomes to a neutral third party. An additional interesting initiative was the recommendations that networks seek to have health plans agree to data-sharing as part of the contracting process. At both Summits (2000, 2001), participants agreed that a great deal of data exists. The more important issue was to create the funding and commitment to analyze the experience.

Strategies in exploratory model of reimbursement and coverage

Those following the emerging field of CAM coverage recognize that a great deal of exploration is underway involving many different types of services in an array of coverage formats. This was captured in two additional recommendations at the Integrative Medicine Industry Leadership Summit meeting, from the employer perspective. A key recommendation was to focus research spending on the "design labs" of real world delivery experiments rather than in controlled trials. Second, the employer group recommended exploring CAM coverage through adding value to discussions that already exist in the employer community. Two examples of initiatives where

CAM is viewed as potentially having a role are employer-based disease management, and employer efforts to measure and advance the health and productivity of the workforce. (Sean Sullivan, CEO, Institute for Health and Productivity Management, employer break-out co-facilitator; break-out session one oral report; THE INTEGRATOR and Integrative Medicine Communications, Newton, MA)

A brief sampling follows of the unusual, rich initiatives presently under way in the "petri dish of real world experimentation," as Sullivan put it, from which we could gain insight through significant analysis.

- *PCP naturopathic physician* For five years, Regence Blue Shield of Washington allows members to choose naturopathic physicians as their primary care providers (PCPs). Some 3,000-5,000 plan members have been in this care for 3-5 years.

- *Guided imagery tapes for surgery patients* California Blue Shield commenced a program in 2000 through which all patients scheduled for 90 distinct elective surgeries would be mailed a guided imagery tape.

- *Core, broad CAM benefit* Health Net of Oregon has begun covering a wide array of CAM providers in the broadest, non-mandated CAM benefit in the nation.

- *Integrative clinic-based disease-specific programs* In numerous hospital sponsored and stand-alone, multi-practitioner "integrative clinics," practitioners are creating clinical programs which are not being reimbursed.

- *"Non-pharmacological" primary care* HMO of Illinois, a Blue Cross plan, allows members to choose a chiropractor as a primary care physician.

- *Pre-post surgery programs* Kaiser Northern California has brought in mind-body Peggy Huddleston to train practitioners in mind-body programs to deliver pre- and post-surgery.

- *Natural products on HMO websites* Between 75-100 million health plan members presently have access to discounted natural products as part of CAM benefits through their health plans.

- *Medicaid CAM* Acupuncture and naturopathic medical services are among the CAM therapies which are covered in some states under Medicaid.

- *Medical symptom reduction programs* CIGNA Healthcare has partnered with mindfulness meditation pioneer Jon Kabat-Zinn, PhD, to explore the potential cost-savings from the multi-week medical symptom reduction programs which have been shown to have significant clinical benefits.

- *Core CAM benefit for health system employees* Cincinnati-based Mercy Health Partners has created a two-tiered core CAM benefit, based around a health risk assessment and a nurse "health coach," which attempts to reflect CAM's dual roles in health promotion and maintenance and in disease-specific applications.

- *CAM in Medicare* American Specialty Health, Inc. has partnered with HMOs in more than one state to offer special sets of CAM services as covered CAM benefits for seniors.

- *Promoted acupuncture benefit* T. Rowe Price has had a rich acupuncture benefit on the books for a number of years which the employer has actively promoted to its members.

- *Group focused services* In Minneapolis, a physician with HealthEast is working with a PPO on a strategy for being reimbursed for delivering services to a group of individuals with like conditions in a group environment.

- *Natural product substitution* Portland, Oregon-based Michael Levin, is actively promoting an intriguing program for giving members the option of specific, lower-cost natural products for conventional pharmaceuticals for a handful of conditions.

- *CAM in community health* In numerous federally-funded community health centers nationwide, CAM providers are part of the mix.

- *Cost offsets in integrative clinics* A third of 28 health system-sponsored integrative clinics report an interest in undertaking cost offset research. No outcomes have been reported. (Integrative Clinic Benchmarking Project, THE INTEGRATOR)

- *Employer's onsite integrative clinic* Husky Injection Molding in Ontario has acupuncturists, massage therapists and a naturopathic physician onsite, side-by-side with conventional medical providers, to serve their 1300 employees.

- *CAM in health and productivity* The Institute for Health and Productivity Management, a not-for-profit, employer-focused group. has a board level interest in exploring models for appropriate CAM integration.

The list of projects presently underway which can help demonstrate the appropriate role for third-party payment for CAM is lengthy. Unfortunately, without analysis, we are left with a kind of "organizational anecdote" rather than model projects which can be readily adopted or emulated.

Current federal research initiatives in the petri dish of CAM reimbursement

Outside chiropractic, federal research institutions have taken a few, small steps toward supporting analysis of the real world "petri dish" of diverse CAM reimbursement initiatives. HCFA's funding of the Ornish program is the most significant demonstration project, outside of chiropractic. The most visible effort to create an ongoing information infrastructure is a hopeful new health services research initiative initiated by the NIH NCCAM in the fall of 2000. The initiative represents the first formal funding of projects which look at integration through both payment and delivery. NCCAM sources state that some 80 inquiries and 40 applications were received. According to sources in the industry, at least a handful of these propose to analyze utilization and experience data. This initiative, while an excellent step in fulfilling the health services responsibilities of the NCCAM enabling legislation, involves relatively few dollars, is anticipated to generate only speculative data within the next 2-3 years, and does not come near to responding adequately to the robust nature of CAM payment explorations noted above. Notably, NCCAM sources note that very few of the 40-50 other funded NCCAM projects have any economic dimension.

Notably, the NCCAM concept paper on the health services initiative points out the need to look at both payment and delivery. Given historic problems in getting physicians to adopt best *conventional* practices even when quality research exists, to create appropriate utilization of CAM -- even in a context where effectiveness and cost-effectiveness has been fully established – means knowing how to create relationships which will support appropriate utilization and referral. This suggests the need for a parallel exploration of how CAM networks can create the reporting and personal relationships with conventional practitioners.

Recommendations

Recommendations

1. ***Vastly expand the allotment of federal research and development dollars which directly focus on the inter-related, practical questions of third-party payment and integrated delivery. Fund demonstration projects.***

   Impacting human health means impacting the marketplace. Payers care about efficacy but they need to know about utilization and cost. Promote a meeting between, on the one hand, the employers, networks and managed care firms involved with the CAM payment and delivery industry, and, on the other, federal research agencies (NCCAM, CDC, AHRQ, HRSA, DoD) -- like the May 14, 2001 meeting between NCCAM and the natural products industry -- to explore partnerships in real world research. Consider seriously the view, held by three-quarters of the executives leading the integrative medicine industry, that we can learn more, faster about the optimal role for CAM in the payment and delivery system in the United States through health services research than through our current agenda.

2. **Explore CAM reimbursement not just as few modalities and providers which might be grafted onto conventional practice but as a reflection of a grassroots, consumer-driven and CAM provider-backed effort to create payment model which embraces primary prevention.**

   The gravity in the CAM reimbursement exploration pulls CAM into the shape and size which is allowed by the disease orientation of present reimbursement models. To allow these structures, with their own, inherent, non-integrated, reactive tendencies to dominate the exploration or reimbursement may be to miss the opportunity which CAM represents in US payment. Use this exploration to help open up our national conversation about what we want from what we call "health care." For instance, the current coding and payment system honors the complexity of declining health. The incentive structure supports the provider making a case for complexity (and additional payment) if the patient needs to see a specialist, a new drug, a hospitalization. We need to understand how to better capture and code for the complex process of health enhancement. Convene a Blue Ribbon, multi-stakeholder, brainstorming panel which will explore strategies for coding and coverage, which respect the complexity of primary prevention, personal empowerment, health promotion and health creation.

3. ***Create incentives which will support multi-year contracting between purchasers and plans.***

   CAM, and all primary prevention and health promotion, face an economic justification for abdication of health-oriented approaches from healthplans and employers. Classic, lowest common denominator thinking: *If we invest in health, the individual will take advantage of the services then jump to a lower cost plan which doesn't pay for health promoting programs.* Plans and employers must be incentivized, and if need be, mandated, to move to multi-year contracting. Year-to-year contracting does not support the longer-term investments in health creation.

4. **Continuously acknowledge the critical importance of government in evolving CAM's appropriate role in payment and delivery.**

   The non-patentable, low-tech nature of CAM products and services ensures the continuous under-funding of CAM research, policy and advocacy from the private sector. Under funding creates a false impression of lower value. Government has, of necessity, a special role to play if these services -- which represent a kind of natural health care commons -- are to find their optimal place in US payment. CAM becomes an extension of public health. The Commission should urge the creation of a federal office, outside of the NIH, which will serve as an energetic center for stimulating ongoing exploration.

5. **Focus resources on strategies for building the relationships which will support optimal reimbursement patterns.**

   Good policy and good research require good relationships for good implementation. This truism is especially important in overcoming the historic polarization between CAM and convention. Give CAM and integrative medicine providers seats at the policy and regulatory tables where reimbursement policy is shaped. Optimal coverage of CAM implies optimal referral patterns as well as optimal access. Create health services research programs which explore models for creating partnerships between distinct networks of conventional and CAM providers.

Appendices

A. Distillation of Survey Data

B. Typical Product Design and Management

C. Product Design and Pricing: Unusual

D. Industry Findings: Member Experience

E. Industry Findings: Practitioner Experience

F. Industry Findings: Employer/Plan Experience

A. Distillation of Survey Data

Table 1: Perceptions of Potential Cost Offsets from CAM in 10 Surveys

The following table brings together into one place data points from an array of studies which ask for perceptions of whether complementary and alternative medicine (CAM) reduces the use of conventional providers, treatments or prescription drugs.

Survey Sponsor (Year)	Population Surveyed	Perceptions of Conventional Service Offsets
Consumers		
Landmark Healthcare (1997)	Adult U.S. residents with insurance coverage using CAM	• 30% said CAM diminished use of conventional treatment
Alternare Health Services, Group Health Cooperative of Puget Sound, Premera Blue Cross (1997)	Managed care members in two Washington state managed care organizations who used covered CAM services (1)	• 55% said CAM lowered use of conventional services • 61% said CAM lowered use of prescription drugs • For patients of acupuncturists and naturopathic physicians, responses were higher, ranging from 59% to 66%
Stanford University, American Specialty Health Plans, HealthNet (1998)	Adult U.S. residents using CAM	• 55% said CAM lowered use of conventional services (3) • The type of CAM use with the least effect on conventional services was vitamin therapy (21%) • Nearly two-thirds (64%) of those who saw chiropractors or practitioners of traditional Chinese medicine (TCM) noted cost offsets.
Traditional Acupuncture Institute (1996)	Patients of licensed acupuncturists	• 84% of those who were seeing an MD were seeing one less following acupuncture • 70% who had surgery recommended were able to avoid the surgery
Integration Strategies for Natural Healthcare (1995)	Patients of licensed naturopathic physicians (ND)	• 48% of all patients believed their treatment had lowered use of prescription drugs • 68% said that after seeing an ND, they successfully cared for conditions at home for which they would have seen a doctor in the past
Sorelli B/Triad Healthcare (1999)	Adult U.S. residents using chiropractic	• 33% said a chiropractic visit lowered use of prescription drugs
Physicians		
Sisters of Providence, Fransciscan Health (Medalia Healthcare) (1997)	Primary care physicians in a 45 clinic network	• 30% said appropriate use of CAM could provide more cost-effective care • 69% said appropriate use of CAM could lead to savings under capitated contracts
Baptist St. Vincent Health System (1999)	All health system physicians	• 58.9% said CAM can be valuable in achieving more cost-effective care
Payers		
Landmark Healthcare (1998)	HMO executives in firms which cover some CAM (2)	• 21% said CAM lowers cost of care • 33% said CAM is cost-neutral
International Foundation of Employee Benefits Professionals (1999)	Human resources executives in corporations which cover some CAM	• 0% have analyzed whether or not any cost-offsets were achieved from CAM.

Notes: (1) Covered services in the study were provided by credentialed networks of massage practitioners, acupuncturists and naturopathic physicians Perceptions of service and drug offsets tended to increase with the level of training and scope of practice of the providers. (2) Most of the covered CAM was chiropractic. (3) The findings ranged from just 22% for users of "vitamin therapy" to 64% for users of chiropractors or traditional Chinese medicine.

Source: Integration Strategies for Natural Healthcare; THE INTEGRATOR, April 2000

Table 2: Demand/Marketplace and Effectiveness/Cost and as Motivations in CAM Inclusion Decisions in Five Surveys

Survey Sponsor *	Landmark Healthcare	International Foundation for Employee Benefits Professionals	American Compensation Association	Price-waterhouse-Coopers	Health Forum/ American Hospital Association
Year	1998	1999	2000	2000	2000
Surveyed	HMO executives	Employee benefits professionals	Employee benefits professionals	Benefits professionals, Fortune 200 firms	Nurse executives
Method	Telephone interview of HMOs with at least 5000 members	Written survey	???	Telephone survey	Fax survey
Surveyed	Random sample of 449 HMOs	1709	???	30	1200
Number	114	534	???	30	103 ^^^^
Requested	*Top Reason ^*	*Top Reason*	*Top Reason*	*All Reasons*	*All Reasons*
Demand and Market-Related issues	Requested by employers, groups (38%) Mandates (38 %) Differentiate from or meet competition (12%) Attract members (4%)	Request from employees (30%) Competitive edge (7%) Mandates (13%)^^	Employee requests (27%) Mandates (9%) Attract/retain employees (9%)	Employee requests (63%) Mandates (8%)^^^	Attract new patients (49%) Differentiates from competitors (29%)^^^^^
Total	92%	50%	45%	>63%	>49%
Effectiveness and cost issues	Clinically effective (8%) Lower health costs (0%)	Potentially more effective care (13%) Good fit with wellness programs (7%) Potential cost savings (3%)	Potential cost effectiveness (14%) Potential to address rising costs of health and disability/ cost containment (14%) Fits with existing wellness benefits (14%) Potential long-term group health savings (11%) Impact time off work (2%)	Potential cost savings (31%) Potential for more cost effective care (31%)	Clinical effectiveness (53%) Physician request (27%)
Total	8%	23%	55%	>30%	>50%

^ The Landmark survey asked a question on motivation which allowed for multiple responses: 71% noted consumer and marketplace issues, 29% effectiveness of therapies and 29% mandates. The survey also asked executives whether they viewed CAM as additive or a replacement: of those with programs, 54% stated that CAM reduces costs or nets out evenly.

^^ "Don't know" and "no response" noted by 27%.

^^^ An "other" category (18%) includes elements of both categories (PCP referral, local healthplan offering, competition).

^^^^ A "fax glitch" limited returns.

^^^^^ An additional option, "reflects organizational mission" (38%), crosses into both categories. When asked for the "top reason," 62% noted patient demand and 20% organizational mission.

Source. Weeks J and others. Manuscript in development entitled An Examination of the Emerging Economic Models of Complementary and Alternative Medicine in Managed Care, Employee Benefits and Hospitals.

B. Typical Product Design and Management

Table 3: Summary Data on CAM Activity in Selected Blues Plans

Note. This data is not to be viewed as a definitive product of an extensive survey. Data do not include plans with chiropractic-only benefits.

Characteristic	#	States
Offer discount CAM programs	7	MA, GA, NC, CA-BC, CA-BS, OR-BS, HI
LAc as a covered benefit, optional rider or core (all but 3 due to mandates)	7	NH-BC, NY, CO, CA-BC, OR-BC, WA-BC, WA-BS
ND services as a covered benefit, optional rider or core (all but one due to mandates)	6	NH-BC, CT-BC, MT (soon), WA-BC, WA-BS, AK
Massage as covered benefit, core	2	WA-BS, WA-BC
Direct entry midwifery as covered benefit, core	2	WA-BS, WA-BC
DC as covered benefit	--	Data not presented here; "assumed" in most by BCBA National Association
New programs known to be under discussion but not announced	5	NH, CT, RI, OH, IA
Offering CAM providers as primary care provider option to members	2	IL-BC, WA-BS
Different CAM networks through which CAM services, beyond chiropractic, are contracted	8	Alternare, Landmark, TAI, Alignis, Consensus, AMI, ASHP, CHP

Source: Integration Strategies for Natural Healthcare, Seattle, WA 1999 THE INTEGRATOR June 1999

Table 4: Blue Cross of California CAM Services

CAM Services Already Offered in Core Benefit	
Chiropractic	8 years
Acupuncture	5 years
CAM DC, LAc networks	American Specialty Health Plans (ASHP)
Healthy Extensions	
Access	Self-refer
Payment	Discounted direct pay
Practitioner services	Massage, yoga, hypnotherapy, fitness
Programs	Pritikin, nutrition
Products (books, tapes, memberships, etc.)	EverLife Store, Home Fitness Club, NordicTrack, others
Supplements	Essentials (Metagenics), plus EverLife, ASHP
Network	Direct contract, plus ASHP
Implementation	Individual and small group plans; large group by 1st qtr. 1999
Current lives	4.4 million members

Source: THE INTEGRATOR, January 1999

Table 5: Univera Acupuncture-Massage Core Benefit

Feature	Description
Location	Upstate New York
Network partner	Landmark Healthcare
Covered lives	130,000
Covered services	Acupuncture, massage[1]
Co-payment	$20
Conditions	Limited by plan design
Visits	10 maximum
Access	Gatekeeper referral
Network size	50 massage therapists, 10-12 acupuncturists
Starting date	By January 1, 2000, all members

[1] A chiropractic benefit is also offered under a state mandate.

Source: THE INTEGRATOR, April 2000

Table 6: Health Net of Oregon Core CAM Benefit

Feature	Description
Location	Oregon, statewide
Network partner	Complementary Healthcare Plans
Covered lives	100,000
Covered services	Chiropractic, acupuncture, naturopathic medicine, massage
Co-payment	• $10 or $15 for DC, ND, LAc • Always $25 for massage
Conditions	• Medical necessity • "Scope of license less CHP adjustments" based on payer parameters
Massage features	• "No medical necessity, since massage practitioners can't diagnose" • Direct access • Higher co-payment ($25) • Visit limits of 9 on $500 benefit, 18 on $1000, and 27 on $1500.
Visit limits	See "Dollar limits"
Dollar limits	• Core benefit is $500 • "Buy-up" to $1000 or $1500 levels for groups • No buy-up for individuals
Access	• Direct (no gatekeeper) • No pre-treatment authorization
Discount/ affinity	As a "wrap-around," after covered benefits are fully utilized
Network size	Statewide, approximately 400, with over one-half DCs
Starting date	April 1, 2000, as policies renew.

Source: THE INTEGRATOR, May 2000

Table 7: Plan Strategies which May Limit Services from CAM Providers

Note: The paradox of the current CAM network industry is that, in a moment when consumer interest in CAM is on the rise, the incentive structure for the CAM networks and HMOs may be to limit access to CAM care. This table describes some means by which CAM provider payments may be limited and the percentage of dollars which remain with the CAM network or HMO are highest.

Strategy	Comment
Fee Schedules	• Providers may be asked to accept lowered fee schedules in subsequent years
Prior Authorization	• Difficulty in gaining authorization for initial treatment or extended visits may shift depending on financial pressures, rather than on medical necessity
Withholds	• Use by networks may push providers to limit services in the hopes of re-couping 20% to 30% of their pay (the "withhold") • End-of-year payment of withholds may be related to factors other than productivity, such as the network's financial status and other perceived capital requirements
Co-payment levels	• Significant co-payments ($15-$20 to 50%) may limit patient access
Network limits	• Smaller networks may not include a patient's favored CAM provider • Low fee schedules may limit a CAM network's ability to expand • Access to services may be geographically difficult
Maximizing profits from new benefits	• The highest profit year for a new benefit is often the first, before the covered benefit is well-known • First-time contracts may be set very high, to capture as much income as possible
Gatekeeping	• An actuarial firm states that chiropractic utilization may decrease by as much as 75% [1] • Use of chiropractic in managed Medicare was found to be at about 1/10 of FFS use [2] • A Washington state study found direct access use of acupuncture, naturopathy, and massage at 100% more than a gatekeeper plan [3]

[1] Milliman and Robertson, 1999 (report to follow, December issue).
[2] US Office of the Inspector General, 1991-1992 (see Aug-Sept 1999 INTEGRATOR).
[3] Health Forum Institute, presentation by Peter West, MD, and John Weeks, February 1999

Source: THE INTEGRATOR, November 1999

Table 8: Chiropractic Usage Levels in Referral and Direct Access

Medicare (referral required)	
1996	0.61%
1997	0.96%
1998	1.08%
Medicare Fee for Service (no referral required)	Approx. 4.25%
American Chiropractic Association, estimate of use in the public	6.5%

Source: Office of the Inspector General (OIG) for the US HHS, June 26, 2000: *Chiropractic Care: Comparison of Medicare Managed Care and Fee-For-Service* released a report June 26, 2000. Printed in THE INTEGRATOR, 2000.

Table 9: Cost Shifting in Pricing a CAM Benefit

This information is included particularly for individuals who may not directly be involved in CAM benefits or benefit management but who wish to understand the interplay of such factors as co-payments, reimbursement levels and PMPM costs. These numbers were developed for a chiropractic carve-out product.

Column 1: Typical benefit structure at a $55 visit average.
Column 2: Starter-kit type structure, with a high co-pay on a relatively low ($40) provider fee
Column 3: Benefit in which PMPM cost is kept down ($0.73) through harsh limits on provider payments ($21) .

	Column 1	Column 2	Column 3
Shifted Factor	**Typical Benefit**	**"Starter Kit" Model**	**Cuts in Provider Fees**
Benefit design			
Benefit limit	$1500	$1500	$1500
CoPay amount	$10	**$20**	$10
Utilization			
Membership	1000	1000	1000
Penetration rate	80%	80%	80%
Raw utilization	5%	5%	5%
Utilization rate	4%	**1%** (gatekeeper)	4%
Member months	12000	12000	12000
Annual utilization	480	**120**	480
Claims expenses			
Cost/visit	$55	**$40**	**$21**
Gross claims	$26,400	$4,800	$10,080
Gross copay	$4,800	$2,400	$4,800
Net claims	$21,600	$2,400	$5,280
Net claims PMPM	$1.80	**$0.20**	**$0.44**
Administration			
Total administrative	$3811.76	$423.50	$3,520
Administrative PMPM	$0.32	**$0.04**	$0.29
Total cost PMPM	$2.12	**$0.24**	**$0.73**

Source: THE INTEGRATOR, April 2000.

Table 10: Typical Network Fee Schedules to CAM Providers

Each fee listed here has been offered by at least one payer. Note that these fees typically *include* co-payments of at least $10 by the patient. Thus the exposure to the HMO or insurer may be less than 50% of the total fee.

Provider Type	Low End	High End
Chiropractor	$17	$30
Acupuncturist	$29[1]	$75
Massage Therapist[2]	$35	$73
Naturopathic Physician[3]	$115	$225

[1] This figure was after a 20% withhold.
[2] Based on a 61-90 minute session.
[3] Initial 61-90 minute evaluation and management. Typically the rate is just below or at the MD schedule.

Source: INTEGRATOR November 1999

Table 11: Naturopathic Physician Fee Schedules in Washington State

	Office Visit-New Patient					Established		Consult
Healthplan	99201 Minimal 10 mins	99202 Brief 20 min	99203 Limited 30 min.	99204 Extended 45 min.	99205 Compre. 60 min.	99213 Limited 15 min	99215 Compre 45 min	99244 60 min.
Regence Blue Shield (PPO)	40.21	63.13	88.06	128.67	160.41	49.02	118.44	174.30
Regence Blue Shield (HMO)	40.58	63.95	88.96	129.95	162.75	48.78	114 79	N.A.
United Healthcare of WA	30.00	51.00	70.00	95.00	128.00	40.00	90.00	130.00
Premera Blue Cross	30.00	51.00	70.00	95.00	128 00	40.00	90.00	130.00
Group Health Cooperative of Puget Sound	30 00	51.00	70.00	95.00	128.00	40 00	90.00	130.00
First Choice Health Network	30.00	43.00	70.00	95.00	132.00	40.00	97.00	134 00
Uniform Medical Plan	40 58	63 95	88.96	129.95	162.75	48.78	114.79	N.A.
Pacificare of Washington	30.00	45.00	65.00	85.00	115.00	40.00	80.00^	115.00

^ Listed as 40 minutes.

Source: THE INTEGRATOR, March 2001.

Table 12: Distribution of Dollars in an Employer's Non-Mandated CAM Rider

Note: While the following does not encompass all possible scenarios, the figures presented were offered by West Coast executives involved with the CAM industry. The table is built out from an assumption of a $1.40 PMPM payment to a CAM network for a non-mandated, covered rider offered by an employer through an HMO. Two noteworthy omission in this analysis: first, a comparative breakdown in the inflation of prices on conventional services through managed care's overhead; and second, linkage to a specific CAM benefit design.

PMPM = Per Member Per Month

Payee	**Payments as % of Network PMPM**	**Scenario 1: High % to Providers** Provider 80% of network, HMO at 70% above		**Scenario 2: Low % to Providers** Provider at 40% of network, HMO at 200% above	
		PMPM	Distribution in 100,000 lives	PMPM	Distribution in 100,000 lives
Total Payment by Network to Provider	40-80% < network revenues	$1.12 PMPM to providers	$112,000	$0.56 PMPM to providers	$56,000
Total Payment by HMO to Network *"Wholesale cost" of rider*	--	$1.40 PMPM to network	$38,000	$1.40 PMPM	$84,000
Total Payment by Employer to HMO [1] *"Retail cost" of rider* [2]	70-200% > network	$2.38 PMPM to employer	$98,000	$4.20 PMPM to employer	$280,000
Employer PMPM paid to providers	13-47%	47%	NA	13%	NA
Cost of $50 CAM service to employer	NA	$106	NA	$384	NA

[1] These multipliers were based on conversations with two executives and confirmed by one HMO executive.
[2] "Retail costs" include broker fees of 0.5% to 10% or higher, based on the annual premiums generated by the rider.

Source: THE INTEGRATOR, November 1999

C. Product Design and Pricing: Unusual

Table 13: Mercy Caring Employee CAM Benefit

Characteristics of Base Benefit: All Employees

- Available to employees and family
- Must join Mercy Caring by filling out a risk appraisal sent to home
- Must work with a Mercy Personal Health Partner on guidance to services
- *Well-Advised: Your Guide to Total Health Care* sent to each household
- Partner services and assessment are paid entirely by employer
- Other services 50/50 employer/employee payment
- Benefits are per calendar year
- Under wellness services and a diagnosis is not needed
- *Services only available through Mercy Holistic Health and Wellness facilities*

Services in Base CAM Benefit	Visits per year
Acupuncture	4
Biofeedback	4
Fitness Assessment	1
Hypnotherapy	1
Health Guidance	2
Massage/bodywork	6
Energy medicine/reflexology	6
Holistic nutrition consultation	2
Weight mgmt. (10 week class)	1

Enhanced Benefit: Individuals with "Serious Conditions"

- Individual identified as high risk by program medical directors
- Must have a diagnosis of a serious health condition
- Must be participating in a formal disease management program
- If one meets these conditions, CAM benefits are paid on the same basis as other covered services (95/5)
- Can have up to 30+ covered visits per modality
- PHP helps guide this program

Note: This demonstration project uses an SF 12 with some additional questions: conventional services utilization; unscheduled emergency room visits; medication usage; pain scale; days of work missed; use of any therapies or classes at the centers; and a Lichert scale for effectiveness.

Source: Mercy Health-Partners, Cincinnati, Ohio; THE INTEGRATOR, September 2000

Table 14A: Two CAM-PCP Plans at a Glance

Feature	HMO Illinois/Alternative Medicine, Inc. (AMI - IL)	Regence Blue Shield (WA)
CAM-PCP type	Chiropractic Physician	Naturopathic Physician
Reason for development	Approached by vendor	Response to state mandate
First month of operation	November 1998	January 1996
Potential Member Pool	800,000	300,000
Members on CAM-PCP plan	Approx. 200	Approx. 3,000
CAM-PCP network	AMI	Internally Credentialed
Promotion of the product	None by HMO, late 1999 by AMI; in HMOI 2000 directory	None, except listing in Regence' provider directory
Total network providers	Initially 16, Growing to 35	45-60
Access to prescription drugs	Through AMI's affiliated MDs/DOs [1]	NDs have a limited prescription formulary; other drugs via MDs/Dos [2]
MD/DO relationships	AMI MD team leader plus contracted network	Developed by individual ND-PCPs; required for hospitalizations
At risk	AMI	Regence
Payment model	Capitation plus bonus, shared "back-end"	PPO fee schedule
Availability of experience data	Rich, but very thin (via AMI)	No analysis or reporting despite significant data

[1] Following a media account of the HMOI/AMI product, American Chiropractic Association president James Mertz, DC, restated its historic position on prescription drugs: "The ACA is opposed to any movement within the profession to add the prescribing of drubs to the doctor of chiropractic scope of practice." (*ACA News Bulletin*, November 30, 1999)
[2] The naturopathic physician prescriptive formulary in Washington state was developed based on the idea that they have access to agents derived from natural sources. Examples are hormones and some antibiotics.

Source: THE INTEGRATOR, January-February, 2000

Table 14B: AMI Comparative Data with HMOI Normative IPA Results on DC-PCP Plan

Period from January 1, 1999 – December 31, 2000

	AMI	HMOI
Days/1000	74.8	244.8
Admissions/1000	25.7	65.5

Note: The data looks at roughly 300 covered lives. Pharmacy costs were also lower in the DC-PCP plan than in the HMO Illinois normative data.

Source: Alternative Medicine, Inc.; THE INTEGRATOR, May, 2001

Table 15: Influence of Insurance Mandate on Revenues of Selected ND-PCPs

All of the practices selected are naturopathic physicians who chose to participate in insurance coverage and are credentialed as primary care physicians with Regence Blue Shield.

Physician	Pre-Mandate Estimates (1995)			Post Mandate Estimates (1999)				
	Gross ($ 000)	Net ($ 000)	% patients with some naturopathic coverage [1]	Gross ($ 000)	Net ($ 000)	% patients with some naturopathic coverage [2]	% patients with some Regence BS coverage [3]	Patient Contact Hours per week
#1	$130	$35	10%	$200	$50	85%	65%	NA
#2	$145	$50	0%	$230	$80	70%	35%	32
#3	$75	$30	13%	$145	$60	75%	30%	30
#4	$90	$35	4%	$185	$60	65%	35%	32
#5	$75	$25	2%	NA	$35	95%	45%	20
#6	NA	NA	NA	$220	$50	85%	25%	20
#7	NA	NA	NA	$175	$40	80%	30%	16
#8	$110	$25	0%	$230	$65	75%	45%	28
#9	$80	$25	0%	$130	$35	33%	12%	30
#10	$120	$46	0%	$145	$50	60%	45%	22

[1] A small percentage of patients not viewed as covered may have paid cash, then independently billed insurers
[2] Percent of patients with insurance covering some naturopathic services does not equal the percent of practice revenues with reflect cash payments. The cash payments by otherwise insured patients for natural pharmacy, non-covered lab, non-covered services (beyond benefit, not medically necessary, etc.) are substantial. For instance, #3, with 75% of patients covered by insurance, only estimates that insurance reimbursement represents 50% of revenue.
[3] Most of the Blue Shield is Regence ND-PCP program, with which all providers were involved.
[4] The gross for this provider does not include natural pharmacy sales, which were handled as a separate line of business.
[5] The pre mandate data from the 1980s was slightly adjusted to reflect 1995 dollars. Note that clinical hours per week for this provider were also longer
[6] The provider cut back practice hours 20% with insurance In addition, the percent insurance "would have been 90%" had the provider not been using a non-covered, investigational procedure

Source: THE INTEGRATOR, January-February 2000

Table 16: Institutional Involvement in Ornish CAD Reversal Program

Institutional Partners		Insurance Coverage	
Original Program Sites	**New Sites ***	**Cover the Program**	**May Cover on a Case-by-Case Basis**
• Alegent Immanuel Medical Center/Alegent Heart Institute *, Omaha, NE • Alegent Bergen Mercy Medical Center *, Omaha, NB • Beth Israel Medical Center, NY, NY • Mercy Hospital Medical Center/Iowa Heart Center *, Des Moines, IA • Broward General Medical Center *, Fort Lauderdale, FL • Palmetto Richland Memorial Hospital *, Columbia, SC • Mt. Diablo Medical Center, Concord, CA • Beth Israel Deaconess/Harvard Medical School, Boston, MA • Scripps Hospitals and Clinics *, La Jolla, CA * Denotes participant in Medicare pilot	• School of Medicine, UCSF • California Pacific Medical Center, SF, CA • Franciscan Health System of the Ohio Valley, Cincinnati, OH • Swedish American Health System, Rockford, IL • Swedish Medical Center/First Hill, Seattle, WA • St. Francis Hospital and Health Center, Blue Island, IL • Windber Medical Center, Johnstown, PA. *In addition, one new program is offered directly through an insurer:* • Highmark BCBS of Western Pennsylvania, Pittsburgh, PA	• Anthem BCBS • Benchmark • Best Choice • BCBS Nebraska • BC California • BS California • BCBS South Carolina • Exclusicare/Mutual • Franciscan Health System Highmark Inc. • Humana Health Plans of South Florida • Mutual of Omaha • Secure Care • Medicare (via pilot)	• Alternative Benefits Plan • Arps Redi Mix Benefits Group • BAAI • BCBS Alabama • BCBS Tennessee • Central States Health & Life of Omaha • Board of Pensions Presbyterian Church • City of Omaha, Companion HealthCare • Federal BCBS • Health Care Preferred – Payless Cashways • Medical Mutual of Omaha • Physicians Health Plan of SC • Plumbers & Steamfitters – Local Union 33 • ProAmerica Managed Care • Provident Health Care • Provident Life • Prudential L.D • Secure Care • Select Benefit Administrator • Travelers • United HealthCare EPO • United Healthcare of the Midlands (SHARE) • Woodward Governor.

Source: Preventive Medicine Research Institute, Sausalito, CA; THE INTEGRATOR, March 2000

Table 17: Potential for Expanded CAM in Medicare + Choice

The following scenario was described by a HCFA official.

	PMPM
HCFA PMPM rate, set county by county	$600
Qualified HMO's line-by-line approved plans for offering "original" Medicare (A plus B) services	$550
"Surplus," which must be reflected in additional benefits	$50
Typical PMPM pricing of for various CAM services as one line in the $50 "surplus"	$1-$5

Source: Integration Strategies for Natural Healthcare, INTEGRATOR April 1999

Table 18: Combined Affinity/Discount and Section 125 Discounts

Service or Discount	**$**
Integrative clinic introductory consult	$250
Less 20% affinity network discount	$50
Total after Affinity	$200
Less 30% Section 125 pre-tax discount	$60
Total after affinity and 125	$140
Total $ savings	$110
Total combined discount rate	44%

Source: THE INTEGRATOR, April 1999

Table 19: Potential Cost Reductions in an HMO with 2 Million Covered Lives

Note: The table is based on data for use of cholesterol-lowering drugs in the entire US population. Estimates would be adjusted to reflect the size and demographics of the HMO, employee or health system population served

Rx's/1000 HMO lives	160.4[a]
Rx's/2 million lives/yr	320,800
Average cost/HMO Rx/mo	$69.22
Eskimo-3 cost/mo	$20.00
Cost reduction/Rx/mo	$49.22

Assume 5% of the Rx population has used nutritional intervention for 12 months

Total Rx's eliminated/deferred	16,040
Ave monthly Rx reduction	1,337
Ave monthly cost reduction	$65,790
Annualized savings	$789,489 [b]

a. Pharmacy cost data from *1998 Novartis Pharmacy Benefit Report*
b. Annualized savings assumes a fully covered benefit. Actual savings increase to the extent patient co-pays are involved.

Source: Based on data provided by Tyler Encapsulations, Portland, Ore. THE INTEGRATOR, August-September 1999

D. Industry Findings: Member Experience

Table 20: Member Experience of Covered CAM in Three Surveys

Surveyed: Users of coverage CAM benefits.

	1997	1999	2000
Survey Characteristics			
Sample size	960	1500	1300
Respondents	675	707	588
Percent	70%	47%	45%
Providers types used/percent *Note: RD/nutritionist < =1%*	AC, DC, LM *% N.A.*	AC/41, mass/34, ND/24	DC/19, AC/22, Mass/50, ND/7
Experience of Care			
Care was helpful ("extremely"/"very"/ "moderately")	92% (56/26/10)	95% (57/29/9)	97% (64/29/4)
Condition changed ("completely cleared"/"significantly better"/"somewhat better")	N.A.	92% (10/61/21)	96% (8/70/18)
Would go back to this provider? ("definitely"/"probably")	N.A.	93% (82/11)	96% (90/6)
Potential Cost Offsets			
Decreased use of conventional care? ("substantial"/"slightly")	55% (25/30)	60% (36/24)	60% (31/29)
Decreased use of prescription meds? ("substantial"/"slightly")	61% (34/27)	60% 36/24	59% (36/23)

Source: Alternare of Washington, 2001, THE INTEGRATOR, May 2001

Table 21: Member Experience of Covered Chiropractic: ChiroAlliance

Survey of patients of covered chiropractic services.

Provider Information	#	%
Intensity of complaints		
Disabling	144	23%
Severe	377	61%
Complaint chronicity		
Acute	351	57%
Chronic	269	43%
Referred by a medical physician		
Yes	295	48%
No	325	52%
Previously tried unsuccessful care		
(could mark more than one)	245	40%
Primary Care physician	108	17%
Massage	92	15%
OTC drugs	88	14%
Physical therapy	83	13%
Other chiropractors	60	10%
Orthopedic	64	10%
Neurology (47) or surgeon (17)	11	2%
Acupuncture (9) or naturopath (2)		
Prescription drugs were given for the condition (n=598)		
Yes	387	65%
No	211	35%
Improvement in activities of daily living/function		
90% or 100%	382	62%
70% or 80%	185	30%
60%, 50%, 40% or 30%	55	9%
20%, 10% or 0%	12	2%
Improvement in pain intensity by % of reduction		
90% or 100%	365	59%
70% or 80%	191	31%
60%, 50%, 40% or 30%	54	9%
20%, 10% or 0%	10	2%
Satisfaction (n=611)		
"Very satisfied"	518	85%
"Satisfied"	84	14%

Source: ChiroAlliance, Jacksonville, FL; THE INTEGRATOR, January-February 2001

Table 22: Six Month Quality of Life and Health Status Data: Tzu Chi Institute

Note: N = 137. The data are based on the standardized sf-36 scale. P<.05

	General Population	Tzu Chi Population	
	Baseline/ Norms	*Baseline*	*After 6 Months*
Physical Function	80.2	70.4	75.6
Role-Physical	85 7	38.1	51
Bodily Pain	78	53.5	61.2
General Health	77.6	52.1	58.5
Vitality	68.9	40	47.2
Social Function	88.3	61.2	68.5
Role-Emotional	87	55 6	63.7
Mental Health	79	63 3	68.1
Physical Composite	51 4	42 5	45 1
Mental Composite	52.6	40.5	43.6

- On a separate index, at six month 82% rated their satisfaction at 8 or higher on a scale which ranged from 0 (poor) to 10 (outstanding). A nearly unanimous 97% said they would recommend the services to friends.
- Baselines on the SF-36 were worse than population norms on all markers. (See Table 2.) Significant, existing health problems were reported: chronic pain (25%), cancer (20%), cardiovascular (20%), thyroid (10%), depression/anxiety (8%), hepatitis (55), diabetes (4%), seizures (4%) and HIV (1%). Over two-thirds (68%) reported at least three health conditions for which they were seeking treatment. Seventy-one percent of the patients were female, with an average age of 49. Over three quarters had a history of smoking for over five years, though most had quit. Roughly 80% had used some CAM prior to enrolling in the Tzu Chi program

Source: Tzu Chi Institute, Vancouver, B.C. (604) 875-5666; THE INTEGRATOR, January-February 2001

Table 23: TapestryCare/Marino Health Centers

Surveyed: Users of network based CAM services.

Question: Did the service in any way change your use of conventional medical visits or prescriptions drugs or OTC medications?

Question	%
Yes, there was a change	78%
No, no change	22%
Decreased conventional office visits	59%
Decreased prescription or OTC drugs	67%
Increased prescription or OTC drugs	4%
Increased office visits	0%

Source: Tapestry Care, 2000. THE INTEGRATOR, January-February 2001

Table 24: Seniors with Blue Shield Medicare Risk CAM Benefit

Survey of seniors with a California Blue Shield Medicare CAM supplement.

Number surveyed	1597
Response rate	46%
% used CAM	41%
CAM was factor in choice of plan	20%
% of these joined due to chiro	27%
% of these joined due to acupuncture	20%
% of users willing to pay extra for CAM coverage	59%
% of non-users willing to pay extra fro CAM	31%
% of all respondents willing to pay >$11/month for CAM	15%
Changes in health status due to CAM?	None associated

Source. John Astin, PhD, Stanford University. THE INTEGRATOR May 1999

E. Industry Findings: Practitioner Experience

Table 25: Conventional Practitioner Views of CAM Integration on Care, Cost and Satisfaction

Survey of conventional practitioners in an mixed staff/network model HMO

Measured	Effective	Cost Effective	Patient Satisfaction	Physician Satisfaction
Better	42.8%	20.8%	78.6%	39.6%
No change	37.7%	15.1%	7.6%	31.5%
Worse	4.4%	35.9%	1.9%	22.0%
Not sure	11.3%	25.2%	7.6%	3.1%
No response	3.8%	3.1%	4.4%	3.8%

Source: Group Health Cooperative, 2001; THE INTEGRATOR, April 2001

Table 26: Physician Views of Specific CAM Providers and Modalities

Survey of conventional practitioners in an mixed staff/network model HMO

N = 159

Measured	General Knowledge "a lot"	Perceive Effective "always" plus "usually"	Interest in Learning
Naturopathy	7.6%	37.7%	12%
Chiropractic	22.6%	64.1%	3%
Homeopathy	6.7%	15.7%	4%
Osteopathy	18.7%	57.9%	6%
Ayurvedic Medicine	0.6%	8.1%	5%
Chinese Medicine	2.5%	27.7%	9%
Massage Therapy	22.6%	72.3%	6%
Acupuncture	14.5%	64.2%	16%
Biofeedback	13.2%	65.9%	11%
Therapeutic Nutrition	5.7%	23.9%	13%
Megavitamin Ther.	3.1%	6.3%	3%
Botanical/herbals	8.2%	32.1%	25%

Source: Group Health Cooperative, 2001, THE INTEGRATOR, April 2001

Table 27: Physician and Patient Views of CAM Treatments

Measured	Physician Perception	Patient Perception
Very effective	11.1%	82%^
Somewhat effective	52.8%	10%
Not effective	10.2%	9%
Not sure	18.7%	--
No response	7.2%	--

^ The question in the patient survey asked not about "effectiveness" but "helpfulness."

Source: Physician data, Group Health Cooperative, 2001. Patient data, The Alternare Group, 1997. The survey of patients of naturopathic physicians, massage practitioners and acupuncturists who utilized covered benefits included both Group Health patients and patients insured by Premera Blue Cross (see January 1998 INTEGRATOR); THE INTEGRATOR, April 2001

Table 28: Physicians and CAM in Three Studies

	U Maryland (1994-95)(1)	Kaiser Northern California (1996) (2)	Medalia Healthcare (1996)(3)
Region surveyed	Nationwide	Northern California	Puget Sound, WA
Surveyed	Primary Care Physicians	Primary Care Physicians	Primary Care Physicians
Response rate	10 6% FP, 13.7% IM, 31.7% Ped.	70.4%	41%
Use in Practice	*Would use in practice:* 65% diet/exercise 24.5% counseling 43.8% behav med 47.6% biofeed./relax. 42.8% meditation 48.7% acupuncture 48% hypnotherapy 30.9% massage/TT 34.3% herbal 29% chiropractic 27.9% homeopathy 21.3% megavitamin 20 6 electromagnetic	*Used in practice or recommended, past 12 months* 89% any 33.6% chiropractic 57.2% acupuncture 30.9% acupressure 42.5% massage 8.8% herbal 8.3% megadoses vitamins 48.9% meditation 67.6% relaxation 31.9% biofeedback 11.5% hypnosis 19.5% yoga ·7.9% Tai chi 58% support groups	*Have ever referred* 73% chiropractic 44% acupuncture 65% massage 37% naturopath
General interest and belief	*Have had some C.E. on:* 19.1% chiropractic 18 3% acupuncture 16.4% acupressure 15.8% homeopathy 30.2% massage 13.8% herbal 23.6% megavitamin 58.4% biofeedback/ relaxation	75% interested 35% very interested 67% OB-GYN interested 45.3% very interested	35% personal or professional interest 35% taken at least 1 course 61% would like more CE *Believe useful:* 40% chiropractor 36% acupuncture 40% massage 16% naturopath
Reasons for interest/ perception of value		60% shortcomings of conventional methods 85% believe that holistic approach can treat some things more effectively	May be effective *(1 or 2 on 5 scale)*: 38% More cost-effective 30% More satisfied patients 69%
Would like to have plan "make available" to members (PCP)		52% chiropractic 84% acupuncture 62.9% acupressure 43.8% massage 15.5% herbal 6.9% homeopathic 79.6% biofeedback 56.9% hypnosis 48.9% yoga	Believe using *some* CAM can lead to cost savings under capitated contracts: 69%

(1) Berman BM Singh BB et al. Primary Care Physicians and Complementary-Alternative medicine: Training, Attitudes, and Practice Patterns. J Am Board Fam Pract 1998, 11:272-81.
(2) Gordon NP, Sobel DS, Tarazona EZ. Use of and interest in alternative therapies among adult primary care clinicians and adult members in a large health maintenance organization. West J. Med 1998; 169:153-161.
(3) Weeks J. Layton R. Integration as Community Organizing: Toward a Model for Optimizing Relationships Between networks of Conventional and Alternative Providers Int Med 1998; 1:15-25.

Source: INTEGRATOR, November 1998

Table 29: Primary Prevention and Health Promotion in CAM Practitioner-Patient Encounters

Survey of network CAM providers on HEDIS-type questions relative to prevention and health promotion.

	DC	LAc	ND
Number surveyed	252	42	34
Respondents	198	30	23
Rate of response	79%	71%	68%
Do you ask new patients ...			
General Health Issues			
Last physical exam?	86%	80%	100%
Last cholesterol checked?	36%	43%	78%
Last blood pressure checked?	77%	77%	74%
Ever diagnosed with diabetes?	87%	83%	100%
Health Behavior Issues			
If they smoke?	91%	97%	100%
Alcohol consumption?	82%	97%	96%
Exercise regularly?	97%	100%	100%
Drug abuse?	63%	93%	91%
High risk sexual behavior?	19%	30%	83%
Women's Health Issues			
How often they do a breast exam?	28%	47%	87%
Last pap smear?	48%	73%	100%
Last mammogram?	39%	33%	96%
If they are pregnant?	93%	87%	83%
Men's Health Issues			
Last prostate exam?	54%	53%	87%

Source: Complementary Healthcare Plans, Portland, Oregon, 2001; THE INTEGRATOR, May 2001

F. Industry Findings: Employer/Plan Experience

Table 30: CAM Utilization Experience in an HMO and PPO Plan

Measured	HMO: . Referral only, no cap on services	PPO: Direct access/ capped benefit	Total
Total Payments *	$883,305	$1,043,991	$1,927,296
Average enrollment in plan during study*	374,833	461,392	836,225
Cost per member per year	$2 36	$2 26	$2.30
Cost per member per month	$0.20	$0.19	$0.19
Total members/insured using CAM benefits	2540	5550	8090
% of eligible using CAM benefits	0.6%†	1.2%†	1.0%
Average payment per user	$347	$188	$238
% of 12 month activity in first 3 month period	23%‡	21%‡	N.A.
% of 12 month activity in last 3 month period	27%‡	27%‡	N.A.

* From November 1, 1996, through October 31, 1997.
† $p < 0.001$ for comparison of percent of eligible using CAM benefits between plans
‡ $p < 0.001$ for comparison first three months to last three months (within both plans)

Source: Stewart D, Weeks J, Bent S Utilization, Patient Satisfaction and Cost Implications of Acupuncture, Massage, and Naturopathic Medicine Offered as Covered Health Benefits: A Comparison of Two Delivery Models. Accepted for publication, *Alternative Therapies in Health and Medicine*.

Table 31: Large Employer Views of CAM

Question	Finding
Reasons for coverage	
Employee request	63%
Potential for cost savings	31%
Potential for more effective care	31%
State mandates	6%
Other (competition, PCP referral, local plan offering)	18%
What is covered?	
Some CAM	76%
Non-chiropractic CAM	59%
Acupuncture	48%
Nutritional counseling	17%
Massage therapy	14%
Beliefs about CAM	
CAM is cost effective	63%
CAM has value	83%
Level of analysis (if offer)	
Analyze data	17%
Assessed impact on medical costs	6%
Plan to analyze data	20%
Do not offer CAM	
Don't expect to expand coverage in next 2 years	86%
Lack of effectiveness evidence an obstacle	75%
Additional costs an obstacle	56%

Source: PricewaterhouseCoopers, 2000; THE INTEGRATOR, December 2000

Table 32: Findings of the IFEBP Report on Employers and CAM

Survey Questions	Comment
Use among respondents	**45%**
Top modalities among users	Massage (54%) Herbs (50%) Chiropractic (40%) Relaxation/stress (31%)
Would personally pay more more for a benefit package with CAM	53% of users
Top reasons for use	"Well-being" (62%) "Clinical effectiveness" (60%)
Employers offering chiropractic[1]	86%
Offer CAM other than chiropractic	19%
Began offer non-chiro CAM in last 4 years	49%
Have explored potential cost offsets	**0%**
Offer CAM as core benefit	66%
Offer CAM via riders/supplemental plans	7%
Offer CAM discounts via networks	4%
% not offering but considering new CAM	9%
Primary reason for introducing CAM	
Request from employees	30%
State mandates	13%
More effective care[2]	13%
Greater competitive edge	7%
Fit with wellness programs[2]	7%
Potential for cost savings[2]	3%
Don't know or no response	27%
Top reasons for not offering	42%
Type of CAM other than chiropractic offered (Note: this is "offered" not "covered ")	Acupuncture (75%) Massage (40%) Nutritional counseling (28%) Naturopathy (18%) Relaxation therapy (17%) Herbal medicine (16%) Homeopathy (10%) Chinese medicine (9%) Yoga (6%) Other (14%)[3]
Biggest obstacle: CAM user view	"ignorance and negativity" (35%)
Biggest obstacle: Non-user view	"inadequate research" (44%)
Believe some CAM services are covered through quietly "re-assigning codes"	52%
Expect acupuncture to be as broadly covered in 10 years as chiropractic today	46%
Expect more emphasis on CAM offerings (may include discounts.)	**67%**

[1] Often due to state mandates

[2] Janice Stanger, a CAM expert with William Mercer (see related article below), links these three items as evidence that nearly a quarter (23%) of employers view CAM benefits as potentially core contributors to more effective health care for employees

[3] Other includes acupressure, fitness center discounts, smoking cessation, Rolfing

Source: International Society of Certified Employee Benefits Specialists/International Foundation of Employee Benefit Plans,1999, THE INTEGRATOR, December 2000

Outcomes: Selected Pre-Summit Survey Responses from the Integrative Medicine Industry Leadership Summit 2001

Total responses 81 (approximately 77% response rate)

Attendees by Category: percent practitioners (at least part of the week): 45%; practitioner degrees by type: 20 MD, 10 RN, 8 ND, 7 DC, 2 DO, 2 LAc, 1 LM

Of total attendees (consultants included in area of most work): 19% hospitals and health systems; 19% managed care/networks; 15% integrative clinics; 12% academic medicine; 12% national organizations (professional, industry, consumer); 10% information/publications; 5% employers, 5% government/public health/community health; 3% natural products.

Consumer, Employer Top Interest Alignment with CAM Industry

- In ranking stakeholders based on the most interest alignment with the CAM industry, the percentage of respondents selecting each stakeholder at either 1 or 2 are: 94% Consumer, 40% Employers, 22% Hospitals/health systems, 16% Managed care/insurers, and 8% Government/public health.

Important Historic Role for White House Commission

- 76% strongly (28%) or mildly (46%) agree the Commission will be a positive turning point.

Broad Research Design for Positive CAM Outcomes

- 93% strongly (66%) or mildly (27%) agree CAM will look better in research designs which measure broad outcomes.

Majority of Research Funding for Health Services Explorations

- 56% of respondents believe controlled trials (CT) should represent 20% (29%) or 40% (27%) of CAM research funding. Another 28% would fund CTs at 60%.

Split View on CAM Discounts

- 53% strongly (17%) or mildly (36%) agree that CAM discounts are a reasonable place to start. Another 37% mildly (19%) or strongly (18%) disagree, with 10% neutral.

Optimal Health Care Means Major Jump in Premiums for CAM-Integrative Care

- 74% believe that in an optimal integrative system CAM/integrative services will, as a percent of the premium dollar, represent 25% (35%), 50% (30%), or >50% (9%).

Employers Can be Convinced about Economics of CAM

- 85% strongly (38%) or 47% (mildly) agree employers can be convinced of CAM's economic value.

Economic Competition is a Core Obstacle to Integration

- 72% strongly (33%) or mildly (39%) agree than opposing economic self-interests are the core obstacle to integration A total of 22% disagree, with 6% neutral.

Principles Linked to Financial Success

- 89% strongly (57%) or mildly (32%) agree that financial success of integrative healthcare will be advanced by a focused effort to align business models with integrative principles.

Need for a National Lobbying Force

- 84% strongly (52%) or mildly (325) believe CAM's mission as a transformative agent requires a significant lobbying force in Washington, D.C.

Strong Link to Primary Prevention and Health Promotion

- 99% strongly (84%) or mildly (14%) believe the CAM industry should strongly align itself with effort to enhance federal support for health promotion and primary prevention

Source: Integrative Medicine Industry Leadership Summit 2001 (THE INTEGRATOR and Integrative Medicine Communications, Newton, MA; May 2001)

Summary Report of the First Annual Integrative Medicine Industry Leadership Summit

Emerging Market, Merging Paradigms:
A Collaborative Exploration at the Business of Integration's Leading Edge

May 2000

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Report
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Executive Summary

Since 1995, the healthcare industry has witnessed a rapid expansion of initiatives to integrate complementary and alternative medicine (CAM) with mainstream payment and delivery. A loosely defined integrative medicine industry consisting of diverse stakeholders has quietly emerged, but with little shared identity or agenda. An invitational Integrative Medicine Industry Leadership Summit was convened in May 2000 to explore collaboration and enhance cross-fertilization.

The Summit was convened by Integrative Medicine Communications and the firm's industry-oriented newsletter, THE INTEGRATOR *for the Business of Alternative Medicine*. Supporting sponsorships were obtained that reflect the diversity of the stakeholders. Summit goals were four-fold:

- Provide an honest reckoning of the current state of the business of integration
- Give participants a clarified sense of industry best practices
- Stimulate networking across stakeholder lines and inside stakeholder categories
- Enhance understanding of the optimal models for collaboration

To help clarify and create an industry identity, Summit organizers used responses from a pre-Summit survey and a discussant-based program with small group breakouts to foster interactivity and relationship building. A follow-up survey was conducted at the end of the Summit to determine the breadth of interest in some ongoing action steps identified by attendees.

Findings and Recommendations

The following findings and recommendations represent repeated outcomes and directions from the Summit. These do not represent a formal consensus of Summit participants. Most perspectives, even those broadly shared, also had strong dissenters.

1. **Consumers will continue to drive integration.** Most integration activity, whether through personal choice of individuals or through institutional initiatives of employers, managed care, or mainstream delivery, will continue to be driven by consumer demand.
   Recommendation: The emerging industry must enhance its ability to capitalize on consumer interest.

2. **Employers, next to consumers, are the industry's optimal stakeholder partners.** The employer's interest in performance -- productivity, functionality, diminished absenteeism, increased quality of life -- make this stakeholder the most productive partner for the industry's efforts to prove its value as effective and cost-effective treatment.
   Recommendations: Find CAM users in the employer community with whom to partner in demonstration projects. Integrate CAM into wellness programs and disease management initiatives. Consider onsite programs.

3. **Success for the industry will require increased inclusion in mainstream payment and delivery.** The integration industry will not succeed solely on alternative medicine's historic business model of cash payment and referral by self/family/friend.
   Recommendations: Supportive data and strategies for implementation must be developed to increase third-party payment and create shifts in physician referral patterns.

4. **Present incentive structures in mainstream delivery cause significant resistance to integration.** Despite support from health system's executive teams and subsets of physicians, integration of CAM services into delivery is frequently experienced as a challenging battleground.

Recommendations: Health system budgeting is wise to assume slow adoption of integrative approaches by system physicians. Good research without the trust of physicians in new approaches may be meaningless. Significant resources must target relationship development. Strategies include increasing provider comfort with CAM through experiential programs to "heal the healers" and placing CAM in health system benefits packages to promote personal use and understanding of CAM among the organizations' providers and staff.

5. **An employer move toward "defined contributions" would boost covered CAM services.** The current system in which employers define benefits artificially suppresses demand for CAM. Expansion of covered CAM services is slow.
   Recommendation: Consider an industry-wide initiative in support of this shift as a means of enabling consumer choice.

6. **Health services research will more rapidly create understanding of optimal integration than randomized controlled trials.** Research methodologies with the broadest possible outcomes are those that will best measure the value of integrated care. The more narrow the research environment, the less likely that CAM's benefits will be positively viewed.
   Recommendation: Consider an industry-wide effort to create more federal or foundation support for the projects and questions identified by stakeholder participants.

7. **Significant pools of practical data on the cost and use of CAM already exist.** Health plans, integrative clinics, CAM providers, and third-party administrators are presently generating a tremendous amount of data. Some owners of this typically proprietary data are willing to share but do not have the internal resources to support analysis.
   Recommendation: Identify and secure funding to support this research.

8. **Demonstration projects present the optimal environment for measuring CAM's value.** Integrative medicine's relatively safe and relatively inexpensive approaches, compared to many new technologies, create an optimal environment for using a continuous quality improvement approach in implementing, measuring, and refining integration efforts.
   Recommendation: Establish partnerships between providers and interested stakeholders on limited projects with defined measure.

9. **Industry leaders view the ultimate success of their mission positively.** Despite significant current challenges in developing successful business models, these leaders believe their emerging industry will increasingly shape U.S. healthcare.
   Recommendation: Develop an infrastructure that will facilitate rapid sharing of best practices and successful models.

10. **The integrative medicine movement's philosophic mission of health creation will only be successful if energized by a thriving industry of health creation.** Present healthcare economics support public and private investment in crisis medicine. Healthcare law-making, funding decisions, research orientation, and media coverage all respond to and reinforce these economic interests.
    Recommendations: Create a visionary blueprint of optimal public policy, payment, and delivery in an integrative medicine model. Develop a national umbrella organization representing integrative medicine industry stakeholders, public health, and consumers, to be the voice and force for health creation.

To follow-up on these developments Integrative Medicine has launched a forum for Summit attendees to facilitate ongoing discussion and collaboration through the firm's website, OneMedicine.com.

A second Summit has been scheduled for May 3-5, 2001. Those interested in participating may contact Tamara Swain at tamara.swain@onemedicine.com or call 617.641.2300 extension 245.

Mission and Timing of the Summit

The founding or rapid expansion of scores of businesses devoted to mainstreaming the payment and delivery of CAM has increased markedly in the last five years. Hospitals added CAM services or created new departments.[1] Venture capital backed national rollouts of CAM businesses. HMOs and insurers initiated or expanded CAM offerings.[2] Leading pharmaceutical firms introduced natural product lines. Employers added or enhanced CAM benefits. Academic medicine established new CAM initiatives in education, clinical delivery, and research. Consumer use, driving this activity, continued to increase.[3]

Emergence of an industry

Amid these developments, outlines of a loosely defined "integrative medicine industry" emerged. The pattern of business activity was haphazard. Internal CAM champions promoted business plans based on the opportunity represented by the reported $47.5 billion market.[4] Developments in CAM delivery were localized, though often anchoring national ambitions. Cross-communication inside stakeholder groups was poor, and communication between stakeholders virtually non-existent. An industry-oriented monthly newsletter, THE INTEGRATOR *for the Business of Alternative Medicine* (Integrative Medicine Communications, Newton, MA), became the *de facto* communication channel on trends, analysis and developments among the parties that constitute the emerging industry.

Paradoxical trends

Trends discovered in reports, surveys, and analysis were often paradoxical. Newcomers in particular expressed excitement over market opportunities.[5] Data on leading healthcare stakeholders showed significant up-trends in use, coverage, inclusion, and perceived value. Yet beyond the hype, surprising business challenges were encountered in the marketplace. Widely publicized pioneering initiatives in integrative clinics, such as the national integrative clinic rollouts sponsored by Catholic Healthcare West and venture capital-backed American WholeHealth, failed. Poorly integrated, non-covered, discount access models dominated HMO activity. Many of these entrepreneurial leaders found a similar pattern: Plans for adding value to healthcare and for achieving success as businesses collided with mainstream practices, habits, and preferences. Quality outcomes data to validate business models and for integrating CAM payment and delivery were not easily extracted from the billions in consumer spending.

Need for collaboration

The collective need to share information and to explore collaboration was clear to many CAM industry pioneers from the beginning. Business challenges encountered in start-up added immediacy to the idea of a gathering of experienced CAM industry leaders. Some simply sought best practices, successful financial strategies, and an opportunity to share. Others argued for development of an industry association. Still others urged a gathering that would promote what they believed to be CAM's core mission of shifting the business of American medicine away from reaction, crisis and symptom suppression toward a patient-centered delivery focusing on undoing causes of diseases and health creation. Collaboration seemed a requirement for giving the CAM movement a chance to significantly influence the future of U.S. healthcare. At the very least, experience of other industries suggested that the maturation of the field required such a step.

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[1] AHA, 1999; Deloitte and Touche, 1999
[2] Landmark Healthcare, 1998; InterStudy, 1998
[3] Eisenberg, JAMA, 1998
[4] Eisenberg (1998), based on high end out of pocket expenses ($34.4 billion) and RBRVs-based provider reimbursements ($13.1 billion) for covered services.
[5] Based on numerous Integrator interviews and reports. For examples, see *Integrative Clinic Benchmarking Project* (February-March, 1999) and *Integrative Clinic Benchmarking Follow-up Report* (March 2000)

Conveners and Goals

In this context, Integrative Medicine Communications, and it's newsletter, THE INTEGRATOR, convened an invitation only gathering on May 18-20, 2000:

> Integrative Medicine Industry Leadership Summit:
> *Emerging Market, Merging Paradigms:*
> *A Collaborative Exploration at the Business of Integration's Leading Edge.*

Futurist and INTEGRATOR editorial advisor **Clement Bezold, PhD**, CEO of the Alexandria, Virginia-based Institute for Alternative Futures, joined INTEGRATOR publisher-editor **John Weeks** as co-facilitator. Eight, diverse organizations committed to supporting sponsorships to help underwrite the costs. (See Appendix 3.) The maximum of 75 participants was quickly reached. (See Appendix 2.) The goals of the Summit were four-fold:

- Provide an honest reckoning of the current state of the business of integration
- Give participants a clarified sense of industry best practices
- Stimulate networking across stakeholder lines and inside stakeholder categories
- Enhance understanding of the optimal models for collaboration.

A discussant-based format was planned to maximize interactivity. The choice reflected the emerging status of the industry: insights and models for achieving optimal clinical and financial success were as likely to be known, or discovered, by attendees as discussants-attendees. Everyone would bring a significant experience base to the gathering. The program format and agenda are attached as Appendix 5.

CAM Stakeholders: Summit Attendees

The invitees, with a few exceptions, were professionals experienced in frontline or organizational leadership of CAM integration initiatives. Leaders of CAM initiatives inside mainstream medical institutions and businesses, rather than the institutions' CEOs, were invited. The group was selected based on a shared sense that appropriate CAM integration would enhance healthcare in the United States, as well as their businesses. *The intent was not to stimulate exchange between advocates and adversaries of CAM, but to foster discussion of divergent perspectives and models among those economically interested in creating successful CAM integration.* More than 90 percent of invitees were INTEGRATOR subscribers. Particularly targeted were individuals who had willingly shared significant business data in THE INTEGRATOR, for instance, through participation in the *Integrative Clinic Benchmarking Project* and *CAM Network CEO Executive Survey.* A significant subset were subscribers to the INDUSTRY/HEALTH program, a combined information/consultative service cooperatively offered by John Weeks/Integration Strategies for Natural Healthcare (Seattle, WA) and Integrative Medicine.

To promote strategic cross-fertilization, the Summit was intentionally populated with representatives from diverse stakeholder organizations.[6] By primary stakeholder affiliation, attendance is described in Table 1. When discussion in the "Committee of the Whole" was moved into five small groups of roughly 15 participants each, these too each included a mixed distribution of stakeholders.

[6] An onsite survey at the end of the Summit yielded a list of stakeholders that respondent attendees thought should be better represented. Requested were more large employers, government officials, consumers, and pharmaceuticals firms.

Table 1: Summit Representation by Stakeholder Type

Stakeholder	Number	Percent
Hospitals/health systems *	12	16%
Managed care/CAM networks	10	13%
Academic medical center *	9	12%
Private integrative clinics	9	12%
Internet e-health	9	12%
National industry or professional association ^	8	10%
Information/content provider	5	7%
Employee benefits	3	4%
Public health	3	4%
Natural products	2	3%
Venture capital	2	3%
Other/consultants	3	4%

* Many of these representatives are involved in delivering services through integrative clinics.
^ Two were mainstream organizations; six represented national CAM professional associations.

Outcomes of Pre-Summit Attendee Survey

One focus of the Summit was to draw a collective portrait of the leadership of the emerging CAM integration industry. To this end, pre-arrival, all 75 attendees received an electronically administered survey and 65 responded. The survey and full results are attached as Appendix 4. Some highlights of the beliefs of the leaders:

Major changes anticipated in conventional clinical services

- *Vast under-utilization*
  Nearly all attendees (97%) believe that CAM is significantly under-utilized relative to conventional care.
- *CAM as first resort*
  The last should often be the first, according to these leaders. Contrary to the conventional view that CAM may be a good recommendation only when conventional treatment fails, 80% of these leaders believe that the optimal use of CAM is before conventional treatment, not as a last resort. Only 6% disagree.
- *Cost-savings in chronic care*
  Chronic disease will be a major area of CAM cost-savings: 71% believe that the most significant savings will come through CAM integration into the treatment of chronic conditions like arthritis, adult onset diabetes, and heart disease.
- *Significant research is in place*
  These leaders question the typical assertion from mainstream medicine that appropriate integration requires new research. Three-fourths (75%) believe more utilization and coverage of CAM is presently well supported by research. A similar percent believe current data support an economic case to employers for expanding CAM coverage in employee benefits.

CAM business success is linked to changes in mainstream practice

- *Change in physician referrals foreseen*
  More than 77% believe the success of their business is linked to creating more physician referrals for CAM. Most are optimistic: Nearly four out of five participants believe that a solid subset of physicians -- at least 25% will routinely refer their patients with chronic diseases to integrative mind-body programs as early as 2005.

- *Changes in payment required*
  Nearly 64% believe increased third-party reimbursement for CAM is key to their success. Only 36% believe that most consumer use of CAM will remain outside the mainstream payment and delivery system.
- *Increased focus on health services research*
  These leaders strongly believe that the most valuable research is health services-type grants. Two-thirds (67%) believe understanding of CAM's optimal role in U.S. healthcare will be gained most rapidly through funding research on outcomes of existing payment and delivery models, "even if that means limiting clinical trials." Asked if they could create "valuable experience data" (which would not be proprietary) for policymakers and other industry participants by applying a $50,000 grant to questions in their industry sector, 88% responded affirmatively.

Collaboration viewed as the critical ingredient in advancement

- *Informal and formal alliance required*
  For these leaders, the success of both their mission and their business is strongly linked to becoming "exceptionally successful collaborators." More than 93% believe their own business would benefit from more collaboration with members of other stakeholder groups; 76% believe similarly about collaborations with like stakeholders.
- *Formalized alliance*
  Eighty percent believe success in their mission is linked to having an ongoing, significant lobbying force for public policy change in Washington, DC.
- *Call for a robust "industry of health creation"*
  More than 81% believe that success in their mission to give U.S. medicine a greater orientation toward health requires "birthing a thriving U.S. industry of health creation."

Attendees were optimistic about their ultimate contributions to healthcare. Almost 88% believe that by 2010, the integrative medicine movement will be viewed as an historic change agent. ***If the beliefs of these integrative medicine industry leaders prevail, the face of U.S. healthcare will change significantly.***

Challenges and Opportunities with Key Stakeholders

An assumption of the Summit organizers -- born out by outcomes of the pre-Summit survey -- was that CAM integration industry leaders believe that success in their business is linked to collaboration with other healthcare stakeholders. But which stakeholders would make the best allies?

The Summit's formal sessions began with an exploration of the alignment of interests, particularly economic interests, between CAM and each stakeholder group. Discussant **Sam Benjamin, MD**, whose integrative medicine experience includes CAM leadership positions in a large health system, academic medical center, and a natural products firm, bluntly distilled the challenge of interest alignment: "The issue is always going to be about revenues. (The thinking is) 'I'm not going to fight you if you are not going to take money out of my pocket. The minute you take the money out of my pocket, I'm going to do everything I can to stop you.'"[7] Is expansion of CAM programs aligned with the economic interests of the mainstream delivery system? Is such alignment greater or less with hospitals than with employers or managed care firms? The question put to the group was this: "The challenge before us, as an industry, is to decide in what ways to form alliances to create projects to move energy, rather than relying on the development until now, which has been grassroots and haphazard."

[7] The only Summit participants quoted in this document are the discussants. Other statements will be identified based on the stakeholder type making the comment. This decision reflects the intention at the Summit to stimulate free exchange of unedited ideas and perspectives.

Interest alignment: Highest with consumers and employers

In small group work, participants strongly identified first the consumer, closely followed by the employer, as the stakeholders with the most significant potential for partnership with the emerging CAM industry. (See Table 2.) Belief in economic alignment fell significantly before reaching the stakeholder viewed as the third most receptive: the hospitals and health systems charged with delivering CAM services. The managed care industry, government, and philanthropy were each noted more than once as potentially aligned, but never among the top three.[8] Venture capital, as a stakeholder, was not listed by any of the five small groups as among the top five stakeholder partners.[9] Public health, while not figuring high in the rankings, was frequently referenced throughout the Summit as potentially a strong alliance.

Table 2: Optimal Stakeholder Partners as Identified in Summit Working Groups

Worksheets for the 5 small working groups -- deliberately mixed groups of 15 individuals -- included a list of the following stakeholders: Hospitals/health systems, HMOs/insurers/CAM networks, government, consumers, employers, philanthropy, internet, CAM professional organization, other professional or industry organization, public health, venture capital, natural products. Groups ranked the top five among them for alliances, with "5" representing the top choice.

Stakeholder	%
Consumers	27%
Employers	26%
Hospitals/health systems	14%
Government	8%
HMOs/insurers	8%
Philanthropy	8%
CAM Networks	5%
Other industry associations	3%

Only stakeholders cited by at least two groups are noted in the table. One additional stakeholder suggested by one group is a subset of employers: large, influential employee benefits consulting firms.

Subsequent summit activity revolved around the potential for relationships with leading stakeholders, and identification of the projects that would help advance those shared interests. The following is a portrait of challenges and opportunities for alignment based on comments by discussants and reports from small groups during the course of the meeting.

Stakeholder #1: The Consumer

The consumer is directly responsible for 80% of the dollars spent on CAM.[10] In addition, discussants representing health plans, employers and health systems all volunteered that responding to the consumer was the principal driver in their sectors' involvement with CAM.[11]

[8] As one group concluded, philanthropy is probably most aligned with the consumer, particularly the underserved consumer, and therefore may be best viewed as linked to that stakeholder.
[9] Venture capital exploration of CAM services was high in the first flush of integration in 1996-1997, and in CAM e-health firms up through the reversal in Wall Street's views in mid-April, 2000. Challenges encountered by pioneers in venture-backed CAM services delivery slowed access to new venture funds.
[10] Eisenberg, 1998 (JAMA)
[11] The consumer as stakeholder was not directly represented by an organization at the Summit. However, 95% of attendees identified CAM therapies and a CAM philosophical approach as significant factors in their own personal health care choices. The CAM consumer was present in the persons of most attendees.

Benjamin cast the consumer's influence as part of a larger cultural shift: "This is part of a fundamental societal demand, a consumer-driven movement to exercise more control over one's life, one's health and, most certainly, one's death."

Alan Kittner, founder and CEO of Onebody, Inc., a California organization with an internet division and a national CAM network serving seven million managed care members through non-covered discount products, challenged attendees with the assertion that "CAM services will remain fundamentally retail unless and until the consumer, rather than the employer, has a greater role in the payment mechanism." He noted that covered CAM services remain a small fraction of CAM spending. (See *HMO's/Insurers*, pg. 13) Kittner offered the view that only a dramatic shift to empower consumers through flexible spending accounts and defined contributions, in employer-based benefits, would make covered CAM a significant force in the cash-based CAM economy.[12]

Consumer empowerment and an anticipated shift to "defined contributions"

Consumer empowerment through defined contributions was a repeat theme. Noted one participant: "The (present) system does not work for consumers. They are speaking out with their dollars. The supply and demand side are not aligned." **Mort Rosenthal**, founder of Wellspace, a Boston-area, venture-backed CAM clinic, questioned the value of pushing for coverage in a traditional model. He recommended developing a "parallel universe" to traditional healthcare – "using the defined contribution model, potentially developing a reimbursement structure." The shift was also implicit in the comments of **Anna Silberman**, CAM leader with Pittsburgh-based Highmark Blue Cross Blue Shield: "Insurance will increasingly become a retail sell."

Stimulating consumer demand

Stimulating consumer demand repeatedly surfaced as a prescriptive measure for enhancing the CAM economy.

- **Cathy Cather**, with employer benefits consultant Towers Perrin, referenced a recent survey of employee benefits managers[13] that listed employee demand as the single most important influencer for adding CAM to benefits: "If we are looking at what are the things we can change to have the biggest impact, stimulating employee demand is number one."
- **Candace Campbell**, executive director of the American Preventive Medical Association, a two-decade-old national advocacy organization representing mainly integrative medical doctors and osteopaths, underscored the potential for downstream benefits from direct to consumer campaigns: "First we have to grab the consumers where they live. The science will follow, the money will follow, the insurance coverage will follow, and the employers will follow."[14]
- Employee benefits consultant **Janice Stanger**, with William Mercer and Associates, recommended "we bring CAM to the patient -- like onsite chair massage -- rather than bringing patients to CAM."

Benefits from a reinvigorated consumer partnership

Four significant benefits for the emerging industry were identified from a reinvigorated focus on the CAM movement's historic partnership with the consumer:

[12] "Defined contributions," as opposed to "defined benefits," is an increasingly discussed theme, if not yet a trend, in employer-based benefits. The shift parallels the move to 401K options from historic retirement packages. (THE INTEGRATOR, July-August, 2000)

[13] American Compensation Association, 2000. (THE INTEGRATOR, July-August, 2000)

[14] The preeminence of the consumer provoked additional commentary questioning the preeminence of research in furthering the CAM economy. Kittner noted bluntly: "The consumer doesn't need data. What is the utility of research if the consumer is already voting with his or her pocketbook." (See discussion under *Research*.)

- Increase CAM's consumer-based, cash economy
- Direct the consumer's political clout on governmental policy issues
- Work with the consumer to produce more favorable institutional decisions

Locate philanthropists who are CAM consumers to be significant investment partners in critical local or industry-wide initiatives[15]

Stakeholder #2: The Employer

The employer payer joins consumers at the top of the chart as a stakeholder partner. Discussant **Sean Sullivan**, CEO with the non-profit Institute for Health and Productivity Management, and a former president of the National Business Coalition on Health, paired the two stakeholders as both interested in exploring integration "from the demand side." Sullivan: "Our whole premise [for being interested in integrative medicine] is that all the things that employers are doing and paying for and trying to manage need to be integrated into a total formula that adds up to the outcomes we are after: health, functionality, capacity, satisfaction and ultimately, for the employer, productivity."

Henry Ziegler, MD, a former director of prevention for the Seattle-King County Department of Public Health, restated the value of the employer partner, including government, in the mix: "What we are saying is we're holistic, and we're looking for big outcomes of healthy, happy, functional, longer-living humans. One of the lovely things about working farther up the stream (than primarily with mainstream delivery, academic medicine, or insurers) is they share that need. Everybody else doesn't. So keep focused on that end, the top end."

Yet despite the potential for economic alignment perceived by most Summit participants, employer consultants Cather and Stanger noted that most employer inclusion of CAM, at this time, relates to employee demand and employer interests in employee attraction and retention. Noted Stanger: "Only 23 percent gave a reason relative to provision of care. Cost saving was way down the list."

Who's on first? Employers and health plan roles in defining CAM benefits

Divergent views were presented on the primacy of the employer in the CAM coverage process. Employer consultant Cather, referencing an American Compensation Association survey, reported that 91% of the employee benefits respondents said that "if they offered CAM, it was offered through insurers – their definition of CAM benefits is what insurers are offering."[16] An executive with a CAM network firm with significant non-covered discount CAM business with HMOs nationwide pointed out that employers served by virtually all of the plans which earlier took tepid approaches to CAM are now pushing the HMOs for actual CAM coverage: "They're coming back (to the HMO) and saying 'what's next?'" Healthplan executive Silberman seconded this perspective: "HMOs really pay for what the employers tell them to pay for."

Defining and creating outcomes that employer's desire

Given the high level of belief that the employer is the CAM industry's critical stakeholder partner, next to the consumer, defining the needs of the employer became a significant focus of discussion in the Committee of the Whole and in projects developed through the small group work. (See Table 3) What are the desired outcomes? How can they be efficiently gathered? (See section on *Research* for additional discussion.) Among the key recommendations:

- Develop a case statement for CAM exploration by employers

[15] Many health system-based integrative medicine programs presently look to philanthropy for start-up and operating support.
[16] American Compensation Association 2000.

- Directly involve employers in decisions about how to define and offer CAM services targeting their needs, which may differ from those of the health plans on whom they now depend
- Convene a high-level meeting to develop metrics that both employers and CAM providers would support
- Develop direct delivery, integrative medicine-oriented strategies for worksite health, disease management, and wellness

Opportunity for win-win

Stanger, the employer consultant with William Mercer, shared that her interest in integrative medicine for employers grew out of a belief that appropriate CAM coverage "creates such a potential for win-win: you give employees something they want and in doing so help employers cut costs and help to have healthier employees who are more productive at work." She believes that by providing information and convenience as well as services, the CAM industry can "change the whole demand curve for CAM services, so that at each cost, there is actually higher demand."

Stakeholder #3: Hospitals and Health Systems

Ranked significantly below the consumer and employer, as a potential partner for exploring and advancing CAM integration in U.S. healthcare is mainstream payment and delivery. The reason was stated bluntly by HMO executive Silberman, whose firm has partnered with the Preventive Medicine Research Institute (PMRI). PMRI promotes expanded integration of the mind-body program for reversing coronary artery disease developed by Dean Ornish, MD. According to Silberman, "There's an inherent conflict of interest (in mainstream delivery) that we're struggling with."

Discussants used both gardening and military metaphors to underscore the depth of the struggle. **Corrine Bayley**, vice president with Southern California-based St. Joseph Health System, fashioned herself as a "CAM gardener" within the 10-hospital delivery system.[17] Bayley noted that, despite the health system's mission to create health in the populations served, "most of the seed has fallen on rocky soil or among the weeds and thorns. Only a surprisingly little has taken root." The core problem, she said, "Despite the system's mission to create health in the populations we serve, most of what we do is treat disease." Sam Benjamin, MD, spoke more harshly, suggesting that integration amounts to "a military or quasi- political exercise." He adds, "We've created an army of traditional physicians with power (over CAM) way beyond their capabilities, and they are [resisting]. Is it worth sustaining the pain that one goes through in institutions that are not responsive to these societal pressures?"[18]

Healing the healer: strategies for penetrating the resistance

Discussion turned to methods for creating a foothold that could lead to more expansive exploration of the potential value for CAM.

- Bayley suggests experiential retreats and introducing conventional providers to integrative programs in an attempt to "heal the healer."
- A health system participant stated, "The hospitals have been a very difficult area to enter. We start gently in a non-threatening manner with lighting, music, aromatherapy and re-training existing nursing staff."
- **Brian Berman, MD**, CAM leader at the University of Maryland, a CAM services provider in an integrative facility, and the head of the most productive NIH-funded CAM center, referenced

[17] The perspective of Bayley, who was not able to be present until after her scheduled discussant presentation, relayed her comments to co-facilitator Weeks, who delivered them for her.

[18] The shaping of integration experience in war and espionage metaphors among leaders of health system-based integrative clinics is not unusual. See the June 2000 INTEGRATOR, which reports interviews with operators of eight such clinics.

an Eastern martial art: "I take an aikido approach. Integration is on many levels -- research, insurance, shared care. Like a baby, it takes a while to be made." He also suggested, "you've got to keep laughing."

- A leading consultant to hospitals on integrative clinics, **Linda Bedell Logan**, CEO of Solutions in Integrative Medicine, notes that most health systems with integrative clinics don't offer covered CAM services to their employees. She recommends benefit expansion to support creation of greater personal understanding of CAM services.
- **Bernita McTernan,** a senior vice president with Catholic Healthcare West, recommended that large health systems support local initiatives, "Decentralized not centralized is the way to go. Empower people at the local levels, then have the decentralized entities decide what they think they want standardized. If there is consensus there, then that may be the way to go."

A shift of payment structure from a productivity basis was viewed by some as potentially helpful in creating more openness to CAM exploration. One member of a Summit small group who is working on a hospital-based project listed length of stay, reduced adverse drug reactions, increased profitability of case rates as potential incentives for inclusion. However, the small group also selected to report a checklist of reasons to consider who should not get involved. Included were: "very conservative medical community" and "lack of internal support from leadership." Logan strongly recommended against integration if health system mission is shaped principally around desires to "tap into consumer demand and create a cash cow."

Stakeholder #4: HMOs/Insurers

HMO/insurance interests were placed surprisingly low on the stakeholder hierarchy, given that the pre-Summit survey found that two-thirds (66%) of the attendees agreed that "significantly increased CAM participation in third-party payment structures is critical for the success of CAM's mission."

Silberman, with the HMO that has joint-ventured with the Dean Ornish program to create Lifestyle Advantage as a vehicle for a national rollout of the program, urged attendees not to write off the HMO stakeholder. "I believe there's a bright future, one where insurance companies will be working with you and not against you. The causes of disease are not being addressed, or reimbursed for, at this time -- healthy behaviors, and the influences of the mind. Our ears are open because we are not doing well. It pays for us to invest in alternative therapies to ultimately reduce risk and reduce utilization," he said.

Challenges of the internal HMO environment

Silberman's internal process in convincing her employer to both cover and offer the Ornish program was challenging. The initial affirmative decision was for marketing reasons, rather than the supportive, published, data-trail created by Ornish and his associates.[19] Silberman is blunt: "There were those who wanted this to fail." Her first challenge was to, "Influence the sarcasm." Only after she was able to show that the Ornish program, delivered and reimbursed by Highmark, resulted in $16,000 savings per patient has she "been able to draw a lot more good attention when I ask for financial support" to expand the program.

Robert Stern, DC, CAM leader with eight-state Anthem Healthcare, described the internal landscape of a large HMO this way: "When you deal with a large HMO, you are dealing with a battleship. Whatever happens, happens through partnership with a variety of stakeholders within the organization -- legal partners, business partners and clinical directors. Allopathic providers and medical directors have a tremendous say in the ability to veto. Without a buy-in of all three

[19] The published research supporting the Ornish program, on both clinical outcomes and cost savings, is generally viewed as among the best in CAM.

you don't have a chance of succeeding." Another representative of a large HMO added an additional, constrictive perspective: "Competition is fierce in our area. It's competition on cost. You can lose based on pennies."

Kittner, founder of a national CAM network, presented data, which is not surprising given this landscape:

- Since 1990, reimbursement of CAM services as a percentage of total CAM spending is "essentially flat" – at 20% reimbursed and 80% out-of-pocket.[20]
- The industry around covered services is small – between just $250-500 million are spent in specialty carve-outs and covered benefits.[21] Only 1-2% of the $21 billion spent on CAM services is reflected in revenues to the carve-out CAM industry.

CAM discounts: Trojan horse for covered CAM benefits?

A spirited exchange emerged around the move of HMOs to offer CAM as only discounted services rather than as covered benefits. This is a dominant trend in states without legislated mandates. CAM network founder Kittner, whose firm's network division manages discount products only, commented, "Call me a cynic, but the reason HMOs are adding these programs is it doesn't add to their medical loss ratio, and it's a convenient way to distinguish themselves from their competitors. They don't put marketing dollars behind it. Marketing budgets are decreasing as others get into it and there's less differentiation. The real indication of commitment is covered benefits. If the dollar is not coming out of budgets, it is not unimportant, but it is not integrated medicine."

Others challenged this negativity toward discounts. Stanger suggested that once discounts become commonplace, plans will need to "move to the next level" to distinguish themselves. A network executive with significant discount CAM business acknowledged the "nice job Bob Stern did in describing the battleship for us," then suggested that discounts are "a real easy entry level for plans which go through (the levels of approval) much more straight-forwardly." Once in, "more often than not, plans are pleasantly surprised with the positive view they get, not only from their members but from employers and the pushback they get on their benefits." Employer consultant Cather endorsed the approach: "You get to have a relationship first" (before asking for something more substantive). The network executive stated that his HMO clients with CAM affinity products are almost all presently fielding requests from employers to add covered services. One participant commented that given the embattled environment, starting with a discount product may, intentionally or unintentionally, amount to a Trojan Horse strategy.

The opportunity

While these leaders tend to view managed care as, in the words of one of the small groups, "work for hire for the other stakeholders" (and not a first priority stakeholder), working with the exceptional managed care player was endorsed. Benjamin urged targeting those managed care companies that "take a more creative position about looking at CAM as a potential vehicle for cost-savings and outcome improvement."

Stakeholder #5: Public Health

Public health, as a potential stakeholder partner, while not prioritized highly as a step for meeting near-term needs of the industry, was repeatedly noted as potentially an exceptional partner. Discussant Ziegler, the former director of public health in the Seattle area, described his own eye-

[20] Ibid 10

[21] Results of a CAM Network CEO Survey involving 16 of the top network businesses and published in THE INTEGRATOR (December 1998; January 1999) found total revenues closer to the $125-150 million. Growth of covered benefits in the intervening two years has been, to all accounts, flat.

opening awareness as he became involved with natural healthcare and naturopathic medicine through his participation in integration initiatives in his area. "If you place a Venn diagram on public health and CAM, I am awesomely impressed by how much you reflect what I believe and what will make a healthier world," he said. Participants noted the strongly overlapping philosophies between the two interests: prevention, environmental factors, and the whole-person, community-based view of health. Ziegler summarized, "In the federal government and public health you've got some powerful allies."

Healthy People 2010: The community as CAM's patient and partner

Most of the participants were aware of the federal government's Healthy People 2010 goals. Ziegler characterized the 2010 initiative as shifting more toward (an integrative medicine) paradigm. "It embodies a great deal more of the determinants of health." He added: "So wrap yourself in it. There's nothing like apple pie and Motherhood."

Some specific recommendations in a public health/CAM partnership:

- *Partnering with community* Logan called integrative medicine "community-based healing." Ziegler, however, noted that while he hears "about the individual as a patient and you partner with them, and the family as a patient and you partner well with them, you don't have the community as patient."
- *Medicaid and HCFA waivers* With waiver authority, a community would be given a great deal more flexibility to pilot and demonstrate integrated medicine.

Research and Data Priorities

Relationships or research?

A rich vein of discussion throughout the two days revolved around identifying and responding to individual stakeholder's information and data needs. Views on the importance of data appear paradoxical. Despite the refrain in mainstream medicine that more evidence is needed prior to increasing integration, three-fourths of the industry leaders believe that increased utilization and coverage are already supported by data. More than 50% took it a step further, agreeing that "creating relationships with mainstream physicians and decision-makers is probably more important than additional controlled research at this moment in the CAM integration process."[22] Less than 29% disagreed. At the same time, 69% believe that increasing reimbursement will require additional research.

One representative of an academic medical center framed the research/relationship prioritization in the context of the level of research in conventional medicine: "Only a minority of conventional interventions are supported by controlled research. The 85% that are not are based on the culture of medicine. We have to change the culture of medicine."

Yet even with this prioritization of relationship development, research -- particularly outcomes-oriented, practical, health services research -- constitutes the backbone of many of the advancement strategies. Nearly nine out of 10 believe that, if they had a $50,000 grant, they could "develop information, explore a process, set up a structure, or analyze experience data which would be valuable to other executives and policymakers in the emerging business of CAM integration."

[22] The views of these leaders were recently supported in a concept paper promoting health services "Integrated Medicine" grants through the NIH National Center for Complementary and Alternative Medicine. The paper, by NCCAM's Richard Nahins, PhD, begins with mainstream delivery failing to reflect the evidence base supporting mind-body interventions.

A two-step process for developing optimal data was recommended:

- *Tool development* A gathering would be sponsored to develop a strategy for measuring outcomes that would most serve the needs of the target stakeholder (employer, managed care, health system, integrative clinic operator, etc.). Participating would be a mixture of experts representing parties involved with the target project. The group would also explore optimal study design. Employer purchasing expert Sullivan noted, "Outcomes are the key, but defining the *right* outcomes is the [final] key. We're always falling short."
- *Demonstration project* Once agreement is reached on appropriate metrics, a demonstration project would be implemented at one or more sites.

Present supremacy of consumer use data

The irony in the excitement of these leaders about creating useful data on effectiveness and cost is that the data, which has chiefly influenced most integration initiatives, is from the market and consumer use. Casting light on the contributions CAM may have in creating more effective or cost-effective care, Onebody, Inc.'s Kittner called into question the "utility of prioritizing research" for the industry. He noted that the "consumer is already the force behind the employer and the consumer doesn't need data." He added, "Good data are hard to implement, even in allopathic care." Benefits consultant Cather, from Towers Perrin, similarly urged promotion of consumer use as the best way to stimulate the employer market.[23]

Controlled trials or utilization data

Summit discussants became acutely aware of the differences in data needs and the framing of research questions among the diverse stakeholders in attendance. In the Summit's final discussant panel, academic researcher Brian Berman, MD, succinctly captured a conventional research perspective, "I haven't heard much about controlled trials these past few days."

The group sense appeared to be that there are distinct values in different types of research. Integrative clinic consultant Logan noted that "academics have efficacy but no cost, payers have cost and utilization but no efficacy – we can't have one without the other." An HMO participant underscored the need to view the research along a spectrum, "I've done the dirty research. I've crunched the corporate business numbers. Claims data are claims data. It's not science. We have to keep these things separate but have (the data) at all levels, just like we need both case series and randomized controlled trials."

Asked to prioritize types of research based on the effectiveness of data in creating change, attendees showed a strong preference for health services research. In the pre-Summit survey, only 18% *disagreed* with the assertion that health services research would lead more rapidly to quality information to shape optimal integration than would controlled trials. In one discussion, a participant with experience working with employee benefits decision-makers suggested that once data is collected, medical journals are not the optimal place for publication, "They don't care about journal-published articles; they want simple rules they can implement." The value of peer-reviewed medical literature was argued as only long-term. In this view, those wishing to influence employer practices, for instance, would be best to publish in an employer-oriented publication. A cautionary note was struck by discussant **Len Wisneski, MD**, whose background includes positions as a medical director for both an integrative clinic and a large employer. He noted that "sometimes there is more up-front cost in integrative care – in the short-term, costs could be higher." This becomes problematic given that the transience of the labor force depresses employer willingness to invest in healthcare projects with long-term outcomes.

[23] The motivators of CAM integration at the present fit into the bell curve of adoption described in *Crossing the Chasm* (Geoffrey Moore, 19991, HarperCollins A. Moore and Regis McKenna McKenna wrote the forward, not the book). The "early adopters" are promoted by believers for whom market data may be sufficient. Vast expansion of the market, and the industry serving it, may require better data on cost and effectiveness, the generation of which was a core concern or these industry leaders.

Health plan data

The experience with the Ornish program at Highmark, described by Silberman, shores up this perspective. The breakthrough moment in the acceptance of the Ornish program was not Ornish's published, peer-reviewed research on the program's effectiveness and cost-savings, but the plan's conclusion, following analysis, that once delivered by Highmark, the program saved the health plan $16,000 per patient.

Stern, from Anthem, also believed that data developed inside the context of CAM delivery and payment would provide the greatest leverage for the industry, "The bottom line is that all you need is one unequivocal study from a medical director of a company the size of ours that shows that, because of CAM services the healthcare management cost has come down and the quality of care has gone up," said Stern.

"Already a ton of data"

One repeated theme was that the issue is not about creating data, per se, but rather in analyzing the data that exists. Rosenthal noted that his clinic's proprietary information system, sensitized to CAM-oriented clinician inputs from his 60 providers, has more than 25,000 patient encounters that have not yet been analyzed due to lack of funding. Logan noted that the computers in her billing system have data on 40,000-50,000 unique CAM patients that also has never been analyzed due to funding priorities. Both volunteered to allow their data to be shared, despite its proprietary nature, should there be funding for analysis.

Employer consultant Stanger captured the need for funds to analyze data: "There is already a ton of data out there we haven't analyzed. Health plans have it, integrative clinics have it. We don't need more data; we need to analyze the data we have. There is already enough data out there to demonstrate the cost-effectiveness or lack of cost-effectiveness."

Collaborative Projects to Move the Industry

The critical need for significant collaboration as the underpinning of industry advancement was strongly affirmed in pre-Summit interviews. Discussant **Clyde Jensen, PhD**, whose professional experience includes executive level positions at allopathic, osteopathic, and naturopathic medical schools, asserted succinctly, "Collaboration beats competition." Jensen gave an example from his own stakeholder experience in working to create a consortium of diverse medical schools to fulfill the perspective that "doctors who train together, treat together." Said Jensen, "No single academic medical center contains all the resources to deliver integrated medical education and research. When you add to that the fact that there is no more fragmented population on the planet than the health education and services population, then it becomes more important to find ways to collaborate than compete."

Summit discussants and attendees were asked to reframe their observations of core challenges and opportunities in the form of exploratory projects and demonstrations that would most rapidly create understanding. Discussants were asked to model this thinking in their initial comments. Participants were asked to do so in small working group sessions during the first two modules. The projects were to be:

- non-proprietary
- collaborative

To focus the imagination, participants were asked to think into two levels of projects: $50,000 and $500,000.[24] Table 3 describes the project ideas that attendees produced. Some were formally presented; others were added during reviews of the Summit transcripts.

Project categories

One set of identified projects focused on the guild-like interests of the emerging industry sector. Examples here are development of state-of-the-knowledge white papers that could be used to market CAM programs to stakeholders and to create and co-fund a campaign to stimulate consumer awareness of, and demand for, CAM services.

Influencing the nation's ability to appropriately integrate care

The leading category of projects, however, reflected undertakings that could have a significant impact on the nation's ability to optimize the integration of care. Consensus, while not complete, appeared to be broadly available for many of these projects. Some highlights include:

- Convening groups to develop effective metrics, then funding demonstration projects with diverse stakeholders -- employers, health systems, integrative clinic operators, managed care, and public health
- Funding analysis of currently available data
- Developing integrative medicine-oriented wellness and disease management models
- Exploring and evaluating the characteristics of successful collaborative clinical processes

The projects recommended by these front-line stakeholders in the emerging integrative medicine industry may be viewed, once funded, as a roadmap leading to rapid understanding.

Creating a collaborative force for change

Summit planners left the small group time on the final day open-ended to create space for responding to the desires of the attendees. Because this was an initial meeting, forecasting whether or how rapidly the diverse stakeholders might move from speculative activity to formal collaboration was difficult. Would sub-groups wish to meet on specific projects that might out-last the Summit? If so, group priorities would have to be clarified.

After the second module, a vast majority of attendees expressed an interest in spending their remaining small group energy on one or more focused projects. Projects were identified by attendees and posted; participants chose which they wanted to attend. The project areas were:

- Research – clarifying priorities
- Integrative clinics -- the value of an ongoing network for data collection and sharing
- National association – the potential of a unified organization to represent the diverse stakeholders in the emerging industry
- Health coaching -- examining the role of, and standards for, a "health coach" in the integrative setting
- Policy summit -- strategies for impacting federal activity
- "Vision group" -- creating a white paper on optimal structures for payment and delivery from an integrative perspective

[24] A backdrop for project identification was a concept paper at the National Institutes of Health Center for Complementary and Alternative Medicine (NCCAM) recommending that NCCAM begin its first set of grant awards in "integrated medicine." This health services research is atypical of NIH grants and a first for NCCAM.

Table 3: Projects Identified to Rapidly Explore and Expand Integration

The following list of projects includes ideas submitted directly as a formal part of the Summit process as well as other project ideas that we referenced or were recommended by speakers. *Many projects have significant overlap. They are listed individually here to allow readers to consider the permutation which makes the most sense to them.*
**In the meeting, participants were asked to identify $50,000 and/or $500,000 projects. Some specifically noted which category they believed their projects would fall. Where they did, this is noted.*

Project	Target Stakeholder	Size*	Comment
Multiple Stakeholders			
Explore development of industry association	Multiple	--	Antecedent to possible formation of the group
Industry coalition/association	Multiple	--	Link stakeholders in an association that would serve as the integrative medicine industry voice, for standards, education, public relations, and research compilation.
Data and strategy consolidation	Multiple	$50,000	Pull together and "repackage" all the most useful and available research for working with employers or with insurers.
Community coalition development	Multiple	--	Convene a community's providers and employers together with a common community-oriented focus for integration.
Create standard survey instruments for feasibility	Multiple	--	Develop separate instruments for surveying employees, employers, consumers, physicians, and administrators on openness to integration.
Summit on CAM in National Policy	Multiple	$50,000	Similarly diverse group as the Summit, expanded, to focus only on national policy issues, particularly in light of the White House Commission. Identify issues that are impeding the development of CAM. Refine a national plan.
Model a new healthcare system	Multiple	--	Use holistic, integrative principles to create an entire delivery system for a specific population. Create the vision for re-creating the system on principles of health creation.
Voice in D.C. to create new funds for CAM health services grants	Multiple	--	Multiple contributors to expand the "pie" of federal funds for exploring real world CAM initiatives.
Create Internet-based mechanism for continued communication between attendees	Multiple	--	Committed by Integrative Medicine during summit and initiated August 2000.
Administrative process pilot	Multiple	--	Pull together diverse parties to develop strategies for streamlining administrative processes to yield greater data and data analysis of CAM.
Create optimal integrative outcomes tool	Multiple	--	Convene group to review types of validated tools (Beck depression, SF 36, etc.).
Study other emerging industries	Multiple	--	Create guidance on best practices for emerging industries.
Consumers			
Internet consumer survey	Consumer, Internet	$50,000	Build the survey to help give consumers more of a voice in how the role of integrative care can best be defined in this country; increase their role in building the infrastructure; and potentially lift the survey onto multiple sites for broader reach
"Got Pain" campaign to make visible successful CAM protocols	Consumer	--	Enhance CAM usage through image, information, and access. Develop clear protocols and information for the consumer Use the Internet for fulfillment, education and protocols, and links to skilled practitioners.
Employers			
Convene employer/CAM meeting to explore collaboration	Employer	$50,000	Explore the value CAM might have in increasing health and productivity. Develop metrics agreeable to both groups.
Employer pilot	Employer	Large	Pilot the project developed at the convened meeting with a set of employers.
Worksite demonstration project	Employer	Large	With a health improvement focus rather than disease management after asking employers to determine the outcomes they deem valuable to support continuation. Publish outcomes.
Combined integrative clinical and health improvement	Employer	Large	Use parallel tracks, one clinical, based on cases with some pathology, and the other a health improvement and wellness track.

Reshape employee wellness programs	Large employers	--	Create an integrative medicine employee wellness program. Basics include stress reduction, credible information on natural products. Various services available onsite.
Influence large benefits consulting companies	Employer	--	Work with leaders to help them change what they think they are doing -- paying for benefits -- to the more important role of prevention.
Develop integrative medicine-sensitive "risk profile" survey	Employers	--	Develop a model survey for employers, with outcomes linked to potential CAM interventions and identified CAM community resources
Reshaping disease management	Large employer, disease mgmt. companies	--	Weave CAM modalities and approaches into disease management, with control as group only using regular disease management program. Locate either onsite or at integrative clinic.
Employer/Health system			
Integrative clinic services for worker's compensation	Health system, employer	$50,000	Focus on a specific diagnosis that has a lot of concern in the workplace; controlled study, limited to one condition.
Health coaching	Employer, health systems, consumers	--	Strengthen ability to work with consumers, including online, phone in-person. Help set standards for individuals in this role.
Qualitative research on collaboration	CAM professions, integrative interests	$50,000	Ensure that CAM works well by exploring and reporting success factors of teamwork in integrative programs
Hospitals and Health Systems			
Employee wellness retreats targeting hospital employees	Health systems	--	Program would have a "heal the healer" focus, giving hospital employees an opportunity to experience more holistic care that they might then better impart or be more open to consider providing.
Share electronic medical records for integrative clinic database	Health systems	--	Develop a shared record for use in 100+ clinics to gather consolidated outcomes and to overcome the administrative problems that limit the ability to produce quality outcomes. (Representatives of at least 20 clinics expressed interest in participating.)
Integrative clinic and CAM services data analysis	Health systems, integrative clinics	--	Provide funds for a skilled researcher to analyze 25,000 patient records in integrative clinic, 35,000-50,000 records in second clinic
Develop strategy paper on "gap funding" for start-ups	Health systems, philanthropy	--	Research best practices in creating donated funds for initial phases of integrative clinics
Create outcomes tool to apply to providers	Health systems	--	Look at the role of delivering integrative services in creating job or professional satisfaction
Develop training manual for nurses	Health systems	--	Strategy is to slowly integrate, through existing providers. Include outcomes tools to evaluate success in terms of LOS, decreased pain, and medication.
Integrate medical education	Health systems, academic medicine	--	Based on those who train together treat together.
HMOs and Insurance			
Selected drug replacement with natural products	Managed care	--	Look at natural product alternative to pharmaceuticals in three focused areas: anti-depressants, cholesterol lowering agents, and GI drugs
Analysis of existing health plan and employer CAM utilization data	Health plans, employers	--	Significant data already exists. What we need is a strategy for analyzing it and making the outcomes public.
Other			
Train CAM providers in outcomes research	CAM professions	--	Many are unfamiliar with basic record keeping and in use of tools to measure functionality
HCFA waiver to explore quality CAM services in a given state	Government, health plans, hospitals	--	Waivers can allow mainstream and CAM providers who are confident of their relationships to explore CAM integration into Medicaid and Medicare populations
Post a shared outcomes tool on common website	Internet, integrative clinics	--	After developing a consensus tool kit, post it for use in creating combined data

Potential for ongoing shared work on the national scene

Many attendees expressed an interest in carrying on work begun at the Summit after they returned to their places of work. To capture the interest level in some ongoing activities, a short survey was handed out near the end of the Summit. Results are reported in Table 4. Ranking highest was interest in an ongoing annual gathering. Roughly 90% of respondents expressed a willingness to join a national industry association and to attend a more limited summit, which focused on policy issues.

Finding less immediate support -- 19% "yes" and 50% "maybe" -- was the idea of a shared education and lobbying fund that would focus solely on increasing the availability of federal health services grants to help fund integrative medicine projects such as many of those identified by the attendees.

Table 4: Onsite End-of-Summit Survey of Potential Interest Areas of Attendees

This survey was distributed near the close of the meeting. Roughly 65% were returned.

Question	Yes	Maybe	No	Blank
National Association *I/my organization would be interested in participating in a dues paying association/coalition to further interests such as those identified at the Summit.*	30 63%	13 27%	4 8%	1 2%
National Policy Summit *I/my organization would be interested in participating in a national policy summit to clarify a national agenda for the emerging industry.*	29 60%	12 25%	5 10%	2 4%
White House Commission on CAM Policy *I/my organization would be interested in participating in a communications network to stay in touch regarding activities of the White House Commission on CAM Policy.*	36 75%	2 4%	7 15%	3 6%
Annual Industry Meeting * *I/my organization would participate in a gathering like this as an annual time for industry meeting and sharing.*	43 90%	5 10%	0 0%	0 0%
Joint Fund to Increase Health Services Grants *I/my organization would be interested in contributing to an educational/lobbying fund for the sole purpose of substantially increasing the amount of federal funds available to support "real world" health services type projects such as we have identified here and face in our own businesses.*	9 19%	23 50%	9 19%	7 14%

*Attendees were asked if other stakeholders who are missing from this gathering should be here. Among those noted:

Stakeholder	#
More Employers/Self-funded Employers/Large Employers/WA Business Group on Health	7
Consumers/Public	4
Government/HCFA/Public Officials/Benefit Gatekeepers	4
Other Health Plans	4
More CAM Providers	3
More Academid Medicine Groups	3
AMA/Specific Additional CAM Professional Groups	3
Behavioral Health Provider Associations	2
Pharmacy/Nutracueticals	2
Specific Individuals	2

Next Steps

The strong interest in ongoing cross-fertilization identified and experienced during the Summit has already led to numerous follow-up developments.

- The lead sponsor for the Summit, Integrative Medicine Communications, has created a means for participants to continue to share initiatives through a special portal on the firm's OneMedicine.com site. Launched in November 2000 to serve participants, methods for allowing additional industry members to access the site and participate in ongoing exchanges are under consideration.
- Participant interest in making the gathering an annual event has led to the scheduling of a second Integrative Medicine Industry Leadership Summit on May 3-5, 2001 at the Sunburst Resort in Scottsdale Arizona.
- Some interest groups identified during the Summit have commenced communication on shared issues.

Non-attendees interested in participating in an annual Summit should email
Tamara Swain, Summit Coordinator for Integrative Medicine Communications, at
tamara.swain@onemedicine.com

Future impact?

The pre-Summit survey revealed that these integrative medicine industry leaders believe that the integrative medicine movement will be viewed as a significant change agent in US healthcare. The method for manifesting this change will be collaboration, the heart of the Summit's mission. 86% believe our success will be tied to becoming "exceptionally successful collaborators."

These two perceptions were linked in a question posed on the Summit's opening night by co-facilitator, futurist Clement Bezold, PhD, with the Institute for Alternative Futures: "Will this Summit be an historic meeting for integrative medicine and for American healthcare?" Time, only, will tell if the relationships formed, and the new directions identified, will answer Bezold's question in the affirmative.

Appendix 1

Summit Leadership

Program Development
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With support from:
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Pre-Summit Survey and Data Collection
John Weeks, question development
Charlie Priester, administration

Other Sources of Informal Pre-Summit Consultation on Program Plans
Thanks to: Tom Snook, Eric Leaver, Joseph DeNucci, Debra Canfield, Sister Diana Bader, RoseAnn Kushner, RN, William Stewart, MD, Anita Schambach, Michael Shor, MPH, Michael Levin, Angela Mickelson, Peter Amato, Tracy Gaudet, MD, Linda Bedell Logan, Melinna Giannini, Raven Rufner, Woodson Merrell, MD, Larry O'Connell, Richard Furber, Ray Seaver, Richard Brinkley, George DeVries, Pamela Snider, ND, Lou Sportelli, DC,

Appendix 2

Summit Attendees

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* Following the Summit, Janice Stanger, Sam Benjamin and Jery Whitworth have moved on to new positions elsewhere.

Appendix 3

Primary Summit Sponsors

Integrative Medicine Communications, Newton MA is an information services company empowering healthcare professionals, consumers, and executives to combine the best of conventional and alternative medicine for optimal healthcare. The company delivers a suite of unbiased, science-based clinical information to professionals and consumers as well as unrivaled business intelligence and advisory services. The company serves individual healthcare providers as well as large institutions, professional associations, and information providers including Health Forum, a subsidiary of the American Hospital Association, the American Society of Health System Pharmacists, and the American Academy of Physician's Assistants. Integrative Medicine Communications' products are not sponsored by any manufacturer and are peer-reviewed by an 87-member board of health professionals.
More information is available at www.integrativemedicine.com or by calling 877.426.6633.

THE INTEGRATOR ***for the Business of Alternative Medicine*** is a subscription-based, monthly newsletter, first published in 1996, that captures and analyzes the latest business intelligence and trends in the growing industry of integrative medicine. Since the newsletter's inception, the content has been developed by publisher/editor John Weeks, considered a national expert in the business of integration. The INTEGRATOR is published by Integrative Medicine, Newton, MA. Called "an enormous contribution to this entire field of inquiry" and "a reality check" by Harvard Medical School's David Eisenberg, MD, THE INTEGRATOR and Weeks are widely cited in the mainstream and healthcare media. Weeks is Principal with his Seattle-based information and consulting firm, Integration Strategies for Natural Healthcare. For more information email isnh@quidnunc.net

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American Specialty Health is a vertically integrated health services organization with more than 400 employees focusing on complementary and alternative healthcare. The company operates several wholly owned subsidiaries including American Specialty Health Plans (ASHP), American Specialty Health Networks (ASHN), and healthyroads.com. ASHP is the nation's first and largest chiropractic/acupuncture health plan, contracting with nine of California's 10 largest health plans and covering more than 3.7 million members in California. ASHN provides complementary healthcare programs and networks to health plans and employers nationwide, including acupuncture, chiropractic, massage therapy, naturopathy, and dietetics. Together, the two companies contract with more than 50 health plans nationwide and cover more than 20 million members. Healthyroads.com is a comprehensive e-health site offering a directory of complementary health care providers nationwide, information on complementary and alternative medicine, and more than 1,200 health and wellness products. More information is available at www.healthyroads.com

Angela A. Mickelson/HL&B is a principal in the health care law firm of Hooper, Lundy & Bookman, Inc. HL&B, based in Los Angeles, California, is the largest healthcare law firm in the country dedicated exclusively to representing the interests of institutional and professional

providers, provider associations and political subdivisions in healthcare business, regulatory, and litigation matters. Ms. Mickelson specializes in HMO and other managed care system development, licensure, regulatory compliance, contracting and business counseling. She also maintains a general business practice, with emphasis in the areas of conventional and integrative medicine provider organizations, business acquisitions and sales, tax-exempt organizations and financing, corporate restructurings, affiliations and joint ventures, and business development and operations.

Health Business Partners is dedicated to the global advancement of the emerging health industries: nutrition, natural products, e-health, and complementary healthcare. HBP provides direct investment capital and financial and advisory services to companies in these industries exclusively. More information is available at www.healthbusiness.com

Health Forum is the enterprise created when The Healthcare Forum, a nationally recognized healthcare leadership development and education association, joined with the American Hospital Association's publishing, data and information subsidiaries. Health Forum offers healthcare leaders access to new information and fresh ideas, which they can use to strengthen their organizations' clinical and business performance. More information is available at www.healthforum.com.

Inner Harmony Wellness Center is designed as a model of the new health paradigm, combining conventional and alternative medicine in the Clarks Summit area of Pennsylvania. It is an integral part of the community, complementing the existing health care system, and offering a full range of holistic services and healing modalities. In promoting health, the Center is committed to keeping in step with the changing needs of the community by providing opportunities for self-renewal and growth.

Institute for Health and Productivity Management has been established to promote the vital relationship between employee health and performance. The Institute's vision is to establish the value of employee health as a business investment in corporate success. To realize this vision, the Institute has set four strategic goals:

1. To become a global resource on health and productivity by assembling the substantive evidence to support the value of investing in employee health.
2. To develop the tools, metrics, and methods to drive and measure enhanced corporate performance through investments in health.
3. To be the champion of investing in health capital as a strategy for corporate success.
4. To educate and equip purchasers, providers, and suppliers to generate greater value from investing in employee health.

More information is available at www.ihpm.org

Appendix 4

Selected Findings from a Pre-Summit Survey of Attendees

The survey was mailed and administered electronically. Initial responses plus follow-up calls and emails netted 65 responses out of 75 total, an 87% response rate.

Area/Assertion	Strongly Agree	Mildly Agree	Neutral	Mildly Disagree	Strongly Disagree
CAM and Conventional Practice					
CAM is significantly under-utilized relative to its place in an optimal U.S. healthcare system.	51 78%	12 18%	1 1%	0 0%	1 1%
The optimal use of most CAM treatment is before more invasive agents and therapies have been tried rather than after conventional treatment has failed.	35 53%	17 26%	9 13%	3 4%	1 1%
In 2005, at least 25 percent of conventionally trained physicians working with their patients who have chronic conditions will routinely offer, or refer them for, more inclusive CAM-oriented interventions and therapies.	22 34%	28 43%	5 7%	7 10%	2 3%
Creating relationships with mainstream physicians and decision-makers is probably more important than additional controlled research at this moment in the CAM integration process.	13 20%	20 31%	12 18%	13 20%	6 9%
A necessary requirement for CAM business to be financially successful is to change the clinical and referral patterns of mainstream physicians.	26 41%	24 38%	4 6%	7 11%	2 3%
Creating allies and referring partners of conventionally trained MD/DOs is better described as a "conversion" process than an "educational" process.	7 11%	16 24%	20 31%	11 17%	9 14%
Employers					
Employers can be convinced of the economic case for greater inclusion of CAM.	21 33%	29 45%	6 9%	7 10%	1 1%
One necessary shift for the appropriate integration of CAM into covered benefits is for consumers and employers to contract with HMOs/insurers for at least 3-5 years so costs of front-end interventions are more likely to be recouped.	17 26%	19 29%	18 28%	5 7%	5 7%
HMOs and Insurers					
Most of consumer use of CAM will always remain outside the mainstream payment and delivery system.	2 3%	21 34%	6 9%	22 36%	10 16%
Increasing third-party CAM payment and delivery system CAM integration beyond the current status requires more controlled clinical trials on CAM.	19 29%	26 40%	4 6%	12 18%	3 4%
The most significant cost savings from CAM will be from the treatment of chronic conditions like arthritis, adult onset diabetes, and heart disease.	21 33%	25 39%	10 15%	4 6%	3 4%
The only way CAM providers should get involved with managed care is through negotiating special arrangements that reflect the complexity of CAM's distinctive services.	17 26%	14 22%	13 20%	13 20%	6 9%
For CAM integration through networks to be optimized, CAM networks must take the leadership role in analyzing and publishing outcomes.	42 64%	15 23%	4 6%	2 3%	2 3%
Significantly increased CAM participation in third-party payment structures is critical for the success of CAM's mission.	26 41%	16 25%	4 6%	13 20%	4 6%
We already have significant research data on many CAM approaches which convincingly argue that these approaches should be substantially more widely utilized and reimbursed now.	24 38%	25 39%	6 9%	7 10%	2 3%
Government/Federal Research					
The government will be the major player in shaping meaningful coverage of CAM.	7 11%	14 22%	12 19%	21 33%	9 14%
To foster the most rapid understanding of how CAM therapies and providers can be optimally used to resolve the cost crisis in U.S. healthcare, government should focus on funding research on outcomes of present payment and delivery models even if that means limiting funding of clinical trials.	19 29%	22 34%	11 17%	11 17%	1 1%

(continued ...)

Area/Assertion	Strongly Agree	Mildly Agree	Neutral	Mildly Disagree	Strongly Disagree
If my organization had a $50,000 grant for a priority, but non-proprietary project, we could develop information, explore a process, set up a structure, or analyze experience data which would be valuable to other executives and policymakers in the emerging business of CAM integration.	48 73%	10 15%	4 6%	2 3%	1 1%
CAM's mission as a transformative agent in healthcare will not be realized unless there is an ongoing, significant lobbying force for change in public policy in Washington DC.	32 49%	21 32%	6 9%	4 6%	2 3%
Partnership and Collaboration					
In my day-to-day work in CAM I feel isolated from other members of the CAM industry.	4 6%	19 29%	15 23%	15 23%	11 17%
I currently am directly engaged with at least one project that formally involves at least one organization from another stakeholder category.	57 89%	7 11%	0 0%	0 0%	0 0%
I currently am directly engaged with at least one project that formally involves an organization which is in my own stakeholder category.	46 75%	15 25%	0 0%	0 0%	0 0%
My own business success would benefit from partnerships and collaborations with members of other stakeholder groups.	50 75%	11 16%	3 4%	1 1%	0 0%
My business success can be enhanced through greater collaboration with other organizations within my own stakeholder group.	39 60%	10 15%	9 14%	4 6%	2 3%
Success in our mission and our business will be linked to our ability to overcome our present atomization and become exceptionally successful collaborators.	47 73%	9 14%	7 10%	1 1%	0 0%
Future of Healthcare and CAM Integration					
In 2010, the CAM movement and industry will be viewed as a significant, historic change agent in transforming US healthcare.	31 47%	27 41%	3 4%	3 4%	1 1%
In 2010, managed care (PPO, HMO, etc.) will still be a major player in U.S. healthcare payment.	14 22%	25 39%	8 12%	8 12%	8 12%
By 2005, the Internet will be a core component of most CAM payment and delivery strategies.	20 31%	23 35%	14 21%	3 4%	4 6%
Complementary and alternative medicine is a tool of our deeper mission of transformation, which will only be successful if we help birth a thriving U.S. industry of health creation.	37 59%	16 25%	9 14%	2 3%	0 0%
Personal Experience					
CAM therapies and a CAM philosophical approach are significant factors in my own personal healthcare choices.	43 67%	17 26%	3 4%	0 0%	1 1%
Creating a financially successful business in CAM is harder than I expected.	22 34%	16 25%	14 21%	9 14%	2 3%

Appendix 5

Summit Program Description

Overview The program was divided into four modules. Individual modules began with 75 minutes in Committee of the Whole. Five-minute comments from each of four discussants kicked off the exchange, followed by roughly 45 minutes of discussion. Pre-planned, small group work followed the first three Committee of the Whole sessions. For the first two modules, small group work focused on identifying and developing projects which would advance integration. For the third module, by choice of attendees, small group work focused on actual collaborative projects. Following each small group session, the Committee of the Whole regrouped and the work of the small groups was reported and discussed.

1. THE HEALTH OF OUR BUSINESS/OUR BUSINESS OF HEALTH CREATION

Assertion:
Complementary and alternative medicine is a tool of our deeper mission of transformation, which will only be successful if we help birth a thriving U.S. industry of health creation.

Objectives:
- Explore our individual and collective missions.
- Evaluate the incentive alignment in various sources of financial support and partnership.
- Examine the relationship of our mission and our money.

Perspectives and Questions:
Is our involvement in CAM an end in itself? Do we share a greater purpose? Is CAM a change agent?...With the devolution of the HMO movement's promise to carry the torch for shifting incentives in care delivery, is the CAM movement now the torch bearer for health creation? Are our current business and clinical models for integration living up to this billing? Are we actually treating disease by restoring health, or are we merely replacing modalities?...Can a health creation mission be successful without a thriving industrial engine, to create and expand business models, to identify and promote appropriate public policy? What are examples of businesses which have been successful financially in health creation? What can we learn from them?...Which stakeholder partners are most financially aligned with this mission? HMOs? Employers? Hospitals and health systems? Federal research funds? Public health? Venture capital? Reaffirmed relationships with the consumer?...How can health creation be compatible with economic timelines?...Where is the money to lift the CAM industry toward its mission?

Discussants
Corrine Bayley, VP, St. Joseph Health System
Sean Sullivan, President, Institute for Health and Productivity Management
Anna Silberman, VP, Highmark Blue Cross Blue Shield
Sam Benjamin, MD, CAM Leader, SUNY Stony Brook

2. INTEGRATION AND TRANSFORMATION IN MAINSTREAM DELIVERY

Assertion:
The path to economic success for integrative clinics and other CAM is through partnerships that deeply integrate CAM into the referral mainstream and into transformed conventional practices.

Objectives:
- Understand success factors of current integrative clinic models.
- Consider strategies for penetrating or dissolving physician and organizational prejudice.
- Explore the pros and cons of the integrative clinic business model as an integrative and transformative agent in broader health system delivery.
- Create project and partnership designs to clarify critical infrastructure needs.

Perspectives and Questions:
Most health system integrative clinics are operating in the red. These are new models, proving themselves, so no wonder it is taking time. Build it and they will come is not proving out....Can these clinics – can business of integration models -- be successful if they are only consumer-driven, and if mainstream organizations view participation basically as a marketing strategy? Or must we elevate referral by physicians or payers to a status of chief economic driver?...How do we get there? How can physician interest be maximized and resistance eroded?...Are these clinics merely a carve-out of their own, a way of sidestepping the internal political and educational hassles of direct integration into delivery?...Or, are these clinics a way station toward full-blown integrative care which respects all the alternative or complementary services that might be valuable in the care spectrum? Are integrative clinics change agents in care delivery or simply new business units?

Discussants:

Leonard A. Wisneski, MD, Chief Medical Editor, Integrative Medicine Consult,
Mort Rosenthal, CEO, Wellspace

Linda Bedell Logan, President, Solutions in Integrative Medicine
Catherine L. Cather, Total Health Management Practice Leader, Towers Perrin

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3. INTEGRATION AND TRANSFORMATION IN MAINSTREAM PAYMENT

Assertion:
The optimal alignment of CAM business is on the demand side -- with consumers, employer-payers, and public health.

Objectives
- Examine current and emerging trends in third party payment models.
- Understand the relationship between "gold standard" clinical research and other factors in coverage decisions.
- Explore decision processes on CAM benefits inside payer organizations.
- Create project and partnership designs to clarify critical infrastructure needs.

Perspectives and Questions:
Can the slow progress of HMO evolution on CAM coverage be stimulated? Do we wait upon medical savings accounts and defined benefits as potentially better structures than dominant payer models to allow consumers to use CAM?...Can benefits be expanded without a political strategy (mandates) or intra-organizational political strategy to move CAM from a marketing issue into core benefits? Is the direct access, carve-out network a good model for integration? Are CAM networks transitional entities toward optimal integration?...To what extent can we look to these businesses as visionary leaders?...The kind of outcomes data CAM can readily create, without the NIH's slow time-line, can be most meaningful to employers...The things that employers want -- productivity, functionality, satisfaction, quality of life -- are what CAM providers assert, and consumers claim, they get. This stakeholder is CAM's natural ally...It is the employers who will move HMOs and insurers to cover CAM.

Discussants:
Robert Stern, DC, CAM Leader, Anthem Health Plans
Janice Stanger, CAM Leader, William Mercer & Associates
Alan Kittner, Founder, Consensus Health and onebody.com
Henry Ziegler, MD, MPH, Leader, CAM-Public Health Exploration

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4. COLLABORATION, PARTNERSHIPS, PROJECTS AND PUBLIC POLICY

Assertion:
Success in our mission and our business will be linked to our ability to overcome our present atomization and become exceptionally successful collaborators.

Objectives:
- Create a pool of health services projects which, if implemented, would lay the infrastructure for integration, transformation, and business expansion.
- Explore potential sources for health services research funding.
- Construct and share models for collaborative pilot projects.
- Consider creating a voice in federal policy for the emerging CAM industry.

Perspectives and Questions:
The business and mission of integration will benefit from development of shared infrastructure... To prove our models we must cross-fertilize with other stakeholder interests: clinics with employers, CAM professions with health system leaders, etc...The 7% of the $70 million of NCCAM's budget devoted to integration research is a vast under-funding of our real world activities. We need to access government, foundation and/or collective private sources to create an infrastructure...To make our case, we need to assert our needs, create our lists of quality projects, and enhance support for investment in the business infrastructure for health creation...Without an active presence in D.C., developing relationships with legislative and executive branches, we cannot create a policy context in which we can thrive.

Discussants:
Brian Berman, MD, CAM Leader, Cochrane Collaboration, U Maryland
Candace Campbell, Executive Director, American Preventive Medicine Association
Bernita McTernan, VP Mission/Human Resources, Catholic Healthcare West
Clyde Jensen, PhD, President, National College of Naturopathic Medicine

Journal of Gerontology: MEDICAL SCIENCES
1999, Vol. 54A, No. 12, M600–M606

Complementary and Alternative Medicine Use Among Elderly Persons: One-Year Analysis of a Blue Shield Medicare Supplement

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[2]University of Southern California, School of Medicine, Los Angeles.

Background. Large scale surveys in the United States and abroad suggest that 35–60% of adults have used some form of complementary/alternative medicine (CAM). However, no studies to date have focused on predictors and patterns of CAM use among elderly persons.

Methods. The population surveyed were Californians enrolled in a Medicare risk product that offers coverage for acupuncture and chiropractic care. Surveys were mailed to 1597 members in 1997 and responses received by 728 (51% response rate). Health risk assessment data were also obtained at baseline and 12–15 months following enrollment in the plan. Multiple logistic regression analyses were carried out to examine predictors of CAM use.

Results. Forty-one percent of seniors reported use of CAM. Herbs (24%), chiropractic (20%), massage (15%), and acupuncture (14%) were the most frequently cited therapies. CAM users tended to be younger, more educated, report either arthritis and/or depression/anxiety, not be hypertensive, engage in exercise, practice meditation, and make more frequent physician visits. Use of CAM was not associated with any observed changes in health status. Respondents also expressed considerable interest in receiving third-party coverage for CAM. Although 80% reported that they had received substantial benefit from their use of CAM, the majority (58%) did not discuss the use of these therapies with their medical doctor.

Conclusions. Findings suggest that there is significant interest in and use of complementary/alternative medicine among elderly persons. These results suggest the importance of further research into the use and potential efficacy of these therapies within the senior population.

USE of complementary or alternative (CAM) therapies by large segments of the United States adult population is well documented. Beginning with the landmark study by Eisenberg and colleagues in 1993 (1), findings suggest that 30–50% of the population has used some form of unconventional medical care (2,3), and the most recent surveys suggest that CAM use in the United States is continuing to increase at a rapid rate (4,5). Public interest in unconventional forms of health care prompted the legislature to establish the Office of Alternative Medicine (now the National Center for Complementary/Alternative Medicine—NCCAM) in 1992 as part of the National Institutes of Health to begin assessing the safety and efficacy of CAM therapies. In addition, primarily due to consumer interest (and, to a lesser extent, legislative mandate and demonstrated efficacy), several prominent insurance companies and managed care organizations have begun offering coverage for CAM (6,7).

Rates of CAM utilization vary depending on the particular geographic region and the ways in which "alternative/complementary medicine" is defined. Although some studies suggest that CAM use is greatest among those between the ages of 35 and 50 (1), a recent multivariate analysis found no significant effect of age on CAM utilization (2). To date, there have been no studies focusing on CAM use among elderly persons. The present study was carried out to better understand patterns of and reasons for CAM utilization among an elderly population of Medicare patients enrolled in a supplement plan provided by Blue Shield of California. This focus seems particularly important given the disproportionate amount of health care expenditures that go toward treating the medical needs of this age group as well as the predictions that by the year 2020, seniors over the age of 60 will account for approximately 25% of the population (8).

Along with describing more specifically the patterns of CAM utilization among elderly persons, logistic regression analyses were carried out to test several possible predictors of CAM use identified in previous research. These hypothesized predictors included age (1), income (9,10), educational level (2,10–12), ethnicity, gender, health status (measured by a five-point scale, and the SF-12 (13), and specific health-related problems) (2), and several health and lifestyle habits (2,14–16).

In addition, using health risk assessment data taken from two time points, the study sought to examine whether CAM use is associated with positive or negative changes in health status. Finally, data were collected that assessed the extent to which coverage for CAM factored into these seniors' choice of health plan, as well as the degree to which they desired additional third-party coverage for CAM therapies.

Method

For the present report, one data set consisted of responses to a 10-page written survey developed by researchers at the

Complementary and Alternative Medicine Program (CAMPS) at the Stanford University School of Medicine. The population surveyed were voluntary enrollees in a then new Blue Shield plan—"Shield 65"—a Medicare risk product that offers CAM coverage for acupuncture and chiropractic care. For each of these therapies, members are allowed 20 self-referred visits per calendar year, with a $3 co-pay per visit. (For chiropractic care, this is over and above the standard Medicare coverage involving a $3 co-pay for physician-referred visits deemed medically necessary.)

Surveys were mailed to 1597 plan members in California. In an effort to maximize response rate, a reminder postcard was mailed out to these individuals approximately 1 month following the initial survey mailing. From this second mailing, it was determined that 159 individuals (10%) had disenrolled from the plan. Five postcards were returned undeliverable. Completed questionnaires were received from 728 individuals yielding a response rate of 51% (i.e., 728/1433). In addition, Blue Shield had previously obtained health risk assessment (HRA) data on their plan members. HRA data were available for 675 of the 728 members who completed our survey on CAM use. These data were collected between April and July of 1997. (Blue Shield was not able to provide us with the precise dates of individuals' enrollment in Shield 65 nor their initial HRA assessments, but only this range of dates.) Study participants were mailed a second HRA in July of 1998, approximately 12–15 months following their initial risk assessment and enrollment in "Shield 65." At Time 2, 140 members had disenrolled from the plan. Of the remaining 588 study participants, 496 (84%) responded to the second HRA.

The 25-item questionnaire assessed use of the following 10 CAM therapies: acupuncture; ayurveda (traditional East Indian medicine); chelation therapy; traditional Chinese medicine; chiropractic; guided imagery; herbal medicine; homeopathy; massage; and naturopathy. Brief definitions of each therapy were provided (e.g., "acupuncture—an ancient method of restoring 'chi' or energy, usually by inserting needles at specific points on the skin"). The survey also explored reasons for use of CAM therapies (a close-ended list of 10 health-related problems), self-care activities (e.g., exercise, blood pressure monitoring), health status (5-point scale), and the extent to which they desired reimbursement for CAM.

Data were analyzed (using SPSS statistical software) in an effort to better understand the level of involvement in alternative/complementary therapies by elderly persons and to examine factors that predict use of CAM among this population.

Results

Patterns and Predictors of Use

Table 1 summarizes the demographic characteristics of the sample. When compared to representative national samples of elderly persons, there is a slight overrepresentation of higher income, better educated individuals. The sample also overrepresents Asians and underrepresents African Americans.

Forty-one percent of respondents reported using some form of CAM in the previous year. The most frequently used therapies were herbal medicine (24%), chiropractic (20%), massage (15%), and acupuncture (14%) (Table 2). Of those who used CAM, the majority (80%) reported at least some improvement in symptoms as a result of these therapies. Percentages of respondents reporting "a lot" or "quite a lot" of symptom relief ranged from highs of 86 and 82%, respectively, for homeopathy and imagery, to 57 and 58%, respectively, for acupuncture and traditional Chinese medicine. The majority of CAM users (58%) in the present study did not discuss use of these therapies with their medical doctor or other health care practitioner.

CAM users reported paying, on average, $699 per year out-of-pocket for all visits to CAM providers (e.g., chiropractors, acupuncturists, massage therapists). They made on average 26 visits to CAM practitioners in the previous year and paid on average $71 per visit.

Respondents were also asked to specify the types of over-the-counter herbal medicines and nutritional supplements they used. Among the most frequently used herbs were ginko biloba (3.2%), garlic, and ginseng (1.8% each). Though not considered "complementary/alternative" medicine in the present study, the most frequently used vitamin/mineral supplements were multivitamins (26%), vitamin E (21%), and vitamin C (20%).

The most frequently cited medical reasons for seeing a CAM provider were back problems (43%), chronic pain (26%), general health improvement (25%) and arthritis (20%). For both acupuncturists and chiropractors, the top reasons cited were chronic pain, back problems, arthritis, and general health im-

Table 1. Demographic Characteristics of Survey Sample

Variable	Percent of Sample	Percent Who Used Alternative Medicine
Age (n = 668)		
< 65	4	67
65–69	46	46
70–74	24	37
75–79	15	28
80–84	8	31
> 85	5	23
Race/ethnicity (n = 693)		
White	76	40
Black	3	47
Hispanic	6	50
Asian/Pacific Islander	11	41
Other	4	38
Gender (n = 675)		
Males	45	41
Females	55	40
Education (n = 707)		
High school or less	25	25
Some college	38	45
College degree	15	48
Graduate work	7	41
Graduate degree	15	53
Household income (n = 632)		
< 10,000	13	37
10,000–14,999	15	35
15,000–24,999	15	53
25,000–34,999	18	42
35,000–49,999	17	45
50,000–74,999	12	44
> 75,000	14	38

Table 2. Frequency of Use of Specific CAM Therapies

Therapy	Percent Used
Herbal medicine	24.1
Chiropractic	20.3
Massage	14.7
Acupuncture	13.5
Naturopathy	9.3
Chinese medicine	9.1
Guided imagery	6.5
Homeopathy	5.8
Ayurvedic medicine	3.8
Chelation therapy	1.0

Table 3. Factors Influencing Use of CAM Therapies

General health improvement	45%
Dissatisfaction with conventional medicine	36%
Pain management	34%
Fear of drug side effects	32%
Friend or family member	28%
Stress reduction	20%
Chronic medical problems	18%
Desire for personalized attention	13%

Table 4. Correlations of Hypothesized Predictors With Use of CAM

Variable	Simple *r*
Age	−.18***
Education	.17***
Income	.00
Gender	−.03
Health Status	−.02
SF-12 (Physical)	−.08*
SF-12 (Mental)	−.05
Pain symptoms	.11**
Smoking	−.05
Alcohol consumption	−.08*
Exercise	.19***
Meditation	.28***
Arthritis	.08*
Depression/anxiety	.11**
Memory problems	.08*
Hypertension	−.08*
Loss of social functioning	.09*
Less able to work	.08*
Daily activities limited	.09*
Doctor visits	.14***

*$p < .05$; **$p < .01$; ***$p < .001$.

Table 5. Significant Predictors in the Multiple Logistic Regression ($n = 644$)

Variable	Adj. Odds Ratio	95% CI	*p*
Education	1.2	1.1–1.3	<.01
Being younger	1.4	1.3–2.4	<.0001
Depression/anxiety	2.0	1.1–3.7	<.04
Arthritis	1.7	1.2–2.6	<.01
Hypertension	.60	.24–.55	<.05
Meditation	5.9	3.2–11.1	<.0001
Exercise	1.6	1.1–2.3	<.05
Physician visits	1.4	1.1–1.7	<.001

provement. For massage therapists, the most frequently cited reasons were general health improvement, back problems, chronic pain, and stress reduction. Respondents were also asked what factors influenced them to use CAM therapies in general (i.e., either provider *or* self-care based). The most frequently cited reasons were general health improvement, dissatisfaction with conventional medicine, pain management, and fear of drug side-effects (Table 3).

Bivariate correlations between the hypothesized predictors and the dependent variable were calculated. The variables with significant correlations with the dependent variable were as follows (Table 4): being more educated or younger, having poorer physical health (SF-12); reporting pain, arthritis, depression/anxiety, or memory difficulties; engaging in exercise, monitoring of blood pressure, or practice of meditation; not being hypertensive, greater alcohol consumption, poor health interfering with one's social activities or daily tasks; and more frequent visits to physicians.

Those variables that correlated significantly ($p < .05$) with use of CAM (operationalized as use of any of the previously discussed modalities within the last year) were then entered into the multiple logistic regression. The following factors emerged as significant predictors: being younger, more educated, reporting either arthritis and/or depression/anxiety, not being hypertensive, engaging in exercise, practicing meditation, and making more frequent doctor visits (Table 5). Among those with graduate degrees or higher, 53% reported using CAM as compared with 25% of respondents who had received a high school degree or less. One sees a clear trend with respect to age and CAM use as well with older respondents reporting significantly less use of these unconventional therapies. For example, among those aged 65–69, 46% reported CAM use compared with 31% among the 80–84 age group.

The relationship between health status and use of CAM is somewhat more ambiguous. For example, although there was not a significant correlation between self-reported health status (on a 5-point scale) and CAM use, CAM users *did* tend to make more physician visits and were more likely to suffer from health-related problems such as arthritis or depression/anxiety. Among those reporting making six or more doctor visits in the previous year, 56% used CAM, whereas 36% of those individuals visiting a doctor three times or less used CAM. (It is important to note that the observed correlation between greater number of doctor visits and higher CAM use could be an artifact resulting from respondents interpreting "doctor" visits as visits to CAM providers.) Among those reporting depression/anxiety, 59% used CAM; of those reporting arthritis 47% were CAM users.

CAM users in this study population were also more likely to engage in various self-care activities. For example, 77% of CAM users reported engaging in exercise as compared with 59% of nonusers. Among users, 21% reported engaging in meditation, whereas only 4% of nonusers were involved in this

self-care activity. There was also a nonsignificant trend in the direction of CAM users being less likely to smoke cigarettes or drink alcohol and more likely to monitor their blood pressure.

To test the validity of the logistic regression model, the following technique was employed. Predicted values from the multivariate equation were divided into quintiles. The percentage of respondents within each quintile who used CAM was then calculated. This analysis is typically used to assess the extent to which there is any clinical/policy relevance to the predictor variables beyond their being statistically significant (17). Within the quintile of lowest predicted value scores, 15% used alternative medicine; within the highest quintile, 73% were users. These results suggest the model is fairly strong and has good predictive value along with its being statistically significant.

Effects of CAM Utilization on Health Status

Based on health risk assessment data taken from two time points (between 12 to 15 months, depending on the subject's date of enrollment in the plan), changes in health status were operationalized as changes in any of the following: global self-rating of health (5-point scale); specific health-related problems (arthritis, depression, asthma, hypertension); pain symptoms; social functioning; and ability to carry out work-related activities. Changes in health status, whether in a positive or negative direction, were not associated with use of CAM on any of the risk assessment parameters (i.e., use of CAM did not predict health status at Time Point 2, controlling for Time Point 1 scores). Specifically, among those who used CAM ($N = 180$), 12% reported a negative change in or worsening of arthritis symptoms, 6% reported a positive change, whereas 82% reported no change. Similar patterns were observed on other risk parameters. Changes in overall self-reported health status showed no significant association with CAM use. Among those using CAM, 26% reported a worsening of health status, 7% an improvement, and 67% no change. A similar trend is observed in nonusers of CAM: 28% evidenced a worsening of health status, 10% an improvement, and 62% reported no change. In terms of social functioning, among CAM users, 26% reported some decline in functioning whereas 12% reported improvement. Among nonusers, 20% reported some worsening in social functioning, and 10% some improvement.

Interest in Third-Party Coverage

Modalities for which most members wanted third-party coverage were: chiropractic (50%), massage (43%), acupuncture (33%), and herbs (31%). Twenty-seven percent of respondents stated they had actually joined the plan because of its coverage of chiropractic, whereas 20% stated they had joined because of its acupuncture coverage. Respondents who said that either or both of these therapies were influential in their decision to join the plan (31% of the total sample) were further examined in relation to their use of CAM. Among these individuals, 77% reported being CAM users, whereas 23% stated that they had never actually used CAM, despite their decision to join the plan because of its CAM coverage.

Respondents were also questioned whether they would be willing to pay per month for an optional supplemental plan that would provide coverage for other forms of complementary/alternative medicine. Of those who reported using some form of CAM, 59% said they would be willing to pay some amount, whereas 31% of nonusers stated they would be willing to pay some amount for additional CAM coverage.

Discussion

The present study adds to the growing body of research examining use of complementary and alternative forms of health care (CAM). Although the majority of these studies have typically used more heterogeneous demographic samples, the present study examined patterns and predictors of CAM utilization within a targeted population of elderly Medicare patients enrolled with Blue Shield of California.

Results suggest that substantial numbers of seniors are both interested in and actually using various forms of complementary/alternative medicine. Forty-one percent of those surveyed reported using some form of CAM within the previous year, with herbal medicine, chiropractic, massage, and acupuncture being the most frequently cited modalities. Although the majority of CAM users (58%) did not discuss their use of these unconventional therapies with their conventional physicians, a finding consistent with previous research (1,5), the vast majority (80%) reported receiving some benefit in terms of improvement in symptoms. Lack of communication between elderly patients and their providers about use of CAM is of concern for two reasons. First, it may point to generally poor communication between these patients and their physicians, and may suggest that patients are fearful of sharing such information. Second, without such open communication, doctors *and* patients will be less aware of potentially harmful interactions between their conventional and CAM treatments (e.g., herb-drug interactions). For these reasons, encouraging discussion of CAM use among the growing elderly population is essential (18,19).

Consistent with previous research (2), these elderly CAM users reported back problems, chronic pain, arthritis, and general health improvement as the top reasons for their seeking out these therapies.

Results from the multivariate analyses suggest that the following factors are predictive of CAM utilization in this population: being more educated, younger, reporting either arthritis and/or depression/anxiety, engaging in exercise, practicing meditation, and making more frequent physician visits. The relationship of higher education level but *not* income to CAM use is consistent with a recent national study examining predictors of alternative health care utilization in the general population (2). Also consistent with this study was the apparent association of poorer health status, in particular self-reported anxiety and depression in this sample of seniors, with use of CAM. However, the relationship between health status and CAM use is not entirely clear-cut. For example, although use of CAM was associated with a number of factors indicative of poorer health, CAM use was also associated with certain self-care activities such as exercise, less smoking, and alcohol consumption. These findings suggest that a subset of CAM users may in fact be healthier (or at least more health-conscious) than those who do not use these therapies. It should also be noted that the association between CAM use and more frequent physician visits could in some cases actually reflect better self-care (i.e., preventive health care) on the part of these respondents. This would be consistent with recent research suggesting that a significant portion of CAM use is for prevention and health promotion/health maintenance, rather than simply treatment of disease and illness (3–5).

The finding that CAM use was significantly higher in younger segments of the senior population surveyed may reflect a cohort rather than age effect. That is, it may be the case that recent generations have been more exposed to the phenomenon of CAM (through media, popular culture, social networks, etc.) and are therefore more likely to be familiar and open to experimenting with these therapies. Along these lines, we have unpublished data from an earlier survey (2) suggesting that the younger segments of the senior population are less trusting and satisfied with their conventional health care providers, and in turn have less unquestioning faith or belief in the efficacy of conventional medical treatment.

Finally, the finding that involvement with nontraditional spiritual practices, such as meditation, is associated with CAM use is also consistent with previous research suggesting that involvement with CAM is part of a broader value orientation that recognizes the importance of nonphysical (i.e., mental, spiritual) factors in health (2).

Although it was primarily those seniors who were actually using CAM who stated that they had joined the health plan because of its coverage of acupuncture and chiropractic, results suggest that seniors who use CAM therapies as well as those that do not are interested in having their health plans cover complementary/alternative medicine. In fact, even among those who did not use CAM, 31% stated that they would be willing to pay some additional amount to receive coverage for CAM. The most frequently cited therapies for which respondents wanted coverage were chiropractic, massage, acupuncture, and herbs.

This study also examined the extent to which use of CAM was associated with any changes in health status. No significant relationships were found between use of these therapies and health status as measured by a standard health risk assessment instrument taken at two time points approximately 12 to 15 months apart. One interpretation of this negative finding is that CAM therapies are no more or less effective than conventional approaches. However, it may also be the case that the time between risk assessments was insufficient to capture any significant changes in health status and/or that the HRA may not have been particularly sensitive to the kinds of changes CAM therapies may bring about. Finally, although such analyses that examine correlational associations between changes in health status and use of particular therapies are useful, any definitive conclusions regarding the efficacy of CAM *or* conventional approaches must be based on well-controlled, prospective clinical trials.

The sample used in the present study was not a representative sample of seniors in the United States population in so far as it was limited to one particular state, California, which previous research suggests has significantly higher rates of CAM use (1). Problems with self-selection (response rate of 51%) may also have resulted in a sample biased in favor of CAM, thus inflating estimates of CAM use and interest in such therapies. The sample also tended to underrepresent the poorer, less educated segments of the population, overrepresent Asians, and underrepresent African Americans. It is quite possible that patterns of and reasons for CAM use may vary as a function of one's ethnic/racial background (2), suggesting the need for larger samples and investigations that focus on specific cultural subgroups.

These limitations notwithstanding, we believe the present study adds substantially to our understanding of CAM use in a specific segment of the population—the elderly. Although previous research has suggested that complementary/alternative medicine is primarily used by those aged 35–50, the present study suggests that a substantial number of seniors are: (i) using CAM therapies to address a variety of health-related problems as well as prevent illness and optimize health and well-being; (ii) perceive these therapies to be efficacious; (iii) are not discussing such use with their physicians; and (iv) are interested in having their health plans offer coverage for such therapies. Significant use of and interest in approaches such as chiropractic, acupuncture, and herbal medicine by seniors—a segment of the population that is both growing exponentially as well the largest consumers of health care—suggest the need for more well-controlled studies examining the potential efficacy of these therapies.

As the 35–50 years old postwar Baby Boomers continue to use CAM with greater frequency into their advanced years, both the promise and perils of these therapies need to be further researched. Clinical and cost outcomes based on longitudinal studies need to focus on Medicare-eligible populations to determine if CAM versus conventional versus an integrated model of CAM *and* conventional care results in decreased disability and improved health status. Addressing such clinical, financial, and public policy questions becomes ever more pressing as over 15,000 people per day become Medicare-eligible.

ACKNOWLEDGMENTS

We are grateful to Blue Shield of California, the National Institutes of Health Center for Complementary and Alternative Medicine (NCCAM), and the American Health Association for their support of this study. We would also like to thank Cindy Wood, Ellen DiNucci, and Adeline Hwang for their assistance with this project.

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Received December 1, 1998
Accepted July 7, 1999

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Divider Title: Special Populations

Questions for the Panel on Special Populations: Minorities

What are the functions of your office? Are you aware of any efforts to use complementary and alternative medicine (CAM) to improve the health of minorities? Are there any data?

Does your office focus on cultural diverse health care practices? Is there a link between culturally competent health care services and CAM?

In your efforts to reduce and eliminate health disparities, is there a role for CAM?

What are the coverage and reimbursement issues for CAM use by minority populations? Do these issues vary among different minority groups, and from the general population?

Can you offer any ideas for coverage or payment mechanisms that would increase access to CAM services and products among minorities?

Are minority populations more vulnerable to questionable CAM products and services? If yes, how can this be addressed?

Do you have any suggestions for the Commission to consider as it develops a report and recommendations to the President and Congress?

Questions for the Panel on Special Populations: Underinsured and Uninsured

Describe the uninsured and underinsured populations in the U.S. and why these exist. What programs are in place to provide health care services to the underinsured and uninsured?

Are you aware of any efforts to use complementary and alternative medicine (CAM) to improve the health of these populations? Are there any data on CAM use?

What are the coverage and reimbursement issues for CAM use among the underinsured and uninsured populations? Do these issues vary within these groups and why?

As to access to CAM, can coverage and payment issues for the underinsured and uninsured be addressed by the same or different mechanisms from the general population? Are there other access issues?

Can you summarize the proposals for helping the uninsured and underinsured? Can you offer any ideas for coverage or payment mechanisms that would increase access to CAM services and products among these special populations?

Are the underinsured and uninsured more vulnerable to questionable CAM products and services? If yes, how can this be addressed?

Do you have any suggestions for the Commission to consider as it develops a report and recommendations to the President and Congress?

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Stinson

Divider Title: _____

Nathan Stinson, M.D.

Office of Minority Health, DHHS

13

White House Commission on Complementary and Alternative Medicine Policy

Nathan Stinson Jr, PhD, MD, MPH

Deputy Assistant Secretary for Minority Health

Department of Health and Human Services

May 14, 2001

Thank you for the opportunity to frame the issues and identify questions regarding the use of complementary and alternative medicine by racial and ethnic minorities.

The Office of Minority Health (OMH) was created by the U.S. Department of Health and Human Services (HHS) in 1986, in response to the 1985 *Report of the Secretary's Task Force on Black and Minority Health*. This report analyzed the continuing disparity in health status experienced by Blacks/African-Americans and other minorities when compared to the population as a whole, as reported in the 1983 issue of *Health, United States*. OMH advises the Assistant Secretary for Health and the Secretary on public health issues affecting Blacks/African-Americans, Hispanics/Latinos, American Indians and Alaska Natives, Asian Americans, Native Hawaiians, and Pacific Islanders. OMH strives to encourage change through improving and strengthening the public health infrastructure necessary to address the disparities in health and health care that impact racial and ethnic minority populations. In addition, OMH advocates for improved data

collection and analysis, supports demonstration programs and program evaluations; conducts important information dissemination activities and policy analyses; and, in general, provides leadership through coordination and development activities such as conferences and publications.

Today, there are continuing disparities in the burden of illness and death experienced by racial and ethnic minorities compared to the total U.S. population. These disparities demand national attention, in spite of noteworthy progress in the overall health of the Nation. The demographic changes that are anticipated over the next decade will magnify the importance of addressing disparities in health status. Population groups currently experiencing poorer health status are expected to grow as a proportion of the total U.S. population. Therefore, the future health of Americans will be influenced substantially by the Nation's success in improving the health of racial and ethnic minorities. A national focus on disparities in health status is particularly important as major changes unfold in the way in which health care is delivered and financed.

Eliminating racial and ethnic disparities in health will require greater efforts to prevent disease, promote health, and deliver appropriate, quality health care. Enhancements will entail improved collection and use of increasingly standardized data to identify high-risk populations and to monitor the effectiveness of the health care interventions targeting them. Research on the relationships among health-status variables and racial and ethnic minority identities will help to establish a better understanding of new ways to apply the existing knowledge base in ultimately achieving the goal of eliminating disparities. Improving access to quality health care and delivering prevention and treatment services will require working closely with communities to

identify culturally competent strategies.

In January 2000, the national disease prevention and health promotion agenda for the year 2010 was launched–Healthy People 2010. For the first time, this agenda contains an overarching goal of eliminating disparities. To achieve this ambitious goal, we are asking that organizations in both the public and private sectors (the States and territories, private foundations, local government agencies, community organizations, and the Congress) join efforts. Assistance is needed to (1) inform youth about careers in medicine and health, (2) ensure that congressionally funded programs are designed to increase the number of minority students enrolling in and graduating from professional and allied health care occupational training programs, (3) enhance our efforts in health promotion and education of racial/ethnic minority communities, (4) promote personal responsibility for healthier lifestyles, (5) enhance medical school curricula to improve physician/patient communication, (6) fund research on the underlying causes of disparities in health status and health care, and (7) ensure equal access to quality health care services and equal protection under the law. In applying sound scientific principles and empirical evaluation findings to public health policy and program development, and, in educating individuals and communities about prevention and the health care system, we will stimulate policy, research, and the health care interventions that improve the Nation's health as a whole.

In response to the question, "is there a role for CAM in efforts to eliminate health disparities?" I would answer, "Yes." In each of the areas I have just outlined.

As defined by the National Institutes of Health: Complementary and alternative medicine (CAM) covers a broad range of healing philosophies, approaches, and therapies. Generally, it is defined as those treatments and healthcare practices not taught widely in medical schools, not generally used in hospitals, and not usually reimbursed by medical insurance companies.

Several studies have been conducted on the use of CAM by race and ethnicity. I would like to share with you a few examples of these studies. Nationally representative studies such as the Agency for Healthcare Research and Quality's Medical Expenditures Panel Survey have found the use of CAM medical providers to be lower for Hispanics and African Americans than whites. The use of chiropractors was also found by the RAND Health Insurance Experiment to be higher for Whites than for racial and ethnic minorities. Conversely, Wolsko et al found race and ethnicity were not predictors of using a CAM practitioner among clinic attendees. Among Mexican-Americans, the use of traditional healers has ranged from 4% reported in the Hispanic Health and Nutrition Examination Survey to 20% in a small study of caregivers at a pediatric primary care facility in Houston.

Boutin et al also found that race did not predict the use of CAM among outpatients and physicians at a municipal hospital, although the use of manual healing and herbal medicine did differ by race. Use of traditional folk remedies was associated with Hispanic ethnicity by Palinkas in the SURNET study.

These findings suggest that the use of more expensive therapies such as chiropractic care by

racial and ethnic minorities is lower than the general population, while the use of herbal teas and other less expensive therapies may actually be higher. What is clear from these findings is that it is important for studies to distinguish specific CAM providers and therapies when determining the use of these modalities. We are therefore encouraged that NIH's National Center for Complementary and Alternative Medicine is working with the National Center for Health Statistics (the main statistical agency of the Department of Health and Human Services) to include approximately 10 minutes worth of questions on the use of CAM providers and therapies on the National Health Interview Survey in 2002. Since this is the largest national health interview survey, this will enable future analyses of the use of CAM providers and therapies by race and ethnicity, as well as other socioeconomic and demographic variables.

Recognizing the importance of including this fast-changing health care field in delivery of care, the Health Resources and Services Administration (HRSA) established a Integrative Medicine and Alternative Health Practices (IMAHP) Initiative to provide guidance and technical assistance with the integration of CAM with conventional primary care at BPHC-funded programs. On October 3, 2000, HRSA/BPHC issued a Program Assistance Letter to community health centers, migrant health centers and grantees to provide guidance regarding privileging and credentialing CAM providers, written policies and procedures for CAM modalities, and Federal Tort Claims Act Coverage. As this letter notes, "to be culturally and linguistically appropriate, it is necessary to integrate complementary and alternative therapies with conventional medicine, indigenous healing practices, as well as the primary language of the patient."

The Indian Health Service also recognizes that many American Indian and Alaska Native people use traditional healers instead of Western medicine or in conjunction with Western medicine. In many cases, it is crucial to their healing process to know they have access to both. Some will only take Western medicine after consulting with the traditional healer. Most AI/AN are more comfortable talking to their Western doctor if they know that the Western doctor knows and understands the importance of traditional healing ways. This is why at IHS clinics, traditional healers are now seen as important members of the health care team. These healers are paid by the tribes.

This past year, the National Institutes of Health developed a five-year strategic plan to reduce and ultimately eliminate disparities in health. The National Center for Complementary and Alternative Medicine (NCCAM) is working with the new National Center on Minority Health and Health Disparities to incorporate CAM research issues for racial and ethnic minorities in this strategic plan. NCCAM's Institutional Research Training grants support research training at minority and minority-serving institutions for individuals who are training for careers in biomedical, behavioral, and clinical research related to CAM.

The Agency for Healthcare Research and Quality has been supporting research on CAM since they were created in 1989. In addition to their earlier work on the use of CAM for low back pain and the MEPS findings on the use of CAM which I shared with you earlier, they have been working closely with the NIH to improve the methodology for studying alternative therapies.

During 1995, OMH established a "center without walls", the Center for Linguistic and Cultural Competency in Health Care to encompass existing and new policy, partnering, communications, service demonstrations and evaluation activities related to cultural competency. Activities of this center have included development of a comprehensive research agenda for culturally and linguistically appropriate care. Another project is to develop cultural competency curriculum at the University of Texas Health Science Center. In December 2000, OMH published National Standards on Culturally and Linguistically Appropriate Standards in Health Care. Public comments were incorporated. These recommended standards, if followed, would include more sensitive use of CAM. The first recommendation states "Health Care Organizations should ensure that patients/consumers receive from staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language." This means that providers are familiar with and respectful of various traditional healing systems and beliefs and, where appropriate, integrate these approaches into treatment plans.

Of concern is that approximately 40-50% of the United States population who use CAM, do not currently share this information with their health care providers. This may result in adverse effects (e.g., contraindications, unnecessary use of prescribed drugs or too high dosage, and interference with prescribed drugs). Contraindications are a concern, especially for those with chronic diseases such as diabetes. And, racial and ethnic minorities are more likely to have a chronic disease such as asthma, diabetes, hypertension and kidney disease.

Although rarely discussed in the environmental health literature, culturally related factors can also increase the susceptibility of a member of a minority group or could even be the source of a toxic exposure. Potential sources of toxic exposure include use of traditional medicines such as "azarcon" and "greta" (lead-containing treatments for gastrointestinal distress) brought to the United States by immigrants or well-meaning friends of relatives, and contaminants such as salmonella in rattlesnake capsules pose health risks. Newly arrived immigrants have tragically mistaken toxic plants in the United States for safe, edible plants from their native country.

The most important barrier to receiving safe and effective CAM for racial and ethnic minorities, though, is ability to pay. Racial and ethnic minorities are more likely to live in poverty and have fewer assets. Although we are aware that CAM providers offer sliding fees, our biggest concern is that lack of general health insurance is much more common among racial and ethnic minorities than the general population. In 1998, almost 1 out of 5 African-Americans and Asian or Pacific Islanders, and 1 out of 3 Hispanics under the age of 65 did not have health insurance compared to 1 out of 6 Whites. Since racial and ethnic minorities use CAM to complement Western medicine (not instead of Western medicine), providing general health coverage is of primary importance.

Other barriers to access to CAM which are important to consider for racial and ethnic minorities include differential access to specialists. Attention needs to be paid to location of providers, transportation issues, availability of child care and after work hours, and consideration of preferred language and literacy needs. OMH is sponsoring an Institute of Medicine study on "Understanding and Eliminating Racial and Ethnic Disparities in Health Care." This 17 month

study is in response to a Congressional mandate that a study be conducted on the extent to which bias impacts medicine and health care and its relationship to demonstrated racial and ethnic inequalities in health. Meetings and public workshops are publicized on the National Academy of Sciences website (www.nas.edu).

In addition to learning more about the IOM study and possibly participating in future meetings, we encourage you to become involved in discussions regarding options to cover the more than 39 million uninsured in this country. We also recommend that all patients be asked by health care providers regarding use of CAM, preferably at every visit. Our brief literature review of the use of CAM among racial and ethnic minorities suggests that more research is needed regarding the use of CAM by racial and ethnic minorities, and content of training of health care professionals in CAM–with more detail as to specific modalities. Further research and stronger monitoring efforts are needed to ensure the safety and effectiveness of CAM treatments. We also recommend that providers and third party payors consider the cultural competency standards in their efforts to improve cultural competency of their health care delivery system.