CAM: Understanding Coverage and Reimbursement

May 14th and 15th

Meeting objectives:

- Establish for the Commissioners a common base of information from which to make recommendations.
- Engage stakeholders who are critical to the consideration of coverage and reimbursement for CAM, many of whom have had limited or no involvement in CAM or the Commission.
- Understand the ramifications of coverage and reimbursement decisions on stakeholders.
- Identify ideas for recommendations and future action.

Opening Remarks 8:30 a.m.

Gordon/Groft -- Overview

Overview: Health Care Financing in the U.S. (Timeframe: 8:45 to 9:45)

Health economist/consultant 8:45

Suggested: Len Nichols or Marilyn Moore

Presentation will briefly summarize the history and development of our employer-based insurance system, macro-economic factors that influence coverage and financing (such as supply and demand of labor, financial markets, the age wave, etc.), and other key points (such as the influence of payment methodologies, technology, etc.). Will include information on the insured, the uninsured, the self-employed, and the undersinsured.

Commission Discussion 9:20 a.m.

Panel 1: Federal Purchasers (Timeframe: 9:45 to 11:10)

HCFA: Coverage and Payment Policy 9:45

Presentation will briefly summarize the legislative and regulatory parameters of Medicare coverage (and more briefly, Medicaid) that bind HCFA. Will also outline key payment methodologies and key factors necessary to develop reimbursement policy. Will give an overview of HCFA's research and demonstration program, including CAM-related projects.

OPM: The FEHBP program 10:25

Presentation will briefly summarize the oft-cited FEHBP program, highlighting the strengths and challenges of the program. Will address the program's experience with CAM benefits.

Commission Discussion 10:40

Break 11:10

Survey the members

Pizza & Pickles and Ice Cream Yum Yum

Panel 2: State Perspective (Timeframe: 11:30 to 12:30)

National Governors' Association –
National Association of Insurance Commissioners – WA State Insurance Commissioner How new Benefits, new Services are introduced
National Association of State Legislators –

These presenters will discuss the ideas, opinions, issues, and concerns of their respective State leaders regarding health care coverage and reimbursement. Presentations also will address Medicaid, the uninsured, the medically indigent, rural health, and consumer protection. Relationship between Federal & State Association / Business

Commission Discussion	12:00	
LUNCH BREAK	12:30	(1 hour)

Panel 3: Employer Panel (Timeframe: 1:35 to 3:15)

Fortune 500/large – Ford or GM	1:35	(10 to15 min)
Lucent Tech	1:50	(10 to 15 min)
Proctor and Gamble	2:05	(10 to 15 min)
Employee/Union	2:20	(10 to 15 min)
Employee benefits consultant	2:35	(10 min)

Leapfrog Ralph Snyderman – Ken Pelletier

Presentations will include employers who have successfully incorporated CAM benefits into insurance coverage, and employers who have investigated and rejected incorporation of CAM benefits. The employee benefits consultant will discuss trends in employer coverage, including specific attention to CAM. These presentations will differ from prior presentations by addressing how employers make benefit decisions and how payment decisions are made. Representatives for employees will discuss trends in employee demands regarding health care coverage and related employee benefits.

Commission Discussion	2:35	(40 min)
Break	3:15	

Mary Jane England – Washington (Ken Pelletier)

Panel 4: Health Plans and CAM Benefits (Timeframe: 3:30 to 5:00)

Health Plan 1 *Suggested: Aetna* 3:30 (10 to 15 min)

Health Plan 2 *Suggested: Wellpoint* (10 to 15 min)

Health Plan 3 *Suggested: Blue Cross* (10 to 15 min)

Health Plan 4 *Suggested: Oxford* (10 to 15 min)

Presentations will differ from prior presentations. This panel will focus on how insurance companies and HMOs development benefit plans and establish premiums, and service payment rates (non-proprietary information). Health plans will discuss experiences in evaluating certain CAM services for benefit coverage.

Commission Discussion 4:20 (40 min)

Panel 5: The Uninsured and Underinsured

Minority Issues: Nathan Stinson, MD, PhD 5:00 (10 min)
Asst. Sec. For Minority Health

Uninsured, underinsured, self-employed 5:10 (10 min)
And rural health issues

Commission Discussion 5:20

Close Day 1 5:45

DAY 2 – Reimbursement (half day)

Morning Kickoff: Gordon/Groft 8:30

Panel 6: Health Insurance: National Perspective (Timeframe: 8:40 to 9:45)

Insurers: 8:40

American Association of Health Plans (10 min)

~~Health Insurance Association of America~~ (10 min)

Blue Cross Blue Shield Association (10 min)

Presenters will address key issuers facing the health insurance industry, and influencing the past and future directions of coverage and payment for health services.

Providers:

John Weeks (10 min)

Presenter will discuss trends in coverage of CAM services and products, and issues and trends regarding CAM providers.

Wayne Sickles, practitioner and instructor (10 min) - Concerns of Practitioners who may be pulled into the system

Presenter will discuss specific administrative, practice, and operational issues facing CAM providers in the advent of insurance coverage and reimbursement rules.

Commission Discussion (25 min)

Impact of Coverage and Payment on CAM (Timeframe: 9:45 to 10:15)

Max Heirich, Professor Emeritus, (10 min)
University of Michigan

Commission Discussion (20 min)

Break and Breakout Groups 10:15

Breakout Group Reports 11:30 to 11:45 am

Conference call with Subcommittee 4/9/01

Steve' overview

- 3-day meeting, ½ on coverage and reimbursement
- The coverage and reimbursement portion of the meeting will be somewhat different from previous meetings
- Focus is not on providers or what is being provided, but 'payment' – an area that is highly technical and that is fairly unknown to most commissioners
- The initial part of the meeting will be educational – setting a knowledge framework regarding health financing and health economics, how payers make decisions as to what is covered, and how payers decide what and how to pay for a covered service.
    - This is very necessary for the Commissioners to understand the whole picture here, and how tampering with one thing is perverbial throwing a rock in to a lake – there is always a ripple effect.
- We will hear from the 'drivers" of these decisions: key federal government agencies, representatives of the State perspective, business, health plans, and national associations
- We also will here from providers: those who think reimbursement for their services will be beneficial, and those who are concerned about the ramifications of insurance coverage.
- Your input will be most valuable as this will be one of the more challenging areas in which the Commission will have to make recommendations.

Groft, Stephen (NCCAM)

From: Miller, Maureen (NCCAM)
Sent: Friday, March 23, 2001 6:59 PM
To: 'georged@ashn.com'
Cc: 'chrisw@ashn.com'; Groft, Stephen (NCCAM)
Subject: May meeting

John Weeks

George- FYI

Below is the working structure of the meeting so far. We will be asking some organizations for written input in order to keep the agenda open enough for the much-needed Commission questions, discussion, and break-outs to work on draft recommendations. I will not see you at the meeting next week due to a family commitment, but let me or Steve know your thoughts and reactions. Best regards, Maureen Miller

Rough Cut - May Meeting

DAY 1 -- Reimbursement

Opening Remarks 8:15-8:30

Gordon/Groft

Health Care Financing in the U.S. 8:30-9:00 30
Health economist/consultant
30 (contacting Len Nichols, Urban Institute and Gail Wilensky, Project Hope &dPac)

Commission Discussion

Panel 1: Federal Purchasers 9:00 – 9:45
HCFA: Coverage and Payment Policy 9:45-10:30 45/45
1½ OPM/FEHBP 3 1/2

Commission Discussion 10:30 Break

Panel 2: State Perspective (may not have all 3) 10:45-11:30 45/45 11:30-12:15
1½ National Governors' Association
National Association of
Insurance Commissioners
National Association of State Legislators
Commission Discussion

Lunch 12:15-1:45

Panel 3: Employer Coverage, the Underserved, Uninsured 1:45-2:45
1 hr
Fortune 500/large - Ford or GM?
Lucent Tech?
3rd employer
Nathan Stinson - Minorities, undercovered groups
Uninsured

2:45-3:00 Break

Panel 4: Health Plans and CAM Benefits + Panel 5

Health Plan 1
Health Plan 2
Health Plan 3

2 participants 3:00 - 4:30

4 hours of discussion

Commission Discussion

Close of Day 1

DAY 2 - Reimbursement (half day)

Panel 5: Provider Perspective all 3 = 2 participants

Provider 1 - "pros" of insurance coverage
Provider 2 - "cons" and concerns
Provider 3 - broad provider concerns/what may happen if there is reimbursement

Commission Discussion

Panel 6: Evolving Health System ? wrap up 30° 4:30-5:00

Max Heirich/University of Michigan?
Another speaker to system change

Break and Breakout Groups
End of Reimbursement: 11:30 or 11:45 am

Breakout x 2 - 1½ hrs

Tues AM

~~8:45-9:00~~

Recommendations 1 hr

8:00 - 9:30 - Discussion of Rec

9:30 - 10:30 Rec

Break 10:30 - 10:45

Open Public Comment 10:45-12:00

Fund 12 - 11:45

Introduction - 10:45 - ~~11:00~~ 11:30 - Presentation + Q+A

Research Pt 2 2:00 - ~~2:00~~ Skeptics

Fund 11:30 - 12:45

Skeptics 12:45 - 2:45 &
2:45 - 3:00 Break

Panel / Research 3:00 - 4:30

Open Public Session 4:30 - 5:30

Difficulties in getting CAM research supported by NCCAM

DRAFT QUESTIONS

Date: 3/30/01

Mary Ann Richards

Questions for Foundations:

How does your foundation determine what (CAM) research it will fund?

What types of research are you currently funding or are considering funding?

What role can foundations play in stimulating CAM research, e.g., seed money, grants, publication of research results, research training support, conferences?

What are the obstacles and possible solutions to accomplishing this goal?

How can CAM research coordination be enhanced between the Federal government and the not-for-profit sector?

What policy recommendations can *your foundation* offer regarding CAM research for the Commission's consideration as it develops its report to the President and Congress?

How can we stimulate better CAM research.

Questions for Approaches to Evaluating Research Literature:

What criteria are used when deciding to include a peer-reviewed journal in the NLM database?

Has AHRQ's conducted evidence-based assessments of CAM practices and products?

What criteria are used by the agency when deciding on topics for evidence-based practice reports?

Does the Cochrane Collaboration for Evidence-based Medicine include in its database information on CAM practices and products?

What policy recommendations can you offer regarding...?

legislative Recommendations that are they doing now what do they need to do

Questions for the Research and Research Training Panel:

In discussing approaches to increasing the safety and effectiveness of CAM practices and products, in addition to data collection and clinical trial methodology, consider and the complex questions inherent in CAM that require study such as multiple interventions, complex systems and complex compounds, individualization, the placebo effect, provider/patient interaction, and so forth.

What can CAM practices and products contribute to investigations where there is overlap with conventional areas of research, e.g., wellness/health promotion and disease prevention/preventive medicine, nutrition, chronic conditions, pain management, self care, care for the terminally ill?

What

At what point is the knowledge base sufficient to move results to clinical practice?

What training do conventional investigators need to conduct CAM research?

What training do CAM professionals need to evaluate their own clinical efficacy and conduct high quality research?

How can CAM practitioners become better educated in the critical evaluation of CAM product claims and CAM protocols and clinical research?

How can research collaborations between conventional and CAM institutions be facilitiated.

What policy recommendations can you offer ⊖ Is CAM research easier to publish than ⊕ CAM Research

Questions on Peer Reviewed Journals: ⊕ Literature Gaps in Research

What criteria are used by (*journal*) for accepting articles on CAM research?

Are these criteria similar to or different from criteria used for acceptance of conventional research studies?

What are the unique challenges facing CAM acceptance in conventional peer-reviewed journals?

What are the unique challenges facing CAM peer-reviewed journals?

What are the criteria for accepting a research article?

What are the most common reasons articles are rejected?

How do you choose your reviewers; what qualifications must they have?

What is the average number of revisions made before publication?

What is the average length of time from receipt of an article to publication?

What are the gaps in reporting CAM research results?

Does your audience include CAM practitioners; conventional practitioners?

What policy recommendations can you offer regarding research, evaluation and publication of CAM practices and products in peer-reviewed journals?

General Questions for Federal Agencies (DoD, NSF, AHRQ, Dept. Of Ed, CDC, USDA, and NASA):

How can coordination be established or strengthened among and between Federal agencies that have research and research-related responsibilities, and how can it be enhanced with the not-for-profit and private sectors?

What are the obstacles (conceptual or otherwise) and possible solutions to accomplishing integration of CAM into mainstream research?

What policy recommendations can *(agency)* offer regarding research on CAM for the Commission's consideration as it develops its report to the President and Congress?

Additional Questions for DoD:

Does DoD support any research on CAM practices and programs?

How and why were these selected as the most promising areas of research on CAM interventions?

Does DoD coordinate CAM research efforts across the services?

Does DoD include any CAM practices and products in its clinical programs?

What does DoD consider as the most promising areas of CAM practice 1) to study; 2) to incorporate into military health care?

Additional Questions for NSF:

Does NSF support any research related to CAM practices and products? What can CAM perspectives and approaches contribute to research in the biological, physical, social, and behavioral sciences? Are there areas of research related to CAM that NSF considers promising?

Additional Questions for CDC:

Does CDC support any epidemiologic research or surveillance projects on CAM practices and products? Are there areas of research related to CAM that CDC considers promising?

Additional Questions for USDA, Dept. of Education, NASA, Dept. of Energy:

Does (*agency*) support any research or research-related activities on CAM practices and products? Are there areas of research related to CAM that (*agency*) considers promising?

Rough Cut – May Meeting

DAY 1 -- Reimbursement

Opening Remarks	8:30 a.m.	
Gordon/Groft		
Health Care Financing in the U.S.	8:45 a.m.	(8:45 to 9:45)
Health economist/consultant		
Commission Discussion	9:30 a.m.	
Panel 1: Federal Purchasers		(9:45 to 11:10)
HCFA: Coverage and Payment Policy	9:45	
OPM/FEHBP	10:30	BCBS Rider
Commission Discussion	10:50	
Break	11:10	
Panel 2: State Perspective		(11:30 to 12:40)
National Governors' Association	11:30	
National Association of Insurance Commissioners	11:45	
National Association of State Legislators	12:00	
Commission Discussion	12:15	
LUNCH BREAK	12:40	(1 hour)
Panel 3: Employer Panel		(1:40 to 3:15)
Fortune 500/large – Ford or GM	1:40	(15 min)
Lucent Tech	1:55	(15 min)
Small employer	2:10	(15 min)
Washington Business Group on Health	2:25	(10 min)
Pacific Business Group on Hlth	2:35	(10 min)
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Panel 4: Health Plans and CAM Benefits

Health Plan 1	3:30	(15 min)
Health Plan 2	3:45	(15 min)
Health Plan 3	4:00	(15 min)
Health Plan 4	4:15	(15 min)
Commission Discussion	4:30	(30 min)

Panel 8: Vulnerable Populations

Nathan Stinson – Minorities	5:00	(10 min)
Uninsured	5:10	(10 min)
Commission Discussion	5:20	
Close Day 1	5:45	

DAY 2 – Reimbursement (half day)

Panel 6: Health Insurance: National Perspective (Timeframe: 8:45 to 9:55)

American Association of Health Plans	8:45	(15 min)
Health Insurance Association of America	9:00	(15 min)
Blue Cross Blue Shield Association	9:15	(15 min)
Commission Discussion	9:30	(25 min)

Panel 7: Provider Perspective (Timeframe: 9:55 to 10:45)

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End of Reimbursement: 11:30 or 11:45 am

Obstacles # system
Coverage/BMA other written material

TO: HLL
FROM: Maureen

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John Weeks

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Obstacles # system
Covering HCFA/BMA chiefs
Written material

TO: HLL
FROM: Maureen

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40% of Meeting

Issues
Several of you have been
discussing or other issues
at town hall mtg
Need to think of

Possible Recommend
more on this later

Need to think of
format for future
meetings – after
2 days of meeting
look at this to see if we
are meeting your needs

(1) Summary of Seattle
Town Hall Mtg
(2) Geri Pollen Prepares
a Summary of Oct 5-6 Mtg.

Challenges, Collaborative Opportunities and New Directions for the Integration of Complementary and Alternative Medicine with Mainstream Payment and Delivery

A Report from the
Integrative Medicine Industry Leadership Summit

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

May 2000

Primary Sponsors
THE INTEGRATOR *for the Business of Integrative Healthcare*
IntegrativMedicine

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Inner Harmony Wellness Center
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Triad Healthcare
Institute for Health and Productivity Management

Report:
John Weeks, Publisher-Editor
THE INTEGRATOR *for the Business of Alternative Medicine*

Contents

(Collaborative projects, continued)

Creating a collaborative force for change
Ongoing potential for shared work on the national scene
Table 4: Onsite End-of-Summit Survey of Potential Interest Areas of Attendees

Next Steps
Future impact?

Appendices

#1 Summit leadership
#2 Supporting sponsors
#3 Attendees: name, company, city, state
#4 Pre-Summit survey findings
#5 Program description

Executive Summary

The half-decade since 1995 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 and explore collaboration and enhance cross-fertilization.

The Summit has convened by **Integrativ**Medicine and the firm's industry-oriented newsletter, THE INTEGRATOR *for the Business of Alternative Medicine*. Supporting sponsorships were obtained which 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 utilized a pre-Summit survey and a discussant-based program with small group breakouts to foster interactivity and relationship building. A follow-up survey was administered at the end of the Summit to quantify 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 systems 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 defined 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 which 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 Summit participants.

7. **Significant pools of useful data on the cost and utilization 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:* Partnerships between providers and interested stakeholders on limited projects with defined measures are recommended.

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 US healthcare. *Recommendation:* Develop an infrastructure which 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 and in response to interests of Summit participants, **Integrativ**Medicine has launched a forum to facilitate ongoing discussion and collaboration through the firm's website, OneMedicine.com. A second Summit has been scheduled for May 17-19, 2001. Those interested in participating may contact Marcy Robinson at marcy.robinson@onemedicine.com.

Mission and Timing of the Summit

The half-decade since 1995 has marked the founding or rapid expansion of scores of businesses devoted to mainstreaming the payment and delivery of complementary and alternative medicine (CAM). 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 arc upward.[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 $46 billion market. 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* (**Integrativ**Medicine, Newton, MA), became the *de facto* communication channel on trends, analysis and developments among the parties which constitute the emerging industry.

Paradoxical trends

Trends discovered in INTEGRATOR reports, surveys and analysis were often paradoxical. Newcomers in particular expressed excitement over market opportunities. 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 which 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 US healthcare. At the very least, experience of other industries suggested that the maturation of the field required such a step.

[1] AHA, 1999; Deloitte and Touch, 1999
[2] Landmark Healthcare, 1998; InterStudy, 1998
[3] Eisenberg, JAMA, 1998

Convenors and Goals

In this context, THE INTEGRATOR, and Newton, Massachusetts-based **IntegrativMe**dicine, the newsletter's owner, convened an invitational 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**, joined INTEGRATOR publisher-editor **John Weeks** as co-facilitator. Eight, diverse organizations committed to supporting sponsorships to help underwrite the costs. (See Appendix 2.) The maximum of 75 participants was quickly reached. (See Appendix 3.) 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.* Over 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 **IntegrativMe**dicine.

To promote strategic cross-fertilization, the Summit was intentionally populated with representatives from diverse stakeholder organizations.[4] 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.

[4] An onsite survey at the end of the Summit yielded a list of stakeholders which 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; with coaxing, 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 (96%) 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, 67% of these leaders believe that the optimal use of CAM is before conventional treatment, not as a last resort. Only 5% 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 supports 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* Over three-fourths (77%) believe the success of their business is linked to creating more physician referrals for CAM. Most are optimistic: Nearly four in five 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 two in three (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 US 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." Over nine in ten (93%) believe their own business would benefit from more collaboration with members of other stakeholder groups; three in four (76%) believe similarly about collaborations with like stakeholders.
- *Formalized alliance* Four-in-five (80%) 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"* Over four in five (81%) believe that success in their mission to give US 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 nine-in-ten (88%) believe that in 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 US 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.'"[5] 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."

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 off 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

[5] 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.

each noted more than once as potentially aligned, but never among the top three.[6] Venture capital, as a stakeholder, was not listed by any of the five small groups as among the top five stakeholder partners.[7] 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	Points	Rank
Consumers	20	1
Employers	19	2
Hospitals/health systems	10	3
Government	6	4
HMOs/insurers	6	4
Philanthropy	6	4
CAM Networks	4	7
Other industry associations	2	8

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 which 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.[8] 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.[9] 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 *Managed Care*, below.) Kittner offered the view that only a dramatic shift to empower consumers through flexible spending accounts and defined

[6] 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.
[7] 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.
[8] Eisenberg, 1990, 1997
[9] 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.

contributions, in employer-based benefits, would make covered CAM a significant force in the cash-based CAM economy.[10]

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[11] which listed employee demand as the single most important influencer in 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."[12]
- Employee benefits consultant **Janice Stanger**, with William Mercer and Associates, recommended that "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:

- 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[13]

[10] "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)

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

[12] 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*.)

[13] Many health system-based integrative medicine programs presently look to philanthropy for start-up and operating support.

Stakeholder #2: The Employer

Together with consumers at the top of the chart as a stakeholder partner is the employer payer. 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." 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 employers 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 *Projects Identified to Explore and Expand Integration.*) 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.
- 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 US 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, which promotes expanded integration of the mind-body program for reversing coronary artery disease developed by Dean Ornish, MD: "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, used a biblical story to provide a similar perspective.[14] Fashioning herself as a "CAM gardener" within the 10-hospital delivery system, 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: "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?"[15]

Healing the healer: strategies for penetrating the resistance

Discussion turned to methods for creating a foothold which 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 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.

[14] 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.

[15] 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.

- **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, than 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 which 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 our open because we are not doing well. It pays for us to invest in alternative therapies to ultimately reduce risk and reduce utilization."

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.[16] Silberman is blunt: "There were those who wanted this to fail." Her first challenge: "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 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:

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

- Since 1990, reimbursement of CAM services as a percentage of total CAM spending is "essentially flat" – at 20% reimbursed and 80% out-of-pocket.[17]
- The industry around covered services is small – between just $250-$500 million are spent in specialty carve-outs and covered benefits.[18] 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."

[17] Based on the two Eisenberg studies.

[18] 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.

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-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." Participants noted the strongly overlapping philosophies between the two interests: prevention, environmental factors, and the whole-person, community-based view of health. Summarized Ziegler: "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. Over one-half 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."[19] Less than a third (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

[19] 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.

advancement strategies. Nearly nine in ten 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."

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

- *Tool development* A gathering would be sponsored to develop a strategy for measuring outcomes which would most serve the needs of the target stakeholder (employer, managed care, health system, integrative clinic operator, etc.). Involved would be a mixture of experts representing parties involved with the target project. The group would also explore optimal study design. Noted employer purchasing expert Sullivan: "Outcomes are the key, but defining the right outcomes is the 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 sights.

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 the 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 is 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.[20]

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 is 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 a 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

[20] The motivators of CAM integration at the present fit into the bell curve of adoption described in Crossing the Chasm (Geoffrey ???). 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.

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,

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."

"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 over 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 which 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 which 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 and
- collaborative

To focus the imagination, participants were asked to think into two levels of projects: $50,000 and $500,000.[21] Table 3 describes the project ideas which 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 which 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 which 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 which 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

[21] A backdrop for project identification was a concept paper at the National Institutes of Health Center for Complementary and Alternative Medicine 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 which we referenced or were recommended by speakers.* In the meeting, participants were asked to identify $50,000 and/or $500,000 projects. Some specifically noted which category in which they believed their projects would fall. Where they did, this is noted. Many projects have significant overlap. They are listed individually here to allow readers to consider the permutation which makes the most sense to them.

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 which 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 which 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 IntegrativMedicine 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 which 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 which 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 which 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 of the Miraval Group 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 (with the number of respondents identifying these groups in parenthesis): Consumers/public (4), other health plans (4), more employers/self-funded employers/employee benefits/large employers/WA Business Group on Health (7), Government/HCFA/Public officials/government benefits gatekeepers (4), more CAM providers (3), behavioral health provider associations (2), more academic medicine groups (3), specific individuals (2), AMA, specific additional CAM professional groups (3), pharmacy/nutraceuticals (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, **IntegrativMe**dicine, has created a means for participants to continue to share initiatives through a special portal on the firm's OneMedicine.com site. Launched in September 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 17-19, 2001.
- Some interest groups identified during the Summit have commenced communication on shared issues.

Non-attendees interested in participating in either the internet-based community of collaborators or and an annual Summit should email **Marcy Robinson**, director of marketing for **IntegrativMe**dicine, at marcy.robinson@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. Over four-in-five 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
John Weeks, Publisher-Editor
THE INTEGRATOR *for the Business of Alternative Medicine* (OneMedicine.com)
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Priester, administration
Sue Colliton (IntegrativMedicine), data analysis

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

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Appendix 3

Primary Summit Sponsors

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. 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. isnh@quidnunc.net.

IntegrativMedicine bridges the gap between alternative and conventional medicines through the provision of information and consulting services designed for professionals, consumers and healthcare administrations. Through its online subscription service, OneMedicine.com, IntegrativMedicine currently delivers breaking news, scientific databases, business intelligence and advisory services, with a focus on clinical information, professional training and the business/implementation of integrative medicine. OneMedicine is designed to facilitate web-based access to a virtual warehouse of the world's most credible, continuously updated news and reference materials for both clinical and business integration. www.onemedicine.com

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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

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[Note: delete dash before exclusively]

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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 wholistic 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. 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 76 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 which 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 ...)

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 which 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 which 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

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

Joe,
Maybe AAHP should be
invited to December Mtg.
Thank you
Steve

+ the Bridger one Benny Buett.
Steve

2 Feb 01

Steve,
I think that AAHP
could be considered
for the Reimbursement
meeting.
Joe

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Call for Abstracts and Preliminary Brochure

Building Bridges VII

Assessing Policy Decisions and Their Impact on Health Care Delivery

April 26-27, 2001 ❧ The Westin Seattle ❧ Seattle, Washington

Presented by the American Association of Health Plans in collaboration with the Agency for Healthcare Research and Quality, the Centers for Disease Control and Prevention, and the Blue Cross and Blue Shield Association.

Access conference information through AAHP's website at www.aahp.org

Call for Presentations at www.aahp.org/bridges01.cfm

American Association of HEALTH PLANS®

Power of Integrative CAM Approaches

TO: ALL

FROM: Maureen

① IOM Panel

Read Information

Rough Cut – May Meeting

Clarisse Nightingale

IOM Report on Healthcare

DAY 1 -- Reimbursement

Opening Remarks	8:30 a.m.	
Gordon/Groft		
Health Care Financing in the U.S.	8:45 a.m.	(8:45 to 9:45)
Health economist/consultant		
Commission Discussion	9:30 a.m.	
Panel 1: Federal Purchasers		(9:45 to 11:10)
HCFA: Coverage and Payment Policy	9:45	
OPM/FEHBP	10:30	
Commission Discussion	10:50	
Break	11:10	
Panel 2: State Perspective		(11:30 to 12:40)
National Governors' Association	11:30	
National Association of Insurance Commissioners	11:45	
National Association of State Legislators	12:00	
Commission Discussion	12:15	
LUNCH BREAK	12:40	(1 hour)
Panel 3: Employer Panel		(1:40 to 3:15)
Fortune 500/large – Ford or GM	1:40 (15 min)	
Lucent Tech	1:55 (15 min)	
Small employer	2:10 (15 min)	
Washington Business Group on Health	2:25 (10 min)	
Pacific Business Group on Hlth	2:35 (10 min)	
Commission Discussion	2:45 (30 min)	
Break	3:15	

Judith Feder Health Policy center at Georgetown Univ

9:15 Max Heinrich — 688-7808 Sociologist

What are they doing? Why? What else do they need

3:25

Harkin

Coding

Linda Bedell-Logan – Integrating Coder

Gianni – Alt. Links

Stefan Willhammer

Claudia Fegan –

David Himmelstein → Physicians for a Nat'l Health Plan

Panel 4: Health Plans and CAM Benefits

Health Plan 1 John Weeks	3:30	(15 min)
Health Plan 2	3:45	(15 min)
Health Plan ~~3~~	4:00	(15 min)
Health Plan 4	4:15	(15 min)
Commission Discussion	4:30	(30 min)

Panel 8: Vulnerable Populations

Nathan Stinson – Minorities	5:00	(10 min)
Uninsured	5:10	(10 min)
Commission Discussion	5:20	
Close Day 1	5:45	

DAY 2 – Reimbursement (half day)

Panel 6: Health Insurance: National Perspective (Timeframe: 8:45 to 9:55)

American Association of Health Plans	8:45	(15 min)
Health Insurance Association of America	9:00	(15 min)
Blue Cross Blue Shield Association	9:15	(15 min)
Commission Discussion	9:30	(25 min)

Panel 7: Provider Perspective (Timeframe: 9:55 to 10:45)

Provider 1 – "pros" of insurance coverage	9:55	(10 min)
Provider 2 – "cons" and concerns	10:05	(10 min)
Provider 3 – broad provider concerns	10:15	(10 min)
Commission Discussion	10:25	(20 min)
Break and Breakout Groups	10:45	

End of Reimbursement: 11:30 or 11:45 am

– Candace Campbell - Access to Medical Treatment Act

TO: ALL
FROM: Maureen

Rough Cut – May Meeting

DAY 1 -- Reimbursement

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	Health Care Financing in the U.S. Health economist/consultant	8:45 a.m.	(8:45 to 9:45)	① overview ② time for Commission Breakout
15	Commission Discussion	9:30 a.m.		
	Panel 1: Federal Purchasers		(9:45 to 11:10)	
	HCFA: Coverage and Payment Policy	9:45		
	OPM/FEHBP	10:30		
20	Commission Discussion	10:50		
	Break	11:10		
	Panel 2: State Perspective		(11:30 to 12:40)	
	National Governors' Association	11:30		
	National Association of Insurance Commissioners	11:45		
	National Association of State Legislators	12:00		
35	Commission Discussion	12:15		
	LUNCH BREAK	12:40	(1 hour)	
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	Small employer	2:10	(15 min)	
	Washington Business Group on Health	2:25	(10 min)	
	Pacific Business Group on Hlth	2:35	(10 min)	
30	Commission Discussion	2:45	(30 min)	
	Break	3:15		

Panel 4: Health Plans and CAM Benefits

Health Plan 1	3:30	(15 min)
Health Plan 2	3:45	(15 min)
Health Plan 3	4:00	(15 min)
Health Plan 4	4:15	(15 min)
Commission Discussion	4:30	(30 min)

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End of Reimbursement: 11:30 or 11:45 am

Note from The Desk of
Joseph M. Kaczmarczyk, DO, MPH

13 Dec 00

Steve,

I am responding to your 11 Dec 00 request for the "holes in Access and Delivery."

In my opinion, the following list represents the gaps in Access and Delivery:

- Traditional Healing
- Department of Defense (DOD)
- Office of Personnel Management (OPM)
- Health Resources and Services Administration (HRSA), Bureau of Primary Health Care (BPHC)
- "Big Picture" overview or summary of current CAM activities and particularly the lack of coordination of CAM in the Federal sector
- Role of non-physician licensed conventional health care professionals in CAM delivery
- Demographics of CAM practitioners (Cherkin and Eisenberg unpublished data).

While some of these areas have been addressed in part and others not all at all because of non-availability of invited speakers, the above areas warrant further attention which can be achieved by a number of different mechanisms such as inclusion in future WHCCAMP meetings, high-level formal letters requesting specific information, and written responses to focused questions.

I am prepared to elaborate on these areas and mechanisms.

Please note that the topic of Access and Delivery has been covered so well that not all of this additional information is absolutely essential, so that the pursuit of further information should be prioritized on the basis of value to the report and accessibility.

Joe

Cc: Michele
Gerry

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Joe

Cc: Michele
Gerry

RESEARCH MEETING II

Sessions discussed for Research II are:

Expanding Research: Methodologies and Approaches

Areas of research

~~clinical research/clinical trials~~
health services research/demonstration projects
~~observational research~~
~~frontier research~~ NCCAM - Emphasize
~~basic research~~

Research training + Education

developing a pool of well-trained CAM investigators
incentives for attracting mainstream investigators to CAM research and research training
training CAM practitioners in data collection
creating collaborative research teams
expanding study design
protocol development, application preparation
laboratory, clinical, practice-based
~~medical schools curricula (include AAMC)~~ AAMC — CAM →

Agencies/Organizations

NSF
AHRQ Larry Kaminow
~~HRSA~~
~~SAMHSA~~
DoD (Karl Friedl, ~~Omar Hollenbeak~~)
Dept of Education
CDC (Dietz)
USDA

HCFA

Disseminating Research Results

Publications and Other Methods

Washington Post

Research journal editors
~~science writers~~
NLM
professional society newsletters
stand-alone publications
popular press
world wide web

Info Services +

CAM
Jackie Woodson
Larry Dossey

NEJM
JAMA
A Family Med
JAPHA

Research Results as a Basis for Reimbursement — In Reimbursement

Other Topics Discussed

David Eisenberg, clinical trial model

People Interested in Participating

- Doriane Miller, M.D., RWJ
- Bridget Duffy, M.D., Medtronic
- ~~David Sobel, ___, Kaiser Permanente/Mind-Body Medicine~~
- Robert Rose, M.D., McArthur Foundation/Mind, Brain, Body, and Health Initiative (Science of Mind-Body Interactions, An Exploration of Integrative Mechanisms being presented March 25-28, 2001 in Masur Auditorium)
- ~~Jennifer Jacobs, M.D., MPH~~ ? Wayne Jonas (
- ~~Adrienne Bendich, Smith Kline Beecham (clinical studies on vitamins, minerals and supplements) can't make this meeting but knows about next meeting and will work with us to send a colleague to the next research meeting because she knows already that she will be out of the country.~~

Organizations Discussed

Fetzer Foundation
Kohlberg Foundation
Macy Foundation (report)
Cummings Foundation
George Foundation

Center for Science in the Public Interest (Michael Jacobson)

Other People/Ideas

- Marion McGregor, M.S., DC
  ~~Associate Professor~~
  Texas College of Chiropractic
  Richardson, TX 75082

End-of Life Research Interest Group/NIH Intramural (NIA, NINR, NCI, NCCAM)

- The Future of CAM Research. Areas ready for ~~scientific study/areas in need of~~ new methodologies

Research re. special populations: women (ORWH), elderly, children, ~~minorities~~

NYC

NYC

White House Commission on Complementary and Alternative Medicine Policy

Meeting on the Coordination of Complementary and Alternative Medicine (CAM) Research: Achievements, Opportunities, Obstacles and Solutions

October 5-6, 2000
Hubert H. Humphrey Building, Room 800
Washington, D.C.

Agenda

DAY ONE: THURSDAY, OCTOBER 5, 2000

7:30 a.m. **Registration**

8:30 a.m. **Welcome and Introductions**

- Dr. James S. Gordon, Chair
  White House Commission on Complementary and Alternative Medicine Policy

8:45 a.m. **Session I: Research Priorities and Public Input**

- Dr. Leon Rosenberg, Chair
  Institute of Medicine Committee on the NIH Priority-Setting Process

Panel Discussion

9:30 a.m. **Session II: Federal (NIH) Support for CAM Research**

- Dr. Jeffrey White, National Cancer Institute
- Dr. Claude Lenfant, National Heart, Lung, and Blood Institute
- Dr. Marvin Cassman, National Institute of General Medical Sciences
- Dr. Steven Hausman, National Institute of Arthritis and Musculoskeletal and Skin Diseases
- Dr. Paul Coates, Office of the Director/Office of Dietary Supplements

Panel Discussion

10:45am – 11:00am BREAK

11:00 a.m. **Session III: Academic Centers and Support for CAM Research**

- Dr. Alfred Fishman, University of Pennsylvania
- Dr. Daniel Federman, Harvard University
- Dr. Joseph Pizzorno, Bastyr University
- Dr. William Meeker, Palmer College of Chiropractic

Panel Discussion

12:15 p.m. – 1:30 p.m. LUNCH

1:30 p.m. **Public Comment (Open Session)**

2:15 p.m. **Session IV: Research Support and Collaborations**

- Dr. Stephen E. Straus, Director
  National Center on Complementary and Alternative Medicine

Panel Discussion

3:00 p.m. – 3:15 p.m. BREAK

3:15 p.m. **Session V: Facilitating CAM Research and Regulatory Challenges**

- Dr. Janet Woodcock, FDA, Center for Drug Evaluation and Research
- Dr. David W. Feigal, FDA, Center for Devices and Radiological Health
- Dr. Joseph A. Levitt, FDA, Center for Food Safety and Applied Nutrition
  Dr. Christine Lewis, FDA Office of Nutritional Products
- Mr. David Dorsey, FDA Office of Chief Counsel

Panel Discussion

4:15 p.m. **Session VI: Research in the Regulatory Framework**

- Dr. Floyd Leaders, Botanical Enterprises, Inc
- Mr. Robert McCaleb, Herb Research Foundation
- Dr. Anthony Rosner, Foundation for Chiropractic Education and Research
- Dr. James R. Winn, Federation of State Medical Boards

Panel Discussion

5:15 p.m. – 5:30 p.m. BREAK

5:30 p.m. **Session VII: Outcomes Research Part I - Interface Between CAM Research and Regulatory Agencies**

- Dr. Nicholas Gonzalez, Private Practice
- Dr. Ann McCombs and Dr. Devi Nambudripad, Private Practice
- Dr. Jeffrey White, National Cancer Institute

Panel Discussion

6:30 p.m. **Adjourn**

DAY TWO: FRIDAY, OCTOBER 6, 2000

8:30 a.m. **Session VIII: Guiding Principles of CAM Perspectives and Practice**
Commission Discussion led by the Chair

9:30 a.m. **Session IX: Not-for-Profit Sector Support for CAM Research**

- Dr. John M. Templeton, Jr., Templeton Foundation
- Dyanne M. Hayes, Conrad N. Hilton Foundation
- Dr. Daniel Callahan, Hastings Center
- Ms. Teri Ades, American Cancer Society

Panel Discussion

10:50 a.m. – 11:05 a.m. BREAK

11:05 a.m. **Session X: Private Sector Support for CAM Research**

- Mr. Randy Burkholder, Advanced Medical Technology Association
- Dr. Raymond Ruddon, Johnson and Johnson
- Dr. Frank C. Sciavolino, Pfizer, Inc.
- Mr. Mark Blumenthal, American Botanical Council
- Dr. Annette Dickenson, Council for Responsible Nutrition

Panel Discussion

12:25 p.m. - 1:30 p.m. LUNCH

1:30 p.m. **Public Comment (Open Session)**

2:30 p.m. **Session XI: Outcomes Research Part II- CAM Research and Experimental Study Design**

- Dr. Elaine Cramer, Medical Epidemiology, CDC (By Phone)
- Dr. Leanna Standish, Bastyr University
- Dr. Lydia Segal, Kaiser Permanente
- Dr. Douglas Lloyd, Association of Schools of Public Health

Panel Discussion

3:30 p.m. **Session XII: Federal Agency Support for CAM Research**

- Dr. James Burris, Veterans Affairs
- Dr. William Dietz, Centers for Disease Control and Prevention (By Phone)
- Dr. Craig Vanderwagen, Indian Health Service

Panel Discussion

4:40 p.m. **Wrap-up and Adjournment**

December 14, 2000 WHCCAMP Discussion Items

I. Budget Concerns Raised at Meeting with Staff of Senator Harkin
   A. Proposed Budget of $3.356M Not Available to Commission Must look for Significant Reductions - Estimated 25%-30%
   B. Suggested Resolution is to Eliminate Town Hall meetings after New York City
   C. Consolidate Several Other Meetings with Change in Format of Meetings
   D. Reduce Requirements for Staff Salaries
   E. Take More Active Role in Meeting Arrangements and Travel of Commission Members - Use WorldWide Travel as Agent
   F. Reserve Fenton Communications Time for Release of Interim Report. No Additional Media Contracts Until Near Completion of Final Report

II. Suggestions for Interim Report From Staff of Senator Harkin
   A. Propose Doable, Achievable, Simple, Easily Implemented, Positive, Not Too Expensive Recommendations that Can be Agreed Upon by R's & D's

III. Will Arrange Briefing for Congressional Staffs R & D Similar to Jim's Previous Presentation

IV. New York City Town Hall Meeting
   A. Location
   B. Length
   C. Focus of Meeting - Women's Health, Minority Health, Urban Health, HIV/AIDS, Addiction, Youth, Sports and Athletic Training

V. General Meeting - February 20-21, 2001
   A. Education, and Training of CAM Practitioners
   B. Education and Training of Conventional Health Care Practitioners in Principles of CAM Interventions
   C. Licensure, Credentialing, Certification

VI. Report Outline - DRAFT

VII. Meeting Follow-up

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VI. Report Outline - DRAFT

VII. Meeting Follow-up

White House Commission on Complementary and Alternative Medicine Policy

Proposed Meeting Schedule*

DATE	SITE	TYPE	TOPIC
September 8, 2000	San Francisco, CA	Town Hall (1)	West Coast/Region IX
October 5-6, 2000	**Washington, D.C.**	**WHC (2)**	**RESEARCH Part I**
October 30-31, 2000	Seattle, WA	Town Hall (2)	Pacific Northwest/Region X
December 4-5, 2000	**Washington, D.C.**	**WHC (3)**	**ACCESS & DELIVERY Part I**
January 22-23**, 2001	New York, NY	Town Hall (3)	North/Region II
February 20-21, 2001	**Washington, D.C.**	**WHC (4)**	**EDUCATION/TRAINING**
March 5-6, 2001	**Washington, D.C.**	**WHC (5)**	**INFO DISSEMINATION/Wellness**
~~March 16, 2001~~	~~Minneapolis, MN~~	~~Town Hall (4)~~	~~Mid-West/Region VII~~
~~March 26, 2001~~	~~Albuquerque, NM~~	~~Town Hall (5)~~	~~SouthWest/Region VI~~
~~April 9-10, 2001~~	~~Washington, D.C.~~	~~WHC (6)~~	~~RESEARCH Part II~~
May 14-15, 2001	**Washington, D.C.**	**WHC (7)**	~~ACCESS & DELIVERY~~ **(REIMBURSEMENT)** ~~Part II~~/Research Part II
~~June 22, 2001~~	Atlanta, GA	Town Hall (6)	~~South/Region IV~~
~~July 2-3, 2001~~ June 30 - July 1 2001	**Washington, D.C.** (?) Portland, ME	**WHC (8)**	**REVIEW INTERIM REPORT DRAFT**
Aug Sept Oct ~~September 13-14, 2001~~	~~Washington, D.C.~~	~~WHC (9)~~	~~WELLNESS~~
November 5-6, 2001	**Washington, D.C.**	**WHC (10)**	**REVIEW FINAL REPORT**
Keep in Leep on ~~December 6-7, 2001~~	~~Washington, D.C.~~	~~WHC (11)~~	~~FINAL FULL MEETING~~
March 2002	**Washington, D.C.**	**WHC (12)**	**CLOSING EVENT**

* This information, including dates and locations of Town Hall Meetings, may change based on recommendations from the Commission; ** January 22 will be primarily media activities; January 23 is reserved for the hearing

Reduce by 2 full meetings
Reduce by 3 town Hall Mtg
Reduce by 2 — Part II Report Rec'd Mtg

Sociology
University of Michigan

FACULTY INTERESTS

Max Heirich

The Beginning, Berkeley, 1964-1965, NewYork: Columbia University Press, 1970.

Rethinking Health Care:Innovation and Change in America. (Ms. Revised 1996, Currently being evaluated by several publishers).

"Worksite Physical Fitness Programs: Comparing the Impact of Different Program Designs on Cardiovascular Risks." *Journal of Occupational Medicine* 35(5):510-517, 1993. With A. Foote, J.C. Erfurt, and B. Konopka.

"Saving lives and Dollars Through Comprehensive Preventive Health Care." *Family Business Review* 6(2):163-172, summer 1993. With J.C. Erfurt, A. Foote and K. Holtyn.

Title
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Not the 313 Ann Arbor area code

To: Steve ___ (passon)
Michele ___

Miller, Maureen (NCCAM)

This is in F/up to Jim's request -- although Joe could not reach him/get a response. He may have been better for March.
Maureen

To: mheirich@umich.edu
Subject: White House Commission Request

Dr. Heirich -- The chair of the White House Commission on Complementary and Alternative Medicine Policy (WHCCAMP), Dr. James Gordon, requested that we contact you. I understand that a colleague here at the Commission staff, Dr. Joe Kaczmarczyk, tried to reach you by phone some time ago with regard to our March meeting and was unsuccessful. This meeting, being held next week (the 26 and 27th) is on wellness. We are trying to include brief testimony on workplace issues and, at a minimum, provide Commissioners with information about workplace wellness.

Our question to you, unfortunately at this late date, is for any articles that might be shared with the Commission. In addition, we would be interested in your ideas for possible policy recommendations that would be considered for inclusion in our report. While it would be wonderful to have a response by COB Friday, we would accept your input any time in the near future.

Further, we would like to know if you have any thoughts or ideas regarding coverage and reimbursement of complementary and alternative medicine (CAM) services. The next Commission meeting is May 14 through the 16th here in Washington, D.C., and will focus on this topic as well as additional research issues not covered in a previous meeting. I am the staff lead for the May reimbursement meeting and would like to speak to you -- or receive elctronic/paper information. The agenda for the meeting is still taking place and, depending on the 'evolution' of the panels, the Commission may wish to invite you to speak. If you could respond by email to me on this latter request, and hopefully set a time to talk, I would be most appreciative.

If you are able to provide any information for the March wellness meeting, you may email to axelrodc@mail.nih.gov. Or our contact info is:
fax: 301/480-1691
main phone: 301/435-7592
website: whccamp.hhs.gov

Thank you for your attention to the important work of the Commission.

Maureen Miller, MPH, RN
White House Commission on Complementary
and Alternative Medicine
6701 Rockledge Drive
Suite 1010, MS-7707
Bethesda, MD 20817-7707

Worker Health Program

The Worker Health Program studies workplace interventions and other programs aimed at improving employees' health. Areas of study include Employee Assistance Programs (EAPs), worksite wellness, cardiovascular disease risk prevention, and more general health promotion. Previous Worker Health Program research has demonstrated the effectiveness of regular follow-up counseling in lowering the risks of cardiovascular disease, the number one killer of the American workforce. Our current research in this area is described below.

Demonstration-research on substance abuse in the workplace

A research project is under way in a local automotive plant, to study the potential of nonstigmatized wellnesss interventions to lessen alcohol and drug abuse. It provides a randomized trial examination of the impact of one- to-one outreach versus group interventions. Classes and counseling are offered in the areas of smoking cessation, weight management, nutrition, and alcohol education.

Evaluation of worksite prevention programs

The Worker Health Program accepted a contract from the American Cancer Society to evaluate their worksite programs and to suggest improvements. This study, conducted under the supervision of Cynthia Sieck, was completed in August 1996.

Program guide for worksite health promotion

In October 1995, the National Heart, Lung, and Blood Institute of the National Institutes of Health published a step-by-step guide to implementing a worksite wellness program, based on research at more than 100 worksites. This guide was written by program staff and Bruce Brock, who has collaborated with the Worker Health Program on many projects over the years. It comes as a special tribute to the pioneering work of Jack Erfurt and Andrea Foote, for many years co-directors of the Worker Health Program. Demand for the publication has been high. It has been reprinted and is now available through NTIS, the National Technology Information Service.

National guidelines for worksite programs

Max Heirich, acting director of the Worker Health Program, currently coordinates the work of fifteen organizations preparing recommended national guidelines for worksite health promotion programs. This project began as part of a national effort to respond to congressional health care legislation, and has continued under the aegis of the Association for Worksite Health Promotion.

Health care for the working poor

Max Heirich is collaborating with UEED on a project regarding the provision of health care to the working poor. A number of prevention services now are offered in a low-income neighborhood of Detroit that is active in urban entrepreneurial efforts. Plans to establish a full-service primary care clinic are under way, and efforts are being made to extend to the entire neighborhood the kind of proactive outreach follow-up and case management that has been introduced at worksites.

Note from The Desk of
Joseph M. Kaczmarczyk, DO, MPH

19 Mar 01

Steve,

Here is some information on the two approaches to coding that I've assembled for the upcoming Reimbursement meeting.

I've given a copy to Maureen.

FYI,

Joe

Linda L. Bedell-Logan is President and Chief Executive Officer of Solutions in Integrative Medicine, a newly formed company created by the 1999 merger of Bedell-Logan Billing Systems and Consulting Services for Medical Alternatives. Ms. Bedell-Logan formed these two programs in 1990 after the death of two siblings from cancer and AIDS. As their caregiver, she discovered the great need both for patient advocacy in the insurance arena for complementary and alternative medicine (CAM) and for the integration of CAM alongside allopathic medicine in existing health care delivery systems. Solutions in Integrative Medicine provides consulting services for establishing integrative medicine centers, practice management services for obtaining reimbursement for alternative modalities, and an educational program about the role of integrative medicine. Ms. Bedell-Logan is also a nationally recognized speaker in the promotion of integrated medical services.

Solutions in Integrative Medicine

Post Office Box 207 Saco, Maine 04072-0207

Linda L. Bedell-Logan
President/CEO
Solutions in Integrative Medicine

Written Testimony for the House of Representatives
Committee on Government Reform

Oversight of the Department of Health and Human Services

The Role of Complementary and Alternative Medicine in the Detection and Treatment of Women's Cancers

A Perspective on Access to Integrative Medicine, Insurance Reimbursement and the Barriers in our Current Healthcare System

June 10, 1999
Washington, DC

In 1987 my 25-year-old sister was diagnosed with a Ewing's Sarcoma in the calf of her right leg. The protocol for Ewing's is amputation, chemotherapy, and radiation in that order. This is a very aggressive cancer but thankfully it was caught early enough for treatment. I remember clearly my sister's fear of losing her leg, mortified at the prospect of disfigurement at such a young age.

I was with her at a hospital in Florida during her treatment and remember when the oncologist came into the room and told us there was a new experimental treatment for Ewing's that he would like to

try. The doctor said the procedure involved inserting a tube into a vein near her groin and snaking the tube down her leg to drop chemotherapy directly on the tumor. He told my sister that this would not diminish her likelihood of survival but might well save her leg. On the strength of this hope, my sister opted for the new therapy.

At the beginning of the fourth treatment, the technician could not get the tube to slide into the same path they had been using previously. Somehow the vein seemed obstructed and my sister experienced intense pain. The technician gave up, and the next day they sent her to get a sonogram. The sonogram revealed a grapefruit sized tumor in the very spot they had been using to access her vein. Due to the size of the mass they could not operate. Then because of decreased lymphatic circulation, she developed massive bilateral lymphedema—a painful and debilitating swelling of the limbs. This caused her such intense pain the surgeons made incisions in her legs to "drain the lymphatic fluid". We now know that cutting into a patient with lymphedema is one of the worst things you can do. They put permanent drains in her thighs and both of the points of entry became severely infected. She became wheelchair bound and experienced excruciating pain 24 hours a day. They put her on high dose morphine and antibiotics to control the pain and infection, and we watched her die a slow, horrible death. She was diagnosed in June and died in late January.

After her death we found out my sister had been a guinea pig. The hospital had never performed this procedure before and the physicians hadn't been trained to use it. It had never been tested and is not standard treatment protocol even today. I came away from this experience determined to bring more humane approaches into our supposedly state-of-the-art health care system.

One month after my sister's death I started working for Medicare. My goal was to get down in the trenches and learn how the health care system in this country worked. I received an excellent education for three years at Medicare and then went to work for a large family medical practice. So I've seen the system work from all sides—patient, payer, and provider.

I opened **Solutions in Integrative Medicine** ten years ago. My company provides billing and practice management, consulting, and educational services for alternative and integrative medicine providers. Integrative medicine refers to a well-coordinated combination of traditional Western medicine and well-founded alternative therapies. At our company we have been in the forefront of change, actively advocating for patients whose insurance companies deny payment for effective but non-traditional services. We have been instrumental in developing the administrative and clinical basis for the coverage of a host of effective integrative therapies—often at greatly reduced cost. But this effort has been very tedious which makes it difficult to make a large enough impact for global change.

The US Public Health Service estimates that 70% of the current health care budget is spent on the treatment of approximately 33 million chronically ill individuals. As the population ages, such conditions will consume an even larger proportion of the national health care dollar. With this in mind my company's vision is to change the perspective of the health care industry by providing professional education to insurance carriers, Medicare, physicians and patient consumers.

One of these chronic illnesses is lymphedema, something I witnessed during my sister's ordeal. The principal cause of lymphedema is axillary lymph node dissection—a procedure performed both diagnostically and as part of radical surgery for breast and prostate cancers. Roughly 20% of breast cancer survivors suffer from this malady. There are three major consequences of lymphedema: swelling, recurrent infections, and tumor formation. Lymphedema patients who do not receive early intervention may develop elephantiasis, which can lead to amputation of the limb. Prompt treatment

by specially trained lymphedema therapists who manually drain the engorged tissue has been shown to save limbs, save lives, and save health care dollars. This therapy is called *combined decongestive therapy*. It has been standard treatment in Europe for decades. But today it is considered an "experimental therapy" and is not typically a covered benefit. In the United States, our standard approach is to use expensive pumps that mechanically compress and decompress the affected limb even though this therapy has been shown to have little benefit. In fact it can press lymphatic fluid in the wrong direction and lead to a worsening of symptoms. For this reason, mechanical pumps for lymphedema have actually been banned in some European countries.

In the past two years we have been able to begin educating the insurance industry about *combined decongestive therapy*. We have been able to obtain coverage for Medicare patients in Maine, New Hampshire, Vermont, Massachusetts and Florida as well as many commercial insurance beneficiaries all over the country. This type of education and subsequent coverage has saved Medicare alone tens of thousands of dollars in Durable Medical Equipment supplies and has lowered the hospitalization rate significantly. Due in part to this work, Senator Kennedy sponsored HR 4328, The Women's Health and Cancer Rights Act of 1998, which mandated coverage for lymphedema treatment. Even with this law in place, we are still struggling to obtain coverage for this treatment nationwide. Those patients who do receive this treatment are often those with the disposable income to afford it. The rest of the public receives conventional treatment, costing insurance companies millions of dollars each year.

The treatment of lymphedema is just an example of the education and common sense needed in the insurance industry. The illusion is that best medical practices are based on the results of randomized control trials. In fact it was recently estimated that only 15% of medicine today has been subjected to randomized controlled trials. It is a sad fact that since there is little to be gained by drug or medical equipment companies from the lymphedema treatment regimen I described, little attention or marketing money is focused on such common sense therapies. This is why health care cannot be simply left to the private sector. Too often the perverse incentives of our system lead to short-term thinking and pharmaceutical Band-Aids rather than comprehensive chronic disease management. The result, strangely, is poor quality care at higher cost. And those who can break out of this broken system are only those who can afford to pay out of pocket.

If we do not start moving back toward an outcomes-based, patient-centered, comprehensive care approach to chronic disease management, budgets will be busted, services will be slashed further, and the health, productivity, and competitiveness of our nation will suffer. It is time to heal the business of healing. We have an opportunity to meet patient demand and honor patient choice. Combining well-tested alternative therapies with the best of traditional Western medicine has been shown to improve health and reduce costs. We can have a system that works for patients, health care providers, and insurers. This is a tremendous win-win opportunity. But you cannot count on the private sector alone to take the lead. Health care is a highly regulated industry. We need leadership from government to allow this humane and common sense approach to prosper. With your help we can evolve a health care system that improves the quality of life and death for our citizens without the artificial constraints that are compromising the integrity of our physicians, healers and citizens. We must put prevention of chronic illness in the hands of the patients, treatment of chronic disease in the hands of integrative medicine teams, and acute and traumatic episodes in the hands of conventional medical providers.

Evolving Integrative Medicine

The inability of conventional medicine to address chronic disease has created a shift in patient demand for medical services. Patients, on their own, have found that complementary and alternative medicine (CAM) addresses quality of life issues, provides means for long term care management, and more importantly, often allows for a decrease in pharmaceutical utilization. These fee-for-service modalities are usually paid for out of pocket by the patients. Even when faced with these additional costs, patients seek care outside of their conventional provider networks, thereby creating access to choices that tie into their own belief system(s). However, when patients pay out of pocket for CAM services they may or may not report receiving these services to their Primary Care Physician—thereby creating potentially dangerous disconnects in the continuum of their healthcare.

The concept of regarding the patient as the consumer is a relatively new concept in health care. Concurrently, the philosophy that patient choice may yield more positive outcomes is one that is becoming more widely embraced. Today's healthcare environment is one in which patients/consumers are choosing alternative branches of medicine that are not regulated by insurance guidelines. In the face of this reality, insurers are endeavoring to meet patient demand for alternatives by exploring means of expanding coverage to include these additional modalities.

In the past six years the rise in patient demand for CAM modalities has been repeatedly validated. Two surveys conducted by David Eisenberg, MD and colleagues from Harvard Medical School (1993: NEJM 328:246-252; 1998: JAMA 280:1569-1575) have thoroughly documented the prevalence and trends of use for CAM modalities amongst the American populace. In 1997 Eisenberg et al. found that "...extrapolations [from the survey sample] to the US population suggest a 47.3% increase in total visits to [CAM providers], from 427 million in 1990 to 629 million in 1997...." In both survey years the number of visits to CAM providers exceeded "the total visits to all US primary care physicians." Eisenberg et al. conservatively estimated that total expenditures on CAM modalities in 1990 was "approximately $13.7 billion." The 1997 data indicates that "estimated expenditures for alternative medicine *professional services* increased 45.2% between 1990 and 1997 and were conservatively estimated at $21.2 billion in 1997, with at least $12.2 billion paid out-of-pocket. This exceeds the 1997 out-of-pocket expenditures for all US hospitalizations." Moreover, upon further analysis, we see that "total 1997 *out-of-pocket* expenditures related to alternative therapies were conservatively estimated at $27.0 billion, which is comparable with the projected 1997 out-of-pocket expenditures for all US physician services.

Since 1998 more research dollars have been shifted toward CAM therapies with the establishment of the National Center for Complementary and Alternative Medicine (NCCAM). The Senate Appropriations Committee funded the NCCAM with $50 million to further the work begun under the auspices of the NIH Office of Alternative Medicine with its original budget of $2 million.

As more research results are published, it is affecting the way insurers are covering lives. As patient demand increases, insurers are creating ways to expand coverage to include some CAM therapies. The therapies insurers are attempting to include in benefits packages have little historical financial data (since they are primarily paid for out-of-pocket and not processed through a billing service). Actuaries are finding that insuring CAM therapies is a difficult challenge. Without historical data as a foundation for an insurance plan, coverage of CAM therapies can appear to be too speculative. What is most difficult to determine in these actuarial attempts at coverage planning is the concept that by utilizing CAM therapies a patient will utilize fewer conventional therapies. This concept is most

easily demonstrated when investigating conventional approaches to chronic illness such as arthritis, allergies, pain, hypertension, cancer, depression, cardiovascular disease and digestive disorders. Patients who fall within these categories of diseases are under obligation to move through the insurance system as outlined in Chart 1. These types of diseases are becoming easier to diagnose with more documentation available outlining classic symptoms. For example, less testing will be needed to properly diagnose migraine headaches, chronic fatigue syndrome, and myofascial pain syndrome. However, this gradual decrease in the need for diagnostic testing does not address the quality of life issues and long term treatment costs.

Chart 1

Chronic Migraine Headaches				
Provider		**Plan**		**Outcome**
PCP Evaluation	→	no treatment	→	Referral to Neurologist
	←		←	
Neurologist Evaluation	→	no treatment	→	Refer to radiology for CT scan and/or MRI
	←		←	
Radiology Testing	→	no significant findings/no treatment	→	Refer to pain management specialist
	←		←	
Pain Management	→	patient treated with pain medication	→	Refer back to PCP for medication management
	←		←	
Patients continued care		Patient utilizes pain medication and Emergency Room when in acute attacks.		Patients chronic pain is unresolved and could potentially create long term costs for insurer.

The plan of care referred to in Chart 1 does not entitle the patient to options that may cost less and more directly address the patients' chronic migraines. There are many CAM therapies available that have been found to relieve (without pharmaceuticals) and in some cases resolve migraine headaches. Hesitations preventing the use of CAM interventions at the onset of the complaint are concerns that life threatening problems will be overlooked due to lack of diagnostic testing.

The concept of integrating conventional and CAM therapies is one that embraces the diagnostic process at the primary care physician level to rule out serious illness. The U.S. Public Health Service

estimates that nearly 33 million Americans suffer from chronic debilitating diseases. It is estimated that the medical care of 9 million of these individuals, who are partially or completely disabled, accounts for 70% of the spending in current health care budget. Most of the spending associated with patients who fall into this category occurs in the final stage of the process outlined in Chart 1. These patient issues are unresolved—therefore creating a revolving door of over-utilization of health services—which becomes more costly as the patient grows older. Appropriate CAM therapies introduced after appropriate diagnostic testing may significantly improve the quality of life for the patient as well as control the cost of future medical care.

The patient, in the **Integrative** setting will be educated about their illness, instructed in ways of coping with pain that do not involve pharmaceuticals, and be treated with an appropriate CAM modality that ties in with the patient's belief system, thereby producing a more positive outcome. One of the less obvious benefits to this type of care plan is getting these types of patients off disability and back to work. Integrative medical approaches can also create a partnership based in prevention. CAM techniques encompass lifestyle changes that are significant to the course of prevention. This course is essential to building long term approaches to the prevention of the diseases that continue to drain health care dollars.

In an attempt to collect data many insurers have created rider policies or have become affiliated with pre-credentialed CAM provider networks. Rider policies usually cover an array of the CAM therapies most in demand. Many of these therapies carry strict utilization review guidelines that limit the number of visits or may have a monetary cap. Rider policies are purchased separately from a standard policy. Many employers are demanding policies that include CAM therapies due to a rise in absenteeism as well as employee complaints about lack of choices. Insurers, in an effort to comply with employer requests, will create a rider policy specific to that employer. CAM provider networks contract with some HMO plans. The plans will allow patient access to the providers at a discount to the patient. This option minimizes the risk to the insurer, and allows access to the CAM provider at a discount to the patient. The providers are usually credentialed and screened before entering the network.

Another issue that impairs the ability to implement comprehensive CAM coverage plans is credentialing. In an effort to reduce medical fraud and quackery, medical societies have developed strict licensure laws that govern the scope of practice of physicians and ancillary medical personnel within each state. Many CAM modalities, techniques and therapies are taught to a diverse group of medical providers. For example, craniosacral therapy classes are attended by nurses, doctors, massage therapists, physical therapists and others. Insurers are finding it difficult to credential a provider to perform craniosacral therapy when there is no licensure or certification in the delivery of this care. CAM provider networks across the United States are developing expertise in the credentialing of these providers. CAM provider networks provide credentialing criteria that parallel the teaching institutions most highly respected in their respective fields. The relationship between the insurer and the CAM network is essential to the quality of the care delivered in CAM medicine. Either of these interim coverage steps will allow and help to build a financial basis for the coverage of CAM. This in turn will create access for patients who cannot afford to pay out of pocket. However the CAM network is not a long term solution to patient access because of the lack of integration with conventional medicine.

Coding, Diagnosis and Procedures

Although the process of integration under one coding system has been a challenge, the American Medical Association has taken significant steps toward accepting CAM therapies such as physical therapy, osteopathy, chiropractic, acupuncture, manual therapies, and psychiatric services such as biofeedback and hypnosis. The AMA has adopted CPT codes for many CAM techniques, which in turn has opened doors to access and coverage for patients. The downfall of these conventional coding schemes, created for CAM interventions but conceived from an allopathic perspective, occurs when CAM providers attempt to implement them. CAM providers tend to see patients from a holistic point of view, but the coding schemes assume that human ailments are best described as organ-specific pathologies. How does one "code" the treatment of an intestinal ailment that a CAM provider perceives as related to emotional stress, nutritional deficiencies, lack of exercise and other lifestyle factors? Evaluation and management codes, in fact, specifically prevent holistic care from being performed. If an osteopath, for example, sees a need to do nutritional counseling and some manual adjustment he would not be able to do so under current guidelines. Comprehensive treatment of complex chronic illness almost always demands some significant educational component, but the thoughtful physician simply cannot find in the conventional code book the support needed to do this different kind of medicine. Other branches of medicine outside of the conventional medical education system, view a patient and their illness as one, and do not separate the disease from the patient.

The coding description states that "Evaluation and Management services may be reported separately if, and only if, the patient's condition requires a significant separately identifiable E/M service, above and beyond the usual preservice and postservice work associated with the procedure". Many holistically-trained healthcare providers feel that a large part of the philosophical and educational basis of the medicine they deliver has been compromised with coding that focuses solely on disease and the efficacy of a modality. Physicians who cannot spend quality time with their patients, due to coding restrictions, often refer troubled patients to potentially expensive psychiatric care. Many of these psychiatric claims are denied due to lack of substantial psychiatric diagnosis. Physical therapists as well as chiropractors experience similar challenges. Physical therapy and chiropractic care come from a root of education that includes empowering the patients to better care for themselves. With a reimbursement system based on diagnosis, it is becoming increasingly difficult for CAM providers to care for patients as a whole, while also offering education and options for lifestyle change. Systems are in place that will allow a certain number of visits per year, per patient for a given diagnosis. CAM providers believe that each patient is an individual and will respond differently to any given treatment. With this diagnosis-driven reimbursement system patients have few choices in regard to their health care delivery. CAM psychiatric providers experience a similar problem when a patient presents with chronic pain. These CAM psychiatric providers submit claims to an insurance intermediary in many cases that has expertise in the utilization review of psychiatric claims. If the diagnosis is low back pain, for example, the claim is denied due to lack of "psychiatric diagnosis". However, the provider may change the diagnosis to "adjustment disorder" (may tie in as an inability to tolerate pain) and the claim will be paid. Many of these CAM psychiatric interventions also include manual therapy and self care training which may be referred to as a mind-body program. When the provider submits the claim for the manual therapy part of the treatment to the psychiatric claims intermediary, the claim is denied for two reasons. The first reason is that the procedure codes used to describe the manual therapy cannot be paid for with a diagnosis of adjustment disorder. The second reason is that this intermediary only pays for psychiatric procedures. The provider then changes the diagnosis to read low back pain and sends the claim to the medical policy division. Many times these claims are also returned to the provider denied as the patient has exhausted their physical therapy benefit for the year. It is customary to use physical medicine codes to describe all types of manual therapy services, not just physical therapy. However, many insurance carriers do not take into

consideration the fact that many other types of providers utilize these codes. When the insurer sets a protocol for the number of visits per year by a physical therapist, they attach the guidelines to the procedure codes and the diagnosis codes. Even though the care has a different root of medical origin, these two fields utilize the same procedure codes and are adversely affected by insurance company processing systems that are unable to process claims based on usage by profession. Usage by profession would yield a quality of delivery that would permit integrative medicine to be incorporated into the existing reimbursement system.

In the absence of appropriate AMA approved CPT codes for some CAM therapies, more progressive insurers have created in-house procedure codes in an attempt to meet patient demands for coverage. Many CAM techniques can be described accurately with existing CPT codes, however many of these codes are used in the conventional setting with a different root of delivery. A dilemma that plagues this integration process occurs when existing CPT codes are used to describe CAM therapies, and the root of delivery is not housed in the same reimbursement assessment as conventional therapies. For example, a conventional reimbursement assessment may find it appropriate for a provider to spend 20 minutes with a chronic low back pain patient. Reimbursement for this service is calculated by the severity of the diagnosis. In naturopathic medicine a physician may spend 60 - 90 minutes with a chronic low back patient, which is appropriate based on the root of naturopathic medicine. The conflict occurs when the visit by the naturopath is reduced or denied because the guidelines for reimbursement are based in the root of conventional medicine, which is diagnosis-driven. The challenge for CAM providers is in educating the insurers in order to avoid fraud and abuse issues but also to protect the integrity of CAM approaches, given that the success of these therapies is intrinsic to how the care is delivered. The challenge for the insurer is to develop a reimbursement structure that will allow each profession to utilize the CPT codes currently available and create utilization review guidelines that are based on any given professions root of delivery. In the meantime, it is essential when coding CAM therapies using the CPT tool, that providers are in open dialogue with insurers in an effort to avoid fraud and abuse claims. For example, the appropriateness of utilizing evaluation and management codes to describe homeopathic assessments, even when performed by a MD, are seriously questioned at this time.

Many integrative centers have evolved across the United States. These centers usually include a medical director, usually a physician (MD, DO, or DC), with a staff comprised of such professionals as a naturopathic physician, an acupuncturist, a massage therapist, a nutritionist and a stress reduction program that incorporates lifestyle counseling such as the Jon Kabat-Zinn program, the Herbert Benson program, or the Dean Ornish program.

These professionals that are not easily credentialed by insurers are able to provide services under the direct supervision of the physician. The physician assumes responsibility for the therapists and bills "incident to" the physician. *Incident to Guidelines* for Medicare have very specific language addressing the employment relationship that is needed between the physician and other professional in order to deem incident to billing appropriate.

The education that is taking place in the insurance industry will continue to bring more and more players to the table to create an infrastructure that will introduce CAM to mainstream medicine. In a effort to reduce the cost of health care, more insurers will be allowing reimbursement for modalities that address chronic pain and illness. This in turn will reduce the over-utilization of services by patients who suffer from illnesses that conventional medicine cannot address in many cases without utilizing expensive and invasive interventions and/or pharmaceuticals.

With all of the many changes in medicine taking place, creating state by state variations, it is extremely important that we establish patient access laws at the Federal level. These laws are extremely important for patient safety as well as protecting the integrity of both CAM and allopathic medicine. Such legislation would support the many conventional physicians and CAM providers whom, banding together across the country to provide whole medicine and education for our population, wish to especially focus on preventive disease management and overall cost reduction in today's healthcare system.

DR. GORDON: Melinna Giannini, Jane Hersey, Boyd Landry, Lawrence Auburn Plumlee, and Michael John Rohrbacher. We will have 15 minutes. Each person will speak for three minutes, and then we will have 10 minutes for discussion, for questions, from our group. I will cut it at that 10 minutes.

The first person will be Melinna Giannini.

MS. GIANNINI: Thank you and good afternoon. I come to you from the perspective of the insurance industry.

I used to design, sell, and monitor self-funded medical plans for large employer groups.

I created a company called Alternative Link. We have developed about 4,000 codes that describe what is said, done, ordered, prescribed, or distributed by alternative care practitioners, and each one of these codes has a relative value unit attached to it so that a rate can be developed for each procedure.

This is important because having this system allows comparative analysis between statistical information from conventional medicine and statistical information from CAM.

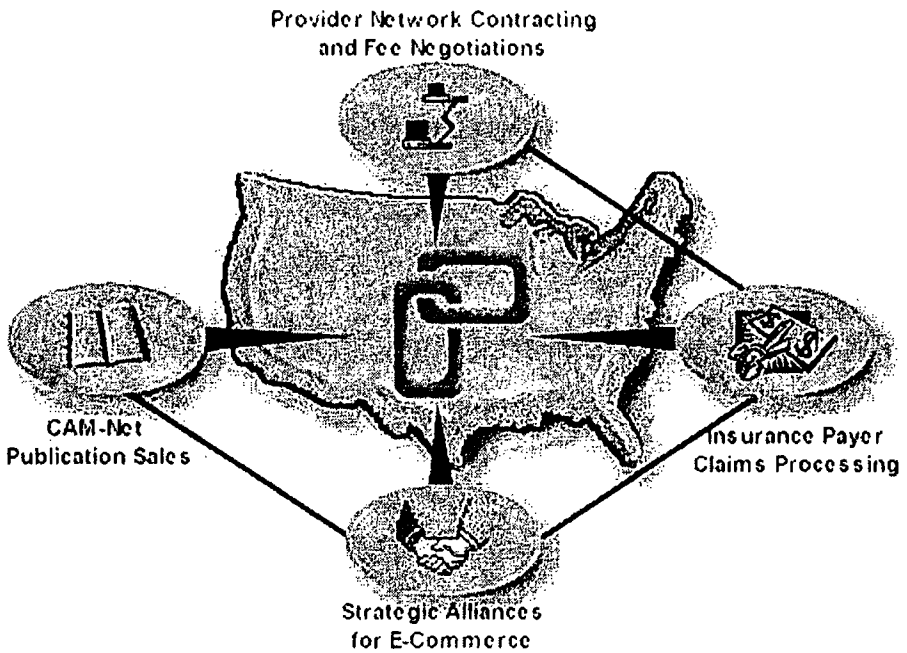
The code set has been published in the Unified Medical Language System at the National Library of Medicine in 1998. They were added to the American National Standards Institute X(12) standard for electronic commerce in 1999. They have been recognized by the American Nurses Association, and they are currently before the Department of Health and Human Services for consideration as a standard for electronic claims processing.

I respectfully suggest that the Commission consider its influence to cause in-CAM funded research to incorporate this code set so that cost-effective CAM treatments can be identified as a solution to escalating health care expenses, especially where these procedures could have an impact on Medicare/Medicaid recipients.

A key barrier to viable CAM coverage is vast differences in state scope-of-practice laws. Alternative Link has a fully developed database to identify legal treatments in each state. I respectfully suggest that the Commission review this information as it pertains to assuring CAM compliance with state laws. This information is key to viable CAM insurance reimbursement because payment of claims outside scope of practice triggers fines as high as $10,000 per line item for payers and providers who are outside of compliance.

This code set and associated scope-of-practice database can assure that data for CAM is viable for future reimbursement. I am leaving a copy of the code set for the Committee's review, and I want to thank you for the opportunity to give this testimony.

Coding and Systems Solutions for CAM and Nursing.



CAM-Net MIS™ products are based on coded procedures for Complementary and Alternative Medicine (CAM) and nursing. Alternative Link's products support electronic and paper claims processing and fee structures for providers, healthcare payors, managed care organizations and affiliate organizations.

The

CAM-Net MIS, developed by Alternative Link, is intended for use by all managed care organizations, health plans, health care facilities, clearinghouses and healthcare providers.

Alternative Link's CAM-Net MIS is a series of software products designed to process claims based on the legal scope of practice of complementary and alternative and other non conventional providers governed by state law.

Our Complementary and Alternative Medicine Billing & Coding Reference provides the only patented coding system for the accurate reimbursement of complementary and alternative medicine CAM services. The Alternative Billing Codes (ABC) are intended for use by all health plans, health clearinghouses and health care providers for processing all electronic claims requiring a code for an alternative medicine CAM procedure, service or supply.

The Integrator

Volume 4, Number 1, July 1999

Billing and Payment Strategies

Alert: Alternative Link Granted Patent on CAM Codes

A set of procedure codes for complementary and alternative medicine (CAM): The question was not *if* somebody would develop them, but *who*, and *when*.

In a move which may have a major, long-term impact on CAM payment and delivery, a U.S. patent (#5915241) was issued June 22, 1999, to New Mexico-based **Alternative Link**. The patent, issued to **Jo Melinna Giannini**, is entitled: "*Method and System of Encoding and Processing Alternative Healthcare Provider Billing.*"

Giannini, whose product development has been followed in THE INTEGRATOR for two years, contacted the newsletter with this breaking news. A feature in the August-September double issue will look at the implications of this patent for the emerging industry. This article serves as a heads-up to all those using CAM coding. An Alternative Link notice to the industry states that "several companies have mistakenly infringed upon specific rights granted by the U.S. patent." The letter urges "those who have developed CAM billing or coding information contact us." According to Alternative Link, the coded procedures include, but are not limited to, the following specialties: acupuncture, chiropractic, botanicals, holistic medicine, homeopathic medicines and homeopathy, massage therapy or bodywork, midwifery, naturopathy and nursing procedures...

Those wishing to read the Alternative Link patent can do so via westlaw.com (download $65), by using the number and name of the patent. Those wishing to obtain a copy of the codes ($99), contact **Integrative Medicine Communications** (617-641-2300). If you have comments on the reach of the patent and the potential meaning of these codes to the emerging industry, please contact THE INTEGRATOR via email (isnh@quidnunc.net) or over the phone (206-933-7983).

BENEFITS & COMPENSATION SOLUTIONS

How to Offer Alternative Medicine (and Keep Your Shirt)

Many employers today are offering access to Complimentary/Alternative Medical (CAM) care and with some states requiring access to CAM, benefits managers may face a new challenge in effectively implementing these programs.

BY MELINNA GIANNINI

Employees are increasingly using Complementary/Alternative Medicine (CAM) programs in addition to traditional healthcare services. The wise employer knows that by offering these services, they may be helpful in attracting and retaining key employees as an important part of the benefits package. However, wouldn't it be nice to know the costs for these programs prior to committing to offering CAM programs? What seems like an easy decision can rapidly become a financial nightmare or a blessing – depending upon how the employer approaches adding CAM benefits to an existing program.

The growth of CAM plan offerings is not limited to creative benefits managers – some states like Washington and Vermont are requiring plans to offer certain CAM services. As the popularity of these plans grow, the need for information resources on CAM plans shall also increase in demand as well. Employers and third party administrators need good advice as they contemplate CAM in an era of escalating health care costs. Consider the following as a guide toward investigating how to implement a CAM plan for your employees.

AVAILABILITY OF PROVIDER NETWORKS

One of the first questions that faces any designer of CAM benefits plans: are there networks of providers available, and if so, how are these networks organized? There are many discount fee-for-service networks, though few of these networks are NCQA certified. It is not advisable to use them for rider, carve-out, or partially insured benefits because the plan can be held legally responsible for the referral. While these networks may seem like an easy solution for adding CAM plan offerings, be sure to test the network for professionalism. Medical providers who maintain office space, carry

malpractice insurance, and offer their patients predictable office hours will not want to discount fees to join discount networks. Healthcare providers usually have a thriving cash business and will only accept managed care contracts if the fee schedule is within the range of their cash practice. National PPO networks are exploring this issue and will soon be enrolling CAM practitioners that are NCQA certified.

Another method for using CAM providers in self-funded employer plans is to have your employees compile a list of providers they currently use. This method provides an additional benefit for the employer aside from saving time on the research: your employees will exhibit a higher level of satisfaction with the offerings which in turn, reduces the number of complaints about the network of CAM providers.

Additionally, payers can also send out a request form to their policyholders asking for a list of CAM providers that they are already using. This is an inexpensive way of starting the process of building regional networks of CAM providers. You may want to do an unannounced site visit to be sure that the CAM provider's office and facilities are satisfactory. Be advised not to expect most CAM providers to understand professional record keeping unless they have already been accepted and trained by an NCQA certified provider network. Remember, most of these providers have not been part of the system and haven't been trained to process paperwork.

SCOPE OF PRACTICE LAWS

Although MDs and Osteopaths are governed by similar scope of practice laws in all states, CAM providers are governed by a different set of laws in each state. And these laws are rapidly changing. National associations of providers are often a good source of information on licensing requirements.

State licensing boards commonly have access to this information, but it is difficult to find the right person who is willing to go and retrieve it. State officials may send entire documents that require days to read while attempting to answer more detailed questions such as: What are the limitations on diagnostic authority for chiropractors in New York? While information gathering can be a laborious process, the process has to be repeated for each practitioner type each year as legislation changes annually.

PLAN DESIGN

Before a plan of benefits is considered, a company needs to look at claims experience. Consider allowing access to CAM for those problems that are big-ticket items for your plan. There are medical management companies with experience in benchmarking a plan's most expensive medical treatments and suggesting CAM treatment protocols in an effort to reduce costs.

High initial co-pays are another plan design feature that will keep employees or policyholders from abusing access to certain CAM benefits. The obvious example of a treatment which could easily be abused is massage therapy (all of us would love to have a massage every week). Consider a 50% co-pay for massage therapy tied to some well defined health problems.

Flexible medical spending accounts are another good way to encourage employee access to CAM benefits. If a provider network is used, the employer can pay the claims from these accounts and capture the data to compare to conventional medical services.

CLAIMS PROCESSING AND DATA CAPTURE

The CAM coding system (ABC-Codes) developed by Alternative Link LLC is the only known source of coding that describes the patient encounter with alternative medicine providers. The codes can be compared with conventional claims to determine the most cost-effective services. The ABC-Codes are compatible with the HCFA 1500 and the UB-92. Payers can also separate the CAM claims by provider type since special code modifiers provide that important information. With this data payers can track which CAM providers are getting the best results for each health problem. Comparisons of the cost-effectiveness and efficacy of both CAM and conventional medicine treatments can also be made.

Alternative Link's ABC-Codes also cover an expansive list of homeopathic remedies, herbs, vitamins and botanicals – including codes for prescription, recommendation, dispensing, and compounding these products. The use of herbal and vitamin-based remedies represents a significant and ever-growing, market segment, and Alternative Link has already coded more than 1,300 homeopathic remedies, 345 Oriental herbs and botanicals and 228 Western herbs and botanicals. Specific brands and products can be coded individually for detailed tracking. The coding system allows the payer to track the use of these products from prescription to result, providing valuable data relating to the medical and financial performance of each product.

LET DATA DRIVE YOUR MODEL

A handful of companies have been too ambitious and have stumbled because of lack of sufficient data. Plan to learn from the experience instead. Business units should be trained to monitor CAM benefits for employee satisfaction. Think of the first year as a test and try several different approaches to see which work best (*see Implementing the Plan below*). A plan implemented in California may be a lot different than one offered in Texas. Ask employees if they want the services about to be offered and ask the CAM providers to describe their most successful treatments. A formal survey of participants and providers may be the best method to properly ascertain which offerings would benefit everyone the most.

CONCLUSION

Offering CAM benefits to employees makes sense in a labor market where benefits offerings are under close scrutiny. However, for some administrators, the mere thought of Complementary/Alternative Medicine offerings are a road filled with peril and potholes as CAM benefits are really an emerging offering. Information sources are not as readily available, or linear, as those which address traditional healthcare services. No one has access to statistical data about CAM yet, and that's the problem. The insurance industry is very good at predicting exposure, and CAM can be measured for effectiveness and compared to conventional medicine. Data needs to be gathered, compiled, and analyzed so that programs can be effectively designed and implemented. Those measures are the key to a successful CAM benefit structure.

Implementing the Plan

Evaluate Your Results Year by Year

Year One: Try riders and dollar limits for certain services, but let CAM providers compete with conventional practitioners to reduce costs for specific health problems. Develop a structured process for all those involved to offer suggestions to make the CAM benefits more efficient. Reward innovation and cooperation.

Year Two: Make the medical management unit that reviews these claims a partner in the decision making for the plan. Have them teach the providers to gather and capture treatment data and associated cost. This will allow the medical managers to compare the proposed treatment to conventional treatment outcomes. Adjust co-pays to discourage or drive patients toward certain treatments.

Year Three: Move statistically effective treatments into core benefits and delete those that were not cost effective. Try treatments under riders that haven't been part of the experiment. Moving these pieces of CAM around in a logical way will allow control of costs at all times while promoting long term savings with effective CAM treatments.

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alternative medicine and e-commerce together

Alternative Link sorts out CAM's specific demands and creates a billing and coding database for payers

by Meredith Rolley

Advances or absences in e-technology are often the engines driving ever-new considerations in healthcare business from the drawing board to the workplace to the bank.

In the case of the business of complementary and alternative medicine (CAM), the matter that has been holding it in economic quarantine is not belief or philosophy. Those forums are still buzzing away under the hot lights of the media, but much closer to the bottom of the business food chain. A tool for accurate and legally compliant claims processing has been missing e-commerce link preventing CAM's full integration into healthcare business - until now.

Recently, a small privately funded family firm in Las Cruces, N.M., Alternative Link has created a model for CAM claims processing and reimbursement which is being considered for the national standard for electronic processing of CAM claims for payers and providers.

Demand for CAM. It would be tough to grasp the potential impact of this little company's invention without some update of CAM business and the factors surrounding its integration into mainstream medicine.

For some time now insurers have been lined up to meet the public's demand for CAM services in health plans. A study done by David Eisenberg, director of Harvard Medical School's Center for Alternative Medicine Research, was published in the Nov. 11, 1998, issue of the *Journal of the American Medical Association*. It describes Americans in the 90s making more visits to CAM practitioners than to primary care physicians - and spending $27 billion out of pocket to do it.

A 1999 survey of HMO executives funded by Landmark, a CAM services organization and specialty health plan in California, showed that 38% of the respondents reported that they offered CAM because of patient demand.

Consumer demand for CAM is further evidenced by the growth of Discounted Fee for Service networks, smart cards and legislative mandates over the last two years. So why aren't CAM claims 'business as usual' for payers?

It turns out that CAM business has its own specific administrative and legal demands, separate and different from those of conventional medicine

Existing payer systems, Medicare and Medicaid can't add CAM benefits without the descriptions of treatments performed by CAM practitioners put into a standardized vocabulary, identified with training standards, and given corresponding codes with relative value units. Further, each states' licensing and scope-of-practice laws (different in every state) must be part of that vocabulary. Finally, the capture of outcomes data such as cost-effectiveness and treatment efficacy - critical for payers to underwrite the cost of adding CAM - have been nonexistent.

The electronic procedural billing codes such as the ones used for conventional medicine are not adequate for the requirements of CAM.

Payers throughout the country are having a very difficult time processing CAM claims, according to Jan Thorpe, executive director of Alternative Healthcare Systems of Maine Ltd. "We will never integrate CAM nationally until we can validate and process claims nationally," Thorpe says.

According to John Weeks in the July 1999 issue of *The Integrator - for the Business of Alternative Medicine*, "The question was not if somebody would develop a set of procedure codes for CAM, but who and when."

The "who" in Weeks' question was insurance visionary Jo Melinna Gianinni, president and founder of Alternative Link. The "when" was June 22, 1999, when Gianinni's electronic CAM billing codes (ABC) and accompanying CAM-designed database system (CAM-net) received a U.S. patent provisional in 90 foreign countries.

The best minds consistently work from an acknowledgement of the future. The most visionary of them devise solutions.

Gianinni perceived this simple truth: Codes equal payment. After 4,000 codes and three years of sweat, the result is a database system providing legal, regulatory and educational support to payers and providers for CAM claims processing.

Even before the patent became final, Gianinni's system was voted into the American National Standards Institute's Implementation Guide For Electronic Standards, and accepted into the National Library of Medicine's Unified Medical Language System. Gianinni's system is being considered for a Level One national standard for billing codes by the Department of Human Services, which administers the Health Care Financing Administration, which in turn governs Medicare and Medicaid.

Alternative Link's ABC codes are the only CAM code set being considered. If selected as the standard, this would mean that by 2002 the billions of potential electronic CAM transactions would each generate fees for Alternative Link.

Motivated by a desire to see CAM practices and treatments available to consumers in all health plans, Gianinni has been an insurance innovator from her early days with New England Financial Group in Albuquerque, N.M.

According to a March 1999 article in *Physician Manager*, "Alternative Link has created the first independent third-party coding system for alternative medical treatments. The system of 4,000-plus codes has attracted government attention, and if widely implemented could make insurance coverage of AltMed routine."

"There has been no legal or regulatory infrastructure upon which CAM business can develop," Thorpe says. "Gianinni, with her CAM-net and ABC codes, has resolved a host of thorny issues for CAM."

The Alternative Link codes will be useful to all healthcare players that process claims, according to Brian Klepper, president of Health Performance Inc., specializing in the construction and repair of MCOs, such as clearinghouses, router, utilization management firms and health plans.

"Gianinni's work is the key to the administration level of the integration of CAM and existing healthcare systems," Klepper says.

"We don't want to anticipate disaster, but between 1997 and 2007, it is estimated that the costs of healthcare will double," *The Integrator's* Weeks says. "There will be segments of the mainstream payment delivery system that will be ready and willing to investigate CAM more thoroughly as an answer to their cost problems. Those that do so will find Alternative Link's codes and database a handy tool."

The Health Insurance Portability and Accountability Act, passed by Congress in 1996, mandates standardization for coding systems and electronic claims transactions, and imposes civil and criminal penalties for misrepresentation. The goal is to reduce insurance fraud, but well-intentioned violations of their rules are easy to make.

"HCFA forms now include a backpage notice that each of 10 billing line-items can be separately charged as fraudulent acts, with penalties as high as $10,000 per line-item. That's $100,000 per page in maximum penalties, a daunting prospect for alternative providers who may be just trying to do the right thing by using conventional code approximations of treatment," said an article published in the Feb. 1998 issue of *Advance, Health Information Professionals*.

Payers will make it a priority to meet legal compliances regarding their electronic commerce, consequently expediting Alternative Link's market acceptance and implementation, says Jack Scanlon, vice president, EDI-USA, routers for about 95% of claims for Blue Cross and Blue Shield, as well as claims for private payers. EDI and Alternative Link have a contractual agreement for future claims delivery.

Opportunities for big payers. "Alternative Link offers a great opportunity to the big payers," Scanlon says. "The final compliance guidelines for the mandates of HIPPA are due out this year. Therefore, payers will be focusing on compliance with electronic billing code standardization. Enter Alternative Link with a resolution, a most fortunate incentive for the huge payers like Aetna, Blue Cross and the big TPAs to implement CAM-net and the ABC codes."

According to John St. George, president of St. George Consulting, "Alternative Link's products perform a service to CAM. CAM business now can take advantage of the cost-saving electronic advantages that other healthcare providers have. E-commerce for CAM will reduce costs of doing business and introduce more resources for healthcare delivery."

The best advice for healthcare players wanting to enter the alternative medicine marketplace is "know the legal parameters in your state or find somebody who does," Gianinni says.

She says beware of "CAM grafting," a phrase coined by Weeks referring to programs like Discounted Fees for Services (DFS), which tack CAM onto programs but fail to integrate them on a legally compliant administrative level.

"DFS is a quick fix devised to market CAM services in exchange for referral volume for providers," Gianinni says. "It is not insurance coverage and it creates more problems than it solves. Foremost is the absence of outcomes data in the DFS model. This is counter-productive to the future of CAM business. Without accurate descriptions of the patient encounter, there is no way to evaluate the CAM treatments you've added to your plan.

"As long as underwriting experience is the measure of treatment protocols, a method is required to connect CAM treatment plans to coded procedures," she says. "When cost is attached to the CAM codes, conventional data can be used as a benchmark to allow or disallow treatments. You must have the data underwriters require for integration of CAM."

Overall, Gianinni says, "the well-conceived plan including CAM must be merged with network development, contracting, coding, pricing, medical management and experience to integrate CAM services into a productive interface with conventional medicine."

Alternative Link's system has been designed to plug into conventional claims processing systems without the need for extensive and costly changes in software.

"It is much less costly to have a system that allows all stakeholders to continue 'business as usual' without revamping current systems," says Judy Lee, director of research for Alternative Link.

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BIOMEDICAL THERAPY

Business Model Allows Full CAM Integration

Meredith Rolley

Medical billing codes have been devised for two reasons: as tools for the settlement of claims for compensation dependent on the codes' ability to communicate information pertaining to diagnostic and therapeutic procedures, and for clear outcome data related to the analysis of efficacy of treatment as well as measures of cost-effectiveness for underwriters.

For over 35 years, the Current Procedural Terminology codes (CPT™) have dominated medical billing codesets for conventional medicine. The CPT™ codes, published by the AMA since 1963, "were developed in response to demands of physicians and agencies for a uniform system of terminology and coding to be used in the reporting of diagnostic procedures and treatment," according to an article on CPT™ in *JAMA,* May 4, 1970. The system has continued to grow and evolve, becoming the basis for e-business in conventional medicine.

The altruistic tone of this 1970 JAMA article, written when the AMA's new system was in its infancy, and its impact on healthcare seems appropriate and sincere. The writer even invites input from the medical community: "Suggestions for the development of future editions of CPT™ will be appreciated by AMA, including new terms and special arrangements. Indeed, a constant flow of stimulating information and recommendations will keep CPT™ current and vitalized."

This year the first complete system of medical billing codes for complementary and alternative medicine has emerged as a result of the efforts of Jo Melinna Giannini and her staff at Alternative Link, LLC. This new service affords the full integration of CAM in the healthcare system after decades of struggle in this area.

The origins of Ms. Giannini's idea for this world-changing project lie in a personal health experience: "In 1992 I developed a very painful kidney problem which started as water retention and discomfort. By May of 1994 the situation had escalated to inability to void fluids, mental confusion, constant pain, and depression. I had had three rounds of tests that included sonograms, cystoscopy, and x-ray flow tests. No diagnosis was ever formulated in all that time. But I was given five rounds of penicillin. I kept getting sicker and sicker. Finally, a friend recommended that I try an alternative M.D., in Roswell, New Mexico. Within two weeks, I had lost 14 pounds of fluid, had gained control of my problem, and felt better than I had in over two years. The holistic practitioner had made me responsible for my own care and I felt empowered versus helpless. Her entire course of treatment, including herbs, injections, follow-ups, and adjustment of dosages was less than $500.00. The previous two years had cost my insurance company $15,000. They happily paid for the tests, doctors, and drugs that did not improve my condition, but were unwilling to pay for alternative treatments."

"The idea dawned on me that if alternative treatments were reimbursable by insurance companies, this was the answer to the health care crisis. *Codes equal pay* was the way it danced in my head. Since that time, the people and support have come together, resulting in the ABC™ coding system."

Alternative Link, LLC was founded in 1996 by Ms. Giannini. Since then, she and her company have developed the ABC™ codes, exclusively for CAM. Simultaneously, this privately-owned company has developed software to support alternative healthcare billing, reimbursement, and office management functions. They have produced a database system (CAM-net™) that is compatible with existing mainstream healthcare systems and facilitates third-party reimbursement decisions for CAM.

The ABC™ billing codes and the CAM-net™ database system have the ability to resolve a host of thorny issues for CAM business. The ABC codes were not designed to replace any existing billing system, but to fill in all the content gaps that exist in current billing methods for CAM modalities. The ABC™ codes provide accurate description of the patient encounter with CAM practitioners of 13 different modalities.

Correct and accurate CAM billing codes and claims support equal reimbursement and legal compliance. Correct and accurate CAM billing codes lead to outcome data, critical to the future of integrated medicine. This level of data capture will show payers actual costs and outcomes by provider type. Without such data, premiums for CAM cannot be set, underwriters cannot develop CAM policies, and meaningful comparisons cannot be made between CAM and allopathic medicine.

Physicians using more and more CAM procedures and products are concerned about their billing methods complying with HIPAA (Health Insurance Portability and Accountability Act) mandating that a "coding must accurately reflect the actual patient encounter." The urgency for compliance is highlighted by civic and criminal penalties for billing misrepresentation, intentional or otherwise, under the HIPAA laws.

The disciplines that CAM-net™ links with the state-by-state scope of practice laws include but are not limited to acupuncture, holistic medicine, massage therapy, homeopathy, naturopathy, ayurvedic medicine, chiropractic, and midwifery. The Nursing Intervention Classification (NIC) codes, Home Health Care codes, and the OMAHA community nursing codes have also been incorporated into this system to meet state compliance laws.

Relative Value Units have been assigned that tie Alternative Link's coded services to conventional pricing (similar to pricing mechanisms attached to CPT™).

CAM-net™ was built to plug-in to existing health care software, and supplies all legal and educational support for payers, providers, and stakeholders, throughout health care.

The approximately 4300 codes include codes for the prescribing, dispensing, and compounding of homeopathic remedies, herbs, and botanicals. Alternative Link has coded over 1300 homeopathic remedies, over 345 Oriental herbs and botanicals, and 228 Western herb and botanicals. They are also now inviting private companies to enter product coding into the system. . .

Alternative Link's system has been voted into the American National Standards Institute Implementation Guide for Electronic Standards (ANSI) and accepted into the National Library of Medicine's Unified Medical Language System. Of the codes sets being considered for an additional Level One National Standard code set, Alternative Link's compilation is the only system offering CAM codes and billable nursing services.

According to John Weeks, distinguished spokesperson for CAM business and publisher/editor for *The Integrator*, "We need to move CAM out of economic and philosophical quarantine. This requires a deeper belief within health care (already held by the patient) that CAM can not only serve the patient but can create a better health care system. The use of Alternative Link's CAM codes assures greater value for integrated medicine than most managed care executives and others in decision-making positions could know."

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