

# Summary Report of the First Annual Integrative Medicine Industry Leadership Summit

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

May 2000

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## **Report**

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## **Executive Summary**

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

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

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

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

## **Findings and Recommendations**

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

1. **Consumers will continue to drive integration.** Most integration activity, whether through personal choice of individuals or through institutional initiatives of employers, managed care, or mainstream delivery, will continue to be driven by consumer demand.  
*Recommendation:* The emerging industry must enhance its ability to capitalize on consumer interest.
2. **Employers, next to consumers, are the industry's optimal stakeholder partners.** The employer's interest in performance -- productivity, functionality, diminished absenteeism, increased quality of life -- make this stakeholder the most productive partner for the industry's efforts to prove its value as effective and cost-effective treatment.  
*Recommendations:* Find CAM users in the employer community with whom to partner in demonstration projects. Integrate CAM into wellness programs and disease management initiatives. Consider onsite programs.
3. **Success for the industry will require increased inclusion in mainstream payment and delivery.** The integration industry will not succeed solely on alternative medicine's historic business model of cash payment and referral by self/family/friend.  
*Recommendations:* Supportive data and strategies for implementation must be developed to increase third-party payment and create shifts in physician referral patterns.
4. **Present incentive structures in mainstream delivery cause significant resistance to integration.** Despite support from health system's executive teams and subsets of physicians, integration of CAM services into delivery is frequently experienced as a challenging battleground.  
*Recommendations:* Health system budgeting is wise to assume slow adoption of integrative approaches by system physicians. Good research without the trust of physicians in new

approaches may be meaningless. Significant resources must target relationship development. Strategies include increasing provider comfort with CAM through experiential programs to “heal the healers” and placing CAM in health system benefits packages to promote personal use and understanding of CAM among the organizations’ providers and staff.

5. **An employer move toward “defined contributions” would boost covered CAM services.** The current system in which employers define benefits artificially suppresses demand for CAM. Expansion of covered CAM services is slow. *Recommendation:* Consider an industry-wide initiative in support of this shift as a means of enabling consumer choice.
6. **Health services research will more rapidly create understanding of optimal integration than randomized controlled trials.** Research methodologies with the broadest possible outcomes are those that will best measure the value of integrated care. The more narrow the research environment, the less likely that CAM’s benefits will be positively viewed. *Recommendation:* Use a four-step process for research design: Begin with a target audience; choose outcomes based on their interests; collaboratively create appropriate metrics; evaluate in demonstration projects. Consider an industry-wide effort to create more federal or foundation support for the projects and questions identified by stakeholder participants.
7. **Significant pools of practical data on the cost and use of CAM already exist.** Health plans, integrative clinics, CAM providers, and third-party administrators are presently generating a tremendous amount of data. Some owners of this typically proprietary data are willing to share but do not have the internal resources to support analysis. *Recommendation:* Identify and secure funding to support this research.
8. **Demonstration projects present the optimal environment for measuring CAM’s value.** Integrative medicine’s relatively safe and relatively inexpensive approaches, compared to many new technologies, create an optimal environment for using a continuous quality improvement approach in implementing, measuring, and refining integration efforts. *Recommendation:* Establish partnerships between providers and interested stakeholders on limited projects with defined measure.
9. **Industry leaders view the ultimate success of their mission positively.** Despite significant current challenges in developing successful business models, these leaders believe their emerging industry will increasingly shape U.S. healthcare. *Recommendation:* Develop an infrastructure that will facilitate rapid sharing of best practices and successful models.
10. **The integrative medicine movement’s philosophic mission of health creation will only be successful if energized by a thriving industry of health creation.** Present healthcare economics support public and private investment in crisis medicine. Healthcare law-making, funding decisions, research orientation, and media coverage all respond to and reinforce these economic interests. *Recommendations:* Create a visionary blueprint of optimal public policy, payment, and delivery in an integrative medicine model. Develop a national umbrella organization representing integrative medicine industry stakeholders, public health, and consumers, to be the voice and force for health creation.

To follow-up on these developments Integrative Medicine has launched a forum for Summit attendees to facilitate ongoing discussion and collaboration through the firm’s website, OneMedicine.com. A second Summit has been scheduled for May 3-5, 2001. Those interested in participating may contact Tamara Swain at [tamara.swain@onemedicine.com](mailto:tamara.swain@onemedicine.com) or call 617.641.2300 extension 245.

## **Mission and Timing of the Summit**

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

### ***Emergence of an industry***

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

### ***Paradoxical trends***

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

### ***Need for collaboration***

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

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<sup>1</sup> AHA, 1999; Deloitte and Touche, 1999

<sup>2</sup> Landmark Healthcare, 1998; InterStudy, 1998

<sup>3</sup> Eisenberg, JAMA, 1998

<sup>4</sup> Eisenberg (1998), based on high end out of pocket expenses (\$34.4 billion) and RBRVs-based provider reimbursements (\$13.1 billion) for covered services.

<sup>5</sup> Based on numerous Integrator interviews and reports. For examples, see *Integrative Clinic Benchmarking Project* (February-March, 1999) and *Integrative Clinic Benchmarking Follow-up Report* (March 2000)

## **Conveners and Goals**

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

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

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

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

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

## **CAM Stakeholders: Summit Attendees**

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

To promote strategic cross-fertilization, the Summit was intentionally populated with representatives from diverse stakeholder organizations.<sup>6</sup> 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.

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

**Table 1: Summit Representation by Stakeholder Type**

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

\* Many of these representatives are involved in delivering services through integrative clinics.

^ Two were mainstream organizations; six represented national CAM professional associations.

## **Outcomes of Pre-Summit Attendee Survey**

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

### ***Major changes anticipated in conventional clinical services***

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

### ***CAM business success is linked to changes in mainstream practice***

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

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

### ***Collaboration viewed as the critical ingredient in advancement***

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

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

## **Challenges and Opportunities with Key Stakeholders**

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

The Summit's formal sessions began with an exploration of the alignment of interests, particularly economic interests, between CAM and each stakeholder group. Discussant **Sam Benjamin, MD**, whose integrative medicine experience includes CAM leadership positions in a large health system, academic medical center, and a natural products firm, bluntly distilled the challenge of interest alignment: "The issue is always going to be about revenues. (The thinking is) 'I'm not going to fight you if you are not going to take money out of my pocket. The minute you take the money out of my pocket, I'm going to do everything I can to stop you.'" <sup>7</sup> 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."

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



**Interest alignment: Highest with consumers and employers**

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

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

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

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

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

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

**Stakeholder #1: The Consumer**

The consumer is directly responsible for 80% of the dollars spent on CAM.<sup>10</sup> 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.<sup>11</sup>

<sup>8</sup> 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.

<sup>9</sup> 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.

<sup>10</sup> Eisenberg, 1998 (JAMA)

<sup>11</sup> The consumer as stakeholder was not directly represented by an organization at the Summit. However, 95% of attendees identified CAM therapies and a CAM philosophical approach as significant factors in their own personal health care choices. The CAM consumer was present in the persons of most attendees.

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

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

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

#### *Benefits from a reinvigorated consumer partnership*

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

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<sup>12</sup> "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)

<sup>13</sup> American Compensation Association, 2000. (THE INTEGRATOR, July-August, 2000)

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

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

Locate philanthropists who are CAM consumers to be significant investment partners in critical local or industry-wide initiatives<sup>15</sup>

## Stakeholder #2: The Employer

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

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

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

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

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

### *Defining and creating outcomes that employer's desire*

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

- Develop a case statement for CAM exploration by employers

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<sup>15</sup> Many health system-based integrative medicine programs presently look to philanthropy for start-up and operating support.

<sup>16</sup> American Compensation Association 2000.

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

*Opportunity for win-win*

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

**Stakeholder #3: Hospitals and Health Systems**

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

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

*Healing the healer: strategies for penetrating the resistance*

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

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

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<sup>17</sup> 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.

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

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

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

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

#### **Stakeholder #4: HMOs/Insurers**

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

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

#### *Challenges of the internal HMO environment*

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

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

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

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

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

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

#### *CAM discounts: Trojan horse for covered CAM benefits?*

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

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

#### *The opportunity*

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

### **Stakeholder #5: Public Health**

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

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<sup>20</sup> Ibid 10

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

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

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

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

Some specific recommendations in a public health/CAM partnership:

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

## **Research and Data Priorities**

### *Relationships or research?*

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

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

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

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

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

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

#### *Present supremacy of consumer use data*

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

#### *Controlled trials or utilization data*

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

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

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

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



### *Health plan data*

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

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

### *"Already a ton of data"*

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

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

## **Collaborative Projects to Move the Industry**

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

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

- non-proprietary
- collaborative

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

### *Project categories*

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

### *Influencing the nation's ability to appropriately integrate care*

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

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

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

### *Creating a collaborative force for change*

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

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

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

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

**Table 3: Projects Identified to Rapidly Explore and Expand Integration**

The following list of projects includes ideas submitted directly as a formal part of the Summit process as well as other project ideas that we referenced or were recommended by speakers. *Many projects have significant overlap. They are listed individually here to allow readers to consider the permutation which makes the most sense to them.*

*\*In the meeting, participants were asked to identify \$50,000 and/or \$500,000 projects. Some specifically noted which category they believed their projects would fall. Where they did, this is noted.*

<b>Project</b>	<b>Target Stakeholder</b>	<b>Size*</b>	<b>Comment</b>
<b>Multiple Stakeholders</b>			
Explore development of industry association	Multiple	--	Antecedent to possible formation of the group
Industry coalition/association	Multiple	--	Link stakeholders in an association that would serve as the integrative medicine industry voice, for standards, education, public relations, and research compilation.
Data and strategy consolidation	Multiple	\$50,000	Pull together and "repackage" all the most useful and available research for working with employers or with insurers.
Community coalition development	Multiple	--	Convene a community's providers and employers together with a common community-oriented focus for integration.
Create standard survey instruments for feasibility	Multiple	--	Develop separate instruments for surveying employees, employers, consumers, physicians, and administrators on openness to integration.
Summit on CAM in National Policy	Multiple	\$50,000	Similarly diverse group as the Summit, expanded, to focus only on national policy issues, particularly in light of the White House Commission. Identify issues that are impeding the development of CAM. Refine a national plan.
Model a new healthcare system	Multiple	--	Use holistic, integrative principles to create an entire delivery system for a specific population. Create the vision for re-creating the system on principles of health creation.
Voice in D.C. to create new funds for CAM health services grants	Multiple	--	Multiple contributors to expand the "pie" of federal funds for exploring real world CAM initiatives.
Create Internet-based mechanism for continued communication between attendees	Multiple	--	Committed by Integrative Medicine during summit and initiated August 2000.
Administrative process pilot	Multiple	--	Pull together diverse parties to develop strategies for streamlining administrative processes to yield greater data and data analysis of CAM.
Create optimal integrative outcomes tool	Multiple	--	Convene group to review types of validated tools (Beck depression, SF 36, etc.).
Study other emerging industries	Multiple	--	Create guidance on best practices for emerging industries.
<b>Consumers</b>			
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.
<b>Employers</b>			
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.

**Summary Report of the First Annual Integrative Medicine Industry Leadership Summit**

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.
<b>Employer/Health system</b>			
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
<b>Hospitals and Health Systems</b>			
Employee wellness retreats targeting hospital employees	Health systems	--	Program would have a "heal the healer" focus, giving hospital employees an opportunity to experience more holistic care that they might then better impart or be more open to consider providing.
Share electronic medical records for integrative clinic database	Health systems	--	Develop a shared record for use in 100+ clinics to gather consolidated outcomes and to overcome the administrative problems that limit the ability to produce quality outcomes. (Representatives of at least 20 clinics expressed interest in participating.)
Integrative clinic and CAM services data analysis	Health systems, integrative clinics	--	Provide funds for a skilled researcher to analyze 25,000 patient records in integrative clinic, 35,000-50,000 records in second clinic
Develop strategy paper on "gap funding" for start-ups	Health systems, philanthropy	--	Research best practices in creating donated funds for initial phases of integrative clinics
Create outcomes tool to apply to providers	Health systems	--	Look at the role of delivering integrative services in creating job or professional satisfaction
Develop training manual for nurses	Health systems	--	Strategy is to slowly integrate, through existing providers. Include outcomes tools to evaluate success in terms of LOS, decreased pain, and medication.
Integrate medical education	Health systems, academic medicine	--	Based on those who train together treat together.
<b>HMOs and Insurance</b>			
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.
<b>Other</b>			
Train CAM providers in outcomes research	CAM professions	--	Many are unfamiliar with basic record keeping and in use of tools to measure functionality
HCFA waiver to explore quality CAM services in a given state	Government, health plans, hospitals	--	Waivers can allow mainstream and CAM providers who are confident of their relationships to explore CAM integration into Medicaid and Medicare populations
Post a shared outcomes tool on common website	Internet, integrative clinics	--	After developing a consensus tool kit, post it for use in creating combined data

*Potential for ongoing shared work on the national scene*

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

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

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

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

<b>Question</b>	<b>Yes</b>	<b>Maybe</b>	<b>No</b>	<b>Blank</b>
<b>National Association</b> <i>/my organization would be interested in participating in a dues paying association/coalition to further interests such as those identified at the Summit.</i>	30 63%	13 27%	4 8%	1 2%
<b>National Policy Summit</b> <i>/my organization would be interested in participating in a national policy summit to clarify a national agenda for the emerging industry.</i>	29 60%	12 25%	5 10%	2 4%
<b>White House Commission on CAM Policy</b> <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.</i>	36 75%	2 4%	7 15%	3 6%
<b>Annual Industry Meeting *</b> <i>/my organization would participate in a gathering like this as an annual time for industry meeting and sharing.</i>	43 90%	5 10%	0 0%	0 0%
<b>Joint Fund to Increase Health Services Grants</b> <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.</i>	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:

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

## **Next Steps**

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

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

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

### *Future impact?*

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

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

## Appendix 1

### **Summit Leadership**

#### **Program Development**

John Weeks, Publisher-Editor  
THE INTEGRATOR *for the Business of Alternative Medicine*  
Principal, Integration Strategies for Natural Healthcare, Seattle, WA

#### *With support from:*

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Clement Bezold, PhD, CEO, Institute for Alternative Futures  
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Sean Sullivan, President, Institute for Health and Productivity Management  
Corrine Bayley, VP, St. Joseph Health System  
Brian Berman, MD, CAM Leader, Cochrane Collaboration, U Maryland  
Anna Silberman, VP, Highmark Blue Cross Blue Shield  
Robert Stern, DC, CAM Leader, Anthem Health Plans  
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Mort Rosenthal, CEO, WellSpace  
Candace Campbell, Executive Director, American Preventive Medicine Association  
Henry Ziegler, MD, MPH, Leader, CAM-Public Health Exploration

#### **Co-Facilitators**

John Weeks, Clement Bezold, PhD

#### **Onsite Program Team**

John Weeks, Clement Bezold, PhD, Jery Whitworth, RN, CCP, Marcy Robinson, Sue Fleischman

#### **Management**

Marcy Robinson, Charlie Priester (Integrative Medicine Communications)

#### **Pre-Summit Survey and Data Collection**

John Weeks, question development  
Charlie Priester, administration

#### **Other Sources of Informal Pre-Summit Consultation on Program Plans**

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Appendix 2

**Summit Attendees**

Peter Amato  
CEO  
Inner Harmony  
Clarks Summit, PA

Sita Ananth, MPH  
Director of Education  
Health Forum  
San Francisco, CA

Linda Bark  
Co-Founder & Co-Director  
World Health & Healing Collaborative  
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\* Following the Summit, Janice Stanger, Sam Benjamin  
and Jery Whitworth have moved on to new positions  
elsewhere.

### Appendix 3

#### **Primary Summit Sponsors**

**Integrative Medicine Communications** 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, Integrative Medicine 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. More information is available at [www.onemedicine.com](http://www.onemedicine.com)

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

#### **Supporting Sponsors**

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

**Angela A. Mickelson/HL&B** is a principal in the health care law firm of Hooper, Lundy & Bookman, Inc. HL&B, based in Los Angeles, California, is the largest healthcare law firm in the country dedicated exclusively to representing the interests of institutional and professional providers, provider associations and political subdivisions in healthcare business, regulatory, and litigation matters. Ms. Mickelson specializes in HMO and other managed care system

development, licensure, regulatory compliance, contracting and business counseling. She also maintains a general business practice, with emphasis in the areas of conventional and integrative medicine provider organizations, business acquisitions and sales, tax-exempt organizations and financing, corporate restructurings, affiliations and joint ventures, and business development and operations.

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

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

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

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

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

More information is available at [www.ihpm.org](http://www.ihpm.org)

Appendix 4

**Selected Findings from a Pre-Summit Survey of Attendees**

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

<b>Area/Assertion</b>	<b>Strongly Agree</b>	<b>Mildly Agree</b>	<b>Neutral</b>	<b>Mildly Disagree</b>	<b>Strongly Disagree</b>
<b>CAM and Conventional Practice</b>					
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%
<b>Employers</b>					
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%
<b>HMOs and Insurers</b>					
Most of consumer use of CAM will always remain outside the mainstream payment and delivery system.	2 3%	21 34%	6 9%	22 36%	10 16%
Increasing third-party CAM payment and delivery system CAM integration beyond the current status requires more controlled clinical trials on CAM.	19 29%	26 40%	4 6%	12 18%	3 4%
The most significant cost savings from CAM will be from the treatment of chronic conditions like arthritis, adult onset diabetes, and heart disease.	21 33%	25 39%	10 15%	4 6%	3 4%
The only way CAM providers should get involved with managed care is through negotiating special arrangements that reflect the complexity of CAM's distinctive services.	17 26%	14 22%	13 20%	13 20%	6 9%
For CAM integration through networks to be optimized, CAM networks must take the leadership role in analyzing and publishing outcomes.	42 64%	15 23%	4 6%	2 3%	2 3%
Significantly increased CAM participation in third-party payment structures is critical for the success of CAM's mission.	26 41%	16 25%	4 6%	13 20%	4 6%
We already have significant research data on many CAM approaches which convincingly argue that these approaches should be substantially more widely utilized and reimbursed now.	24 38%	25 39%	6 9%	7 10%	2 3%
<b>Government/Federal Research</b>					
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%

**Summary Report of the First Annual Integrative Medicine Industry Leadership Summit**

(continued ...)

<b>Area/Assertion</b>	<b>Strongly Agree</b>	<b>Mildly Agree</b>	<b>Neutral</b>	<b>Mildly Disagree</b>	<b>Strongly Disagree</b>
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%
<b>Partnership and Collaboration</b>					
In my day-to-day work in CAM I feel isolated from other members of the CAM industry.	4 6%	19 29%	15 23%	15 23%	11 17%
I currently am directly engaged with at least one project that formally involves at least one organization from another stakeholder category.	57 89%	7 11%	0 0%	0 0%	0 0%
I currently am directly engaged with at least one project that formally involves an organization which is in my own stakeholder category.	46 75%	15 25%	0 0%	0 0%	0 0%
My own business success would benefit from partnerships and collaborations with members of other stakeholder groups.	50 75%	11 16%	3 4%	1 1%	0 0%
My business success can be enhanced through greater collaboration with other organizations within my own stakeholder group.	39 60%	10 15%	9 14%	4 6%	2 3%
Success in our mission and our business will be linked to our ability to overcome our present atomization and become exceptionally successful collaborators.	47 73%	9 14%	7 10%	1 1%	0 0%
<b>Future of Healthcare and CAM Integration</b>					
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%
<b>Personal Experience</b>					
CAM therapies and a CAM philosophical approach are significant factors in my own personal healthcare choices.	43 67%	17 26%	3 4%	0 0%	1 1%
Creating a financially successful business in CAM is harder than I expected.	22 34%	16 25%	14 21%	9 14%	2 3%

## Appendix 5

### **Summit Program Description**

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

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

##### **Assertion:**

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

##### **Objectives:**

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

##### **Perspectives and Questions:**

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

##### **Discussants**

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

#### **2. INTEGRATION AND TRANSFORMATION IN MAINSTREAM DELIVERY**

##### **Assertion:**

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

##### **Objectives:**

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

##### **Perspectives and Questions:**

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

##### **Discussants:**

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

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

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### 3. INTEGRATION AND TRANSFORMATION IN MAINSTREAM PAYMENT

**Assertion:**

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

**Objectives**

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

**Perspectives and Questions:**

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

**Discussants:**

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

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### 4. COLLABORATION, PARTNERSHIPS, PROJECTS AND PUBLIC POLICY

**Assertion:**

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

**Objectives:**

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

**Perspectives and Questions:**

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

**Discussants:**

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