Integrative Medicine Industry Leadership Summit 2001 Report

A SPECIAL SUPPLEMENT TO

ALTERNATIVE THERAPIES
IN HEALTH AND MEDICINE

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SPECIAL STATEMENT

DESIGN PRINCIPLES FOR HEALTHCARE RENEWAL: DRAFT

(note 1)

Preamble

Core principles drive the way healthcare operates and is experienced. Times of change and disturbance call us to examine, clarify, and commit to renew our individual and community practices. The following set of principles emphasizes the integrative nature of optimal healthcare. Such care seeks to create health by engaging new and old approaches to health for the individual, system, community, and environment. Integrative care is grounded in relationships, seeks sustainability, is energized by the unknown, and is crafted through continuous exploration of strategies for uniting the best of the world's evolving practices, outcomes, and traditions.

Principles. These principles, based on a review of the missions and visions of 34 diverse stakeholders, are an initial expression of an effort to create a unifying view of a renewed system for healthcare delivery and payment. These principles are meant not as ideals, but as working tools of design, application, evaluation, and alignment. They are offered here for community review, revision, and amendment by the ad hoc Working Group on the Design Principles of Healthcare Renewal, which grew out of the Integrative Medicine Industry Leadership Summit 2000.

The design principles for accelerating health and well-being in individuals and the health system are as follows:

1. Honor wholeness and interconnectedness in all actions. Body, mind, spirit, community, and environment are an integral whole that cannot be separated into isolated parts. All are involved in healing. Healthcare interventions, regardless of their focus, affect the whole.

2. Enhance the capacity for self-repair and healing. The innate capacity for healing and the individual's personal empowerment in supporting these natural processes are fundamental considerations in all healthcare decisions.

3. Prioritize care in accordance with a hierarchy of treatment. Care and the leveraging of resources to affect care is prioritized along diagnostic and therapeutic hierarchies that begin with education and empowerment in healthy choices, then move to the least invasive approaches, escalating, as necessary, to approaches linked to the increased likelihood of adverse effects or higher costs. The starting point for intervention is established through clarifying, in cooperation with the individual receiving care, the risks associated with foregoing—and undertaking—more invasive approaches. Chronology and cause are fundamental aspects of this healing order.

4. Improve care through continuously expanding the evidence base. Healthcare is a combined art and science in which personal practices and clinical choices and services are continuously evaluated and improved by practitioners, users, and organizations, based on diverse evidence. Included are the desires, perceptions, and outcomes experienced by the individuals at the center of care, the clinical experience and understandings of all members of a provider team, and systematically gathered evidence of experience and outcomes. More stringent evidentiary standards are associated with higher risk or more costly interventions.

5. Embrace the fullness of diverse healthcare systems. Conventional, traditional, indigenous, complementary, and alternative models of care (and their bodies of knowledge) have contributions to make to the healthcare that is culturally most appropriate and effective for individuals and communities. Best practices are discovered through exploring diverse structures for integration including parallel, collaborative, and assimilative models.

6. Partner with patients, their families, and other practitioners. Caregivers profoundly enhance healing and strengthen shared accountability through supporting the informed decision making of the individuals, families, and loved ones they serve, and through inclusive, respectful partnerships with other practitioners with whom they collaborate in care provision.

7. Use illness and symptoms as opportunities for learning and growth. Illness represents an opportunity in which healing and balance are always possible, even when curing is not. Symptoms are guides to health.

8. Explore integration in one's own care. Practitioners, administrators, and individuals are most effective in understanding and delivering integrative healthcare and in embracing these design principles when they follow these principles in their own care choices.

9. Align resource investment with these healthcare principles. The renewal of our healthcare payment and delivery systems is fostered by aligning resource investment—in the personal, public, philanthropic, and private sectors—with these principles. Humble willingness to work to resolve the tensions between one's personal and professional interests and those shared interests expressed in these principles is required of all participants. The renewed healthcare system is a partnership between an expanded commitment to the public health and a thriving industry of health creation.

10. Respect the time required for personal and health system change. Interventions may be swift, but healing, habit change, and transformation take time and ongoing commitment.

Acknowledgments

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INTEGRATIVE MEDICINE INDUSTRY LEADERSHIP SUMMIT 2001

John Weeks

John Weeks is a principal with the Collaboration for Healthcare Renewal Foundation, a nonprofit initiative dedicated to forming collaborative efforts that foster integrated healthcare. From 1996 to 2001, Weeks, based in Seattle, Wash, produced a monthly newsletter, *The Integrator* viewed as the journal of record on practical challenges and opportunities encountered in integrating complementary and alternative medicine and its providers into the mainstream payment and delivery system.

More than 100 representatives of 90 organizations in the emerging integrative medicine industry met in Scottsdale, Ariz, in May 2001. The goal was to examine the state of the business of integrative medicine and to explore opportunities for collaboration. During the 3-day meeting, the 105 participants contributed to interactive panel discussions, reviewed operating principles of 33 healthcare organizations, evaluated a draft statement of design principles for healthcare renewal, and drafted consensus statements on such topics as complementary and alternative medicine (CAM) reimbursement and integrative clinics. By the end of the meeting, several participants agreed to continue their cooperative efforts in working groups established by the new, nonprofit Collaboration for Healthcare Renewal Foundation (CHRF).

Summit 2001 participants were selected to represent the breadth of the integrative medicine industry (Table 1). Nearly half of the attendees were healthcare providers: 20 medical doctors, 10 nurses, 8 naturopathic doctors, 7 chiropractors, 2 osteopathic doctors, 2 licensed acupuncturists, and 1 massage therapist. Eight participants had advanced degrees in public health. More than half of the invited organizations also attended Summit 2000; their continued presence established a sense of continuity and trust.[1] The 2000 and 2001 Summits were convened by the author with the financial support and administrative backing of Integrative Medicine Communications of Newton, Mass, and other supporting sponsors (Table 2).

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METHODS OF STIMULATING COLLABORATION

Three tools were used to engage the collaborative energy of participants: biographical sketches, a pre-Summit survey, and a review of principles. Each of these is described below.

Biographical Sketches

Before the meeting, participants were provided with short biographical sketches of all attendees, including contact information. Informal comments during the meeting suggest that many participants used this information to begin networking with each other.

Pre-Summit Survey

A survey of participants' perceptions and priorities concerning CAM was also administered before the 2001 Summit (Table 3). Of the 105 participants, 81 (77%) responded. Survey findings suggest that Summit participants may have priorities that are not well reflected in current action. Areas of agreement are summarized below.

Research. Participants would significantly reorient present CAM research priorities around real-world explorations. More than 50% believe that a majority of federal research funding should be for such health services exploration. Notably, more than 93% believe that research with broad outcomes (eg, functionality, productivity, satisfaction, cost, cost offsets) is more likely to show CAM in a positive light than is research that focuses on biomedical indicators. When asked for an ideal distribution of CAM research dollars, 29% thought one fifth and 15% thought four fifths of available funds should go to randomized controlled trials (RCTs). None of the survey respondents thought all research funding should target RCTs.

Interest Alignment With Employers. The consumer, not surprisingly, is viewed as having the strongest interest in the emerging industry. Ninety-four percent of respondents ranked consumers as the primary or secondary stakeholders in this industry. Employers were ranked second by 40%, followed by government and public health agencies (23%), hospitals and health systems (17%), and managed care and private insurers (16%). This finding suggests that mainstreaming and integration may be effected best through "demand side approaches," meaning that those who promote integration may be best served by developing strategies that appeal to the consumers and employers who purchase healthcare rather than focusing on changing the patterns of those vested in the current medical-economic structure.

TABLE 1 Participants by stakeholder type*

Hospitals and health systems	19%
Managed care/networks	19%
Integrative clinics	15%
Academic medicine	12%
National organizations (professional, industry, consumer)	12%
Information/publications	10%
Employers	5%
Government/public health/community health	5%
Natural products	3%

* Consultants are grouped by the stakeholder type with which they most frequently work.

Economic Competition. Nearly three fourths (72%) agree that "the opposing economic self-interest of conventional medical providers and their institutions and organizations" is the "core obstacle to optimal exploration and inclusion of CAM in payment and delivery."

Need for a Distinct Policy Voice. More than four fifths view creating an ongoing, lobbying force in Washington, DC, as necessary "if CAM's mission as a transformative agent in healthcare is to be realized." CAM presently has only a limited, refracted, guild-based presence in national policy.

Health Promotion. With near unanimity, the group supports a stronger affiliation of the emerging integrative-medicine industry with efforts to enhance federal support for primary prevention and health promotion.

Economic Viability. More than 80% of the respondents replied that their businesses were doing better than a year ago. In addition, very few believe their businesses have been harmed by the general economic downturn.

TABLE 2 Summit 2001 sponsors

Primary

- John Weeks, *The Integrator*
- Integrative Medicine Communications (http://www.onemedicine.com)

Supporting

- *Alternative Therapies in Health and Medicine*
- American Specialty Health, Inc
- Angela Mickelson (Hooper, Lundy, and Bookman, Inc)
- Bastyr University
- Cancer Treatment Centers of America
- Health Business Partners
- Health Forum/American Hospital Association
- Inner Harmony Wellness Center
- Institute for Health and Productivity Management
- National Integrative Medicine Council
- Triad Healthcare, Inc

Percent of Healthcare Premium That Should Cover CAM or Integrative Services. Twenty percent of respondents believe that CAM and integrative care should be reflected in at least 25% of premium dollars and 30% of respondents put the figure at 50%. Another 9% of respondents thought that more than 50% should be used to reimburse CAM or reflect integrative approaches.

Review of Design Principles

Before the Summit, participants were asked to examine the principles that underlie their work. Organizations that promote new methods of delivering healthcare services are increasingly recognizing the value of clarifying and articulating these fundamental principles. The principles are seen, as one participant put it, "like an acupuncture treatment that opens up energy and allows the collaborative work to get done."

During the opening session of the meeting, representatives of 33 organizations, most of them Summit 2001 participants, mounted posters listing their corporate principles on the walls of the main meeting room. Six participants spoke about their own organization's guiding principles. Following this review and discussion, participants evaluated the newly drafted Design Principles for Healthcare (see sidebar), which provided a reflective basis for the practical issues explored at Summit 2001.

PANEL DISCUSSIONS

Five interactive panel discussions were held during Summit 2001. The topics and panelists are listed in Table 4.

CONSENSUS STATEMENTS

In a series of 4 breakout sessions, participants discussed opportunities, obstacles, best practices, successful tools, and collaborative strategies for advancing their shared interests. Meetings lasted 4 to 5 hours, during which groups of 15 to 30 participants developed consensus reports that were later drafted by the session facilitators. The consensus reports follow.

Employer/Managed Care CAM Networks

This breakout group's assignment was to explore the current environment for coverage of CAM and integrative services with the goal of identifying practical steps to facilitate a qualitative expansion of existing CAM products and services into major payment systems.

Current Status. The group characterized the current state of the industry as being "in the middle of the beginning." The consumer is "carrying the day," with employers using CAM benefits as tools for recruitment and retention, rather than as methods to improve care or to lower cost. Health maintenance organizations (HMOs) and insurers, in response to both consumers and employers, add CAM benefits as value-added services to increase market share. Present success results largely from managed care networks establishing and maintaining relationships with decision makers at multiple levels within their health system or employer clients. Although the size of the CAM market has grown substantially, most activity has been in discount products

TABLE 3 Some perceptions of integrative medicine industry leaders*

Question	Strongly agree	Mildly agree	Neutral/ no opinion	Mildly disagree	Strongly disagree
White House Commission on CAM Policy The recommendations of the White House Commission on Complementary and Alternative Medicine Policy will one day be viewed as a significant, positive turning point in the inclusion of CAM in US healthcare payment and delivery.	28%	47%	21%	4%	1%
CAM Discounts "CAM discount" products offered by employers and managed care organizations, under which employees/members still pay cash for CAM products/services but get a discount off usual fees, are a reasonable first step that will lead toward more coverage and inclusion of CAM.	17%	36%	10%	19%	18%
Employers Employers can be convinced of the economic case for greater inclusion of CAM.	38%	47%	5%	9%	1%
Mission and Design Principles The emerging CAM industry will benefit through a multistakeholder process of clarifying, generating endorsement for, and publicizing a set of principles that announce a unified mission relative to the individual's healthcare experience and the reformation of the broader delivery and payment system.	52%	33%	10%	5%	0%
Principles and Financial Success The financial success of CAM/integrative healthcare will be enhanced by a focused effort to align business models with integrative principles.	57%	32%	9%	1%	1%
Research Measures for CAM CAM/integrative approaches will tend to look better in research designs that examine a broad set of measures, including such things as functionality, cost, satisfaction, cost offsets, and effects on productivity, rather than focusing solely on biomedical indicators.	66%	27%	5%	0%	3%
Third Party Payment Significantly increased CAM participation in third-party payment structures is critical for the success of CAM's mission.	55%	26%	7%	10%	1%
Economic Competition The core obstacle to optimal exploration and inclusion of CAM in payment and delivery is the opposing economic self-interest of conventional medical providers and their institutions and organizations.	33%	39%	6%	16%	6%
Policy Change 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.	52%	32%	9%	5%	2%
CAM for Pain All patients with pain, in all healthcare settings, should be introduced to a wide variety of CAM options.	74%	19%	4%	2%	1%
CAM and Health Promotion The CAM industry should strongly align itself with efforts to enhance federal support for health promotion and primary prevention (diet, exercise, stress reduction, lifestyle changes).	84%	15%	1%	0%	0%

* Participants were each electronically sent a premeeting survey to gather opinions about the industry's future. CAM indicates complementary and alternative medicine. Source: Weeks J. Pre-Summit Survey, Integrative Medicine Industry Leadership Summit 2001, May 2001.

rather than covered benefits. There are not yet enough outcomes data to demonstrate that CAM services confer medical cost offsets compared to conventional strategies for healthcare delivery.

Conditions for Expansion of Covered Benefits. The following examples indicate that CAM coverage is expanding:

- increased access to CAM services by customers of health plans
- new customers among major health systems and employers
- greater scope and diversity of available CAM products and services
- accelerated transition to supplemental riders and embedded benefits from CAM discount programs
- more meaningful and substantive integration with conventional medical services

Continued Expansion of CAM Services and Products. The following conditions are needed to ensure continued growth of CAM services and products:

- continued consumer demand
- increased education, including tools to support the decision processes for consumers, CAM practitioners, conventional practitioners, and decision makers in payer organizations
- development of improved clinical models for integration
- outcomes data that delineate the extent to which CAM products and services offer medical cost offsets compared to conventional care, are clinically effective, and shown to improve employee health and productivity as perceived by employers

Core Obstacles. Availability of adequate outcomes data is the limiting factor to expanding existing CAM products and services into major healthcare systems. The group explored reasons these data are not available, despite years of significant utilization. Several additional obstacles were identified:

- general lack of data collection and inconsistency of the data that are collected
- proprietary interests of networks, employers, HMOs, and insurers resulting in reluctance to share data
- cost of data collection and analysis
- relatively low priority given to economic outcomes, utilization issues, and influences of CAM on the global cost of health by government and other research-funding sources

Working Solutions. The group proposed 2 possible solutions to these issues.

1. Small-scale employer demonstration project. Participants considered a cooperative effort in a small-scale employer demonstration project relating to the clinical cost-effectiveness of 1 or 2 CAM modalities. The demonstration study must adhere to the following requirements:

- The study must be methodologically sound, defensible, low-cost, quick, efficient, and acceptable to large employers.
- The study must focus on an issue that is costly to large employers, such as the rapid rise in prescription drug costs or workdays lost because of repetitive stress injuries
- The data selected for gathering should be judged useful by the Society of Actuaries (SOA) CAM subcommittee (note 2).

2. Utilization and cost studies from network-delivered services. This solution was developed to overcome the lack of quality data on utilization, cost, and cost offsets.

Group participants suggested working with the SOA-CAM subcommittee on arrangements to accept, cleanse, restructure, store, select or sort, and analyze data made available by participants and other organizations. Several network, managed care, and employer participants agreed to work with the SOA-CAM subcommittee to define standards for data collection including issues related to proprietary data. Most group participants agreed that success will be optimized if network firms develop standards for data collection in their contracts with HMOs,

TABLE 4 Discussion topics and panelists

1. Clarifying Our Present Opportunity
- James S. Gordon, MD, Chair, White House Commission on CAM Policy
- Sean Sullivan, JD, CEO, Institute for Health and Productivity Management
- Mort Rosenthal, CEO, Wellspace
- Anna Silberman, CEO, Lifestyle Advantage; VP, Highmark Blue Cross Blue Shield

2. New Strategies for Covered CAM Benefits
- Anita Schambach, CAM Leader, Mercy Health Partners
- Richard Brinkley, CEO, Complementary Healthcare Plans
- James Dillard, MD, DC, Oxford Health Plans
- Richard Sarnat, Cofounder, Alternative Medicine, Inc
- George DeVries, CEO, American Specialty Health, Inc

3. The Employer Connection—Crossing the Chasm
- James Conner, PricewaterhouseCoopers
- Pamela Krol, Director of Health and Welfare Benefits, Lucent Technologies
- Mary Kelly, ND, Onsite Integrative Clinic, Husky Injection Molding
- Lee Murphy, Benefit Performance Associates
- Kenneth Pelletier, PhD, Universities of Maryland and Arizona

4. Promoting Research for Optimal Payment and Delivery
- Janice Stanger, PhD, Director of Health Services, American Specialty Health, Inc
- Christine Goertz, PhD, DC, Program Officer, Health Services Research, NIH NCCAM
- Lou Sportelli, DC, Chair, NCMIC Group; Foundation for Chiropractic Education & Research
- Wayne Jonas, MD, Uniformed Medical Services; White House Commission on CAM Policy

5. Shaping a National Agenda for an Industry of Health Creation
- Michael O'Donnell, PhD, MBA, MPH, President, *American Journal of Health Promotion*
- Peter Amato, Board Chair, National Integrative Medicine Council; founder, Inner Harmony Wellness Center
- Adam Perlman, MD, MPH, Integrative Medicine leader, St. Barnabas Healthcare

insurers, and employers, which then will provide controls for outcome studies. One goal of this initiative is to ensure that findings are made available to the public.

Various participants volunteered to support elements of the work plan, including developing a funding proposal for the project, clarifying a relationship with the SOA, enlisting the support of a set of Fortune 200 employers, providing legal analysis and support, and working with the media on announcing results for the public domain.

Alignment With the Design Principles for Healthcare Renewal. The group identified ways in which its project on CAM networks aligns with the draft of the Design Principles for Healthcare Renewal:

- The coordinated effort to accumulate and analyze aggregate outcomes data reflects an effort "to improve care through continuously expanding the evidence base" (Principle 4).
- Success will support the ability to prioritize care in accordance with a hierarchy of treatment (Principle 3).
- Success will enable payers, providers, and patients to responsibly embrace the full features of diverse healthcare systems (Principle 5).
- The results of this project will optimize the ability of all parties to align resource investment with other principles (Principle 9).
- Finally, success in working together is a step toward partnership in creating better health outcomes (Principle 6).

Facilitators. The employer/managed care CAM networks breakout group was facilitated by the following individuals: Ira Zunin, MD, MPH, MBA, Chair, Hawaii State Consortium for Integrative Health Care; Angela Mickelson, JD, Hooper, Lundy and Bookman, Inc; Janice Stanger, PhD, Director of Health Services, American Specialty Health, Inc; and Sean Sullivan, JD, CEO, Institute for Health and Productivity Management. Dr Zunin led development of this consensus statement, which was approved by executives of 16 participating firms.

CAM and Health System Change

This breakout group's assignment was to evaluate the need for changes in healthcare systems and suggest motivation and directions for change. Integrating CAM with any change in healthcare systems must be preceded by a perceived need (by patients or providers) based on pain or dissatisfaction with the current state of affairs.

Use of Principles. Exploring the principles and philosophy of integrative health is a valuable way to engage conventional practitioners in conversation, rather than initiating discussion around specific modalities and providers. Common ground can be established before entering into more difficult realms. The exploration of shared principles can help foster desirable behaviors at every organizational level, from the microscopic (one-on-one clinical interactions) to the macroscopic (interaction of organizations, coalitions, and systems). The optimal integration approach in the health system is to "think globally and act locally." Complexity theory (note 3) was viewed as a useful tool for shaping strategic thinking.

Components of Successful Integration. Specific components of successful integration models and strategies for fostering integration and addressing resistance to change were identified.

Examples of components of successful integration models include the following: use of guiding principles and philosophy (partnership, diversity, wellness-focused, consumer-focused, and consumer-centered); clear identification of internal resistance to change; sustainable financial viability, including keeping start-up costs low; documentation of clinical outcomes; recognition of the community as a stakeholder; and inclusion of practitioners who adhere to these guidelines.

Examples of specific strategies to foster integration include the following: identification of, and organizational support for, respected champions who are both passionate and tenacious; systematic communication and educational efforts, including internally focused CME and externally focused public education; "charter clinics" that are viewed as demonstration projects for promoting innovation, strategic partnering, and communication among sponsoring stakeholders (local insurers, HMOs, employers, government); offering opportunities for providers and employees within the organization to have firsthand experience with integrative care; weaving CAM integration into the health system's core business so that it is not trimmed away during lean cycles; and creating a national coalition of diverse stakeholders who abide by the principles and philosophy of integrative health in their organizational and business interactions to promote integration and change at the national health-system level.

Examples of specific strategies for addressing resistance to integration and change include the following: addressing sources of resistance individually and privately rather than generically and publicly, finding common ground, using the language of those who are resistant to enhance understanding (eg, using "improvement" rather than the negative implications of "change"), pragmatism, and patience.

Group participants shared a general sense that whereas idealists may argue that creating a parallel healthcare system is necessary because the integration of CAM cannot overcome the deficiencies and shortcomings of a broken healthcare system, integration will be more likely to produce transformative results through an evolutionary process. Idealism produces greater results when combined with pragmatism.

Facilitators. The CAM and health-system change breakout group was facilitated by Milt Hammerly, MD, Director of Integrative Medicine, Catholic Health Initiatives; and Corrine Bayley, Vice President, St. Joseph Health System. Dr Hammerly led development of this consensus statement, which was approved by breakout participants.

National Presence—Policy, Coalitions, Voice

This breakout group's assignment was to identify barriers to collaboration, common ground, opportunities for action steps, potential coalition organizations, and to form an initial shared agenda. For years, leaders of policy-related organizations involved with complementary, alternative, natural, and integrative medicine have imagined the potential for influence and change that could occur if they could raise a unified voice.

Barriers. A request for examples of historical barriers to collaboration produced a quick outpouring: actual philosophic and paradigm differences among the diverse integration interests; unfamiliarity with each other as groups; a lack of personal relationships among leaders; historic and present guild battles over scope of practice; antagonism from some CAM professions toward MDs; and fears and experiences of co-optation, devaluation, and disrespect from emerging integrative medicine interests toward the distinctly licensed, relatively small numbers of CAM professionals.

One repeated theme related to economic fears and concerns. A group participant said that "to give is to lose." The loss can concern individual business or a profession's "territory" and market position. The barriers are felt as all the more intractable because of a perpetual, generalized sense of embattlement among many practitioners, combined with a scarcity mentality that we are involved in a zero-sum game rather than an expanding market. Inside each organization, action toward collaboration is restricted by competing needs for extremely limited time and financial resources. The lack of a level economic playing field (eg, access to federal funding) between conventional and CAM professions and institutions was highlighted.

Many basic, human shortcomings also were expressed as barriers: greed, selfishness, mistrust, dishonesty, fear, intolerance, envy, and ignorance. No party had a corner on any of this internally driven negativity, which is then expressed in healthcare system design.

Toward Common Ground. The breakout group sensed that, rather than "one voice," a symphony of well-orchestrated voices was a better working image of their collaborative goal. Participants agreed on the need to foster a more diverse, pluralistic healthcare system in which resources and authority are both distributed more equitably. The group used the draft of the Design Principles for Healthcare Renewal to probe for common ground. Continuous exploration of, and reference to, shared principles was viewed as a critical roadmap for developing collaboration. Shared principles were tracked, with repeated references to Principles 1, 5, 6, and 9: interconnectedness, diversity and pluralism, partnership, and patient-centered care and health promotion. Mutual education should be expanded among members of each group about other groups' needs. Increasing the individual abilities of players to create and respond to opportunities for collaborative action are key steps.

One suggested strategy was acting locally through community-based, multidisciplinary best-practices gatherings and healing circles. Suggested steps included exploring parallel agendas, perhaps through a series of facilitated meetings; budgeting for more political activism; establishing a formal national coalition; funding a CAM or integrative medicine clinic on Capitol Hill; defining and following the research agenda; reaffirming the connection with consumers; and expanding dialogue with opposing groups.

Key Action Step: Support Creation of a Federal Office. A key area of discussion surrounded the appropriate structure for policy coordination at the national level, particularly with the expectation of recommendations from the White House Commission on CAM Policy in spring 2002. The group agreed that the NIH's National Center for Complementary and Alternative Medicine (NCCAM), a research office, is not a sufficient or appropriate center of activity for all policy issues regarding CAM and integrative care at the federal level. The group supports establishment of an Office for Complementary and Alternative Medicine and Integrative Healthcare inside the US Department of Health and Human Services. The office would have the authority to oversee, coordinate, and direct federal CAM and integrative healthcare activities, including complementing the NCCAM's agenda in such areas as education, policy, health services, outcomes, cost-effectiveness, and field research. The office would have an advisory council and, as necessary, blue-ribbon panels on critical topics, with the first on credentialing, standards, and education. The advisory council and any additional panels would be multidisciplinary, with representatives of all stakeholder groups, including the distinctly licensed CAM professions and emerging health professions. For the office to succeed, leadership would need to be approved by both integrative medicine and CAM stakeholders.

Additional Action Steps. The breakout session concluded with the following general consensus on initial action steps:

- *White House Commission*. Track and provide input to the White House Commission.
- *Use of Principles*. Use the draft of the Design Principles of Healthcare Renewal as a tool for managing relationships between organizations and professions. Take the draft to each participant's organization for review, revision, and response.
- *Advocacy tool*. Develop a grassroots and legislative advocacy primer for participants in the group.
- *Policy endorsement*. Review and respond to some of the common-ground recommendations for action steps. Seek the ability to lend organizational names as endorsements for national coalitions on key issues.
- *Nondiscrimination*. Work toward the enactment of federal policies that lift barriers to services provided by CAM/integrative healthcare providers.

Facilitators. The national presence–policy, coalitions, voice breakout group was facilitated by Pamela Snider, ND, Bastyr University; Matt Russell, National Integrative Medicine Council; and Tony Martinez, JD, American Specialty Health, Inc. Russell and Dr Snider led development of this consensus statement, which was approved by breakout participants.

Integrative Clinics

The Integrative Clinic breakout sessions drew the largest group of participants, totaling 25 to 30 per session. Participants came from diverse environments including academic medicine (both conventional and naturopathic), health-system sponsorship, nonprofit stand-alone, and for-profit stand clinics, alone and private practices.

Survey of Clinic Breakout Participants. Participants first considered outcomes of a survey they completed. Roughly half indicated significant pressure to achieve financial sustainability within 2 years. Despite challenges, participants registered a high sense of purpose and satisfaction in their work.

The survey affirmed that challenges typically were not personal or individual, but systemic and shared. More than 2 dozen

topics were identified as valuable for discussion. A review of challenges and strategies was organized around the following 4 topics:

Referral Development and Marketing. Numerous strategies were suggested for creating a presence among conventional medical staff: receptions to introduce conventional primary care providers to the physical space in which CAM is delivered; surveys of CAM interests and knowledge; "community plunge" methods involving observation and experience; participation in grand rounds; viewing correspondence with conventional providers following referral as an educational opportunity (eg, including herbal monographs with explanations of care); developing clinical programs linked to existing clinical "centers of excellence" in the system; and sending electronic integrative-medicine bulletins on scientific advances. Direct-to-consumer marketing focused on grassroots strategies (eg, health fairs, community lectures, in-house newsletters, columns in community papers, gift certificates, CAM links on health-system Web sites) rather than paid advertising campaigns. A strategy with potential for both direct and indirect support in sponsored clinics is an employee benefit that includes a CAM discount at the clinic.

Cost Containment. Consensus among those working in the hospital and health-system environment was that the flexibility and independence of working under a separate tax ID is critical to success. To start with, most recommended that provider payment be based not on salary but on incentives until a sustainable patient load is established. If salaried, hours not booked for patient care might be used for marketing and development.

Administrative Structure. Suggestions ranged from innovative management techniques ("track each practitioner as a profit center") to long-term thinking ("read Sun Tzu's *The Art of War*"). Most indicated that administrators and even front-desk personnel should be viewed as a core part of the clinic's processes, with inclusion in clinical and educational meetings as a way to deepen their understanding. Interdisciplinary case reviews also are critical for stimulating integrative understanding, and most considered weekly meetings of 60 to 90 minutes to be optimal.

New Revenue Streams. Health-system participants suggested direct involvement with the system's development office to increase the potential for philanthropic support. A basic tool is a small sign that simply acknowledges that the clinic accepts donations. Grant proposals are pursued by some, with an effort to fund some clinic operations in the grants. An underexplored approach is to work directly with employers, either through their corporate wellness programs or such methods as "cafeteria plans" that include integrative services. Some suggested maximizing the sale of nutritional supplements.

Creating a Community Chest of Shared Templates. Most clinics viewed their hard-won lessons and successes as proprietary. However, the group realized that most challenges are cultural or economic and shared rather than individual. This understanding led to a focus throughout the meeting on facilitating the sharing of core documents, not just ideas. The goal is to raise the platform on which everyone operates so clinic developers need not continuously (re)invent strategies, but instead can build off the work of others. This was viewed as particularly important given the common resource and time constraints. Most members chose to offer at least 1 useful tool to the assembled group. Examples included patient survey tools, community needs assessment survey and outcomes, clinical data-collection tools, business administration strategy documents, follow-up letters to doctors who refer patients, workshop outlines, sample articles for a community paper, an internal marketing strategic plan, referral scripts, incentive-based salary formulas, site visit documents, medicinary disclosure forms, herbal monograph resources, sample hospital affiliation agreements, promotional materials, member wellness packages, philanthropic strategy documents, and overviews of employee-benefit discount programs. A strategy for sharing these and additional documents between participants and others from the broader community is under development.

Core Areas of Agreement and Potential Next Steps. Session participants reached consensus on key projects that would be mutually beneficial. The overarching strategy is to create a safe, trusting context for sharing experience and mutual support. This work would not only be engaged at annual Summits, but through an ongoing process. Efforts might include creation of a collective resource of useful, otherwise proprietary documents. These might be stored online or through some other method for efficient access and dissemination. Where possible, strategies for management, referral development, and even creation of philanthropic support should be measured through some form of outcomes analysis to refine a sense of best practices. Future developments will allow a mechanism for including interested parties who are not represented at Summit meetings.

Facilitators. The integrative clinics breakout session was facilitated by Gerard C. Whitworth, RN, CCP, CHRF, and RoseAnn Kushner, RN, CAM Clinic, Stanford University. Whitworth led development of this consensus statement, which was approved by breakout participants.

WORKING GROUPS OF THE COLLABORATION FOR HEALTHCARE RENEWAL FOUNDATION

The breakout sessions and the resulting consensus statements created an interest in some participants in collaborating throughout the year. An anonymous philanthropic grant provided funding to allow the Summit leaders to found the nonprofit CHRF (Table 5), which began developing a network of self-directed, integrated working groups that will expand the activities of their respective Summit breakout sessions.

CHRF's funding strategy seeks to combine direct contributions from involved industry members with philanthropic support for specific projects. Gerard Whitworth, CHRF principal and cofounder, explained that projects prioritized and agreed on by active integration leaders will make the best use of philanthropic dollars. Eight working groups have been identified, 4 are operating, and 3 are funded (Table 6). Funding for these first 3 groups represents 36 commitments of $2000 to $5000 each from involved industry members. Funders include academic medical centers, CAM professional organizations, HMOs, health systems,

committed individuals, natural products firms, and CAM preferred-provider organizations.

Employer/Managed Care Working Group

This group is developing a national CAM effectiveness database project in cooperation with the SOA, PricewaterhouseCoopers, and the Institute for Health and Productivity Management. Developing tools and information to support employer demonstration projects is a second priority. For information contact Ira Zunin, MD, MPH, MBA, at kalen@pixi.com.

Integrative Clinics/Health Systems Working Group

This group's projects include creating a Listserv and phonebridge for conferencing on relevant topics. Another core project is the creation of an electronic knowledge base for operational tools for delivering integrated care (eg, templates, such as intake instruments, outcomes forms, budgets, strategies) that can be accessed by all parties interested in sustainable integrative medicine programs. For information contact Vickie Alleman at valleman@alltel.net.

National Policy Working Group

This group combines efforts and personnel from the Summit meetings and 60 organizations represented at the National Policy Dialogue to Advance Integrated Healthcare held in the fall of 2001. The focus is on articulating and advocating public policy to improve access to high-quality integrated healthcare services, including a full range of health systems, disciplines, and modalities. For information contact Candace Campbell at candace@healthfreedom.net.

Summit Working Group

The Summit working group produces the *CHRF News Files*, coordinates work between the other groups, and organizes the annual Summits. The next Leadership Summit is scheduled for April 25-27, 2002, in Scottsdale, Ariz (Table 7). For more information, go to http://www.thecollaboration.org.

Community Involvement

The cofunding and leadership teams of these working groups are organized with an additional goal of community involvement.

TABLE 5 Collaboration for Healthcare Renewal Foundation (CHRF) Board of Directors

- John Weeks, CHRF
- Gerard Whitworth, CHRF
- Anna Silberman, CEO, Lifestyle Advantage; VP, Highmark Blue Cross Blue Shield
- Sean Sullivan, JD, Institute for Health and Productivity Management
- Clement Bezold, Institute for Alternative Futures
- Candace Campbell, American Association for Health Freedom, National Policy Dialogue
- Tom Shepherd, DHA, Bastyr University
- Tracy Gaudet, MD, Duke University

Whitworth underscores that the nonprofit CHRF is an open-door organization, and that anyone interested in advancing integrated healthcare is welcome. Electronic subscription is presently free to the *CHRF News Files*, thanks to a generous grant from the Center for Integrative Health, Medicine and Research, founded by Lucy Gonda. This newsletter reports business developments relevant to the emerging integrative medicine industry as well as the status of collaborative initiatives. Contact Weeks at pihcp@aol.com to subscribe. Those interested in a specific working group are invited to contact the individuals above or Whitworth at gcwihcr@aol.com.

ADDITIONAL RESOURCES

The following resources are useful for those wishing to further explore the business of integration:

- *Summit 2000 Report*. Integrative Medicine Communications of Newton, Mass, maintains a Summit-related, information Web site at http://www.onemedicine.com/summit. Click the new user button, then you can download the full report.
- The principles documents used as resources in developing the draft Design Principles for Healthcare Renewal are available from Pamela Snider, ND (psnider@ bastyr.edu). Included are statements of principle and mission from more than 40 healthcare organizations ranging from the National Academy of Sciences Institute of Medicine to diverse hospitals, health systems, employee benefits organizations, integrative clinics, and national professional associations.
- *CHRF News Files*, a twice-monthly electronic newsletter on collaborative activity and other developments in the emerging industry. Contact John Weeks at pihcp@aol.com.
- Integrative Medicine Industry Leadership Summit 2002, April 25-27, 2002, Scottsdale, Ariz. Inquiries to pihcp@aol.com.
- National Policy Dialogue to Advance Integrated Healthcare. Outcomes of a November 2001 meeting may be reviewed by contacting candace@healthfreedom.net.
- Back issues of *The Integrator for the Business of Alternative Medicine* remain a unique resource for the business of integration. Contact Integrative Medicine Communications at (877) 426-6633.
- *Integrating Complementary Medicine into Health Systems* (Faass N, ed. Gaithersburg, Md: Aspen Publishing; 2001), offers a wealth information from dozens of people at the forefront of integration work.
- *Complementary and Alternative Medicine Management: Forms and Guidelines* (Bowman M, Lawlis GF. Gaithersburg, Md: Aspen Publishing; 2001) provides practical templates and tools, mostly from Bowman's experience in an integrative clinic in a Colorado hospital.

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TABLE 6 Working groups of the Collaboration for Healthcare Renewal Foundation

Employer/Managed Care Working Group
Voluntary leadership
- Ira Zunin, MD, MPH, MBA, Hawaii State Consortium for Integrative Health Care
- Michael Schor, MPH, Marino Centers for Progressive Health
- Kenneth Pelletier, PhD, Universities of Maryland and Arizona
- Angela Mickelson; Hooper, Lundy, and Bookman, Inc
- Sean Sullivan, JD, CEO, Institute for Health and Productivity Management

Funding ($2000 to $5000 each)
- PricewaterhouseCoopers
- Alternative Medicine, Inc
- Oxford Health Plans
- American Chiropractic Network
- Blue Cross Blue Shield of South Carolina
- Triad Healthcare, Inc
- American Lifecare
- Complementary Healthcare Plans
- Chiroplan
- American Specialty Health, Inc
- Angela Mickelson; Hooper, Lundy, and Bookman, Inc
- American WholeHealth Networks
- Alliance Research Foundation ($10000 for National CAM Effectiveness Database Project)

Integrative Clinics/Health Systems Working Group
Voluntary Leadership
- Milton Hammerly, MD, Catholic Health Initiatives
- Bradly Jacobs, M D, MPH, UCSF Osher Center for Integrative Medicine
- Carmen Pascarella, Marino Centers for Progressive Health
- Mary Helen Morosco, MFT, Memorial Hermann Healthcare
- Barbara Findlay, RN, Tzu Chi Institute

Funding ($3000 each)
- Catholic Health Initiatives
- UCSF–Osher Center for Integrative Medicine
- Beth Israel/Continuum Center for Health and Healing
- Mayo Clinic
- Marino Centers for Progressive Health
- Inner Harmony Wellness Centers
- Center for Integrative Health Medicine and Research
- Duke University School of Medicine
- Cardinal Nutrition
- Southwest College of Naturopathic Medicine and Health Sciences

Integrated Healthcare Policy Consortium/National Working Group
Voluntary Leadership
- Aviad Haramati, PhD, Georgetown University
- Candace Campbell, American Association for Health Freedom
- Pamela Snider, ND, Bastyr University
- Richard Liebowitz, MD, Duke University
- Arnold Chinchulli, DC, Triad Healthcare, Inc
- Janet Kahn, PhD, LMT
- Peter Martin, LAc, Acupuncture and Oriental Medicine Alliance
- Sheila Quinn, Institute for Functional Medicine
- Rick Gallion, Blue Cross Blue Shield of South Carolina

Funding ($2000 each)
- American Holistic Medical Association
- Council of Colleges of Acupuncture and Oriental Medicine
- Cardinal Nutrition
- Angela Mickelson; Hooper, Lundy, and Bookman, Inc
- American Association of Naturopathic Medical Colleges
- American Association for Health Freedom
- American College for Advancement in Medicine
- Association of Bodywork and Massage Professionals
- American Massage Therapy Association
- Standard Process Laboratories

Design Principles for Healthcare Renewal Working Group
Voluntary Leadership
- Pamela Snider, ND, Bastyr University
- Roger Jahnke, OMD, Health Action
- Len Wisneski, MD, Integrative Medicine Council
- Gary Sandman, Integrative Medicine, Inc
- Clement Bezold, PhD, Institute for Alternative Futures
- Alan Dumoff, JD, MSW
- Terry Schmidt, PhD, DHA
- Elizabeth Clay, US House Government Reform

Funding
- None identified

TABLE 7 Summit 2002 sponsors

Convening Sponsor
- Center for Integrative Health, Medicine, and Research

Supporting Sponsors
- Center for Integrative Health, Medicine, and Research
- Angela Mickelson; Hooper, Lundy, and Bookman, Inc
- Triad Healthcare, Inc
- Inner Harmony Wellness Centers
- Bastyr University
- American Specialty Health, Inc
- *Alternative Therapies in Health and Medicine*

Notes
1. These design principles are presented as a draft. Neither the number nor the content of these principles is fixed. Ideas for changes, amendments, additional principles, better language, or a shift in emphasis are actively solicited. This draft is a living document that will be altered, refocused, and refined through community response. Please send comments to pihcp@aol.com.
2. Participation of the Society of Actuaries was confirmed following Summit 2001.
3. The following Web sites provide useful information about complexity theory: http://www.plexusinstitute.com/edgeware/archive/edgeplace/map.html and http://www.organicstrategy.com.

Reference
1. Findings released from the Integrative Medicine Leadership Summit. *Altern Ther Health Med.* 2001;7(1):30-31.

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