Researched and Prepared by:
Clohesy Consulting

For: The Philanthropic Collaborative for Integrative Medicine

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Gaining an understanding of an emerging field of practice like Integrative Medicine is almost totally dependent on the generosity of people who are already too busy and managing too many demands to squeeze in one more commitment. Nevertheless dozens of leaders cooperated with The Philanthropic Collaborative for Integrative Medicine and Clohesy Consulting to complete this study.

The individuals who devoted time and preparation for the lengthy interviews are most deeply appreciated. These include:

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During the interviews many of the participants expressed their gratitude to The Philanthropic Collaborative for Integrative Medicine for recognizing and acting on the need for knowledge-building about how the field of Integrative Medicine is forming.

Family Philanthropy Advisors in Minneapolis administers the work of the Collaborative and has opened doors and provided needed guidance at appropriate moments for this mapping process.

In response to the Collaborative's "Request for Proposals" the mapping study was conceptualized, researched, and written by Stephanie Clohesy and Lorna Lathram with administrative and research assistance from Dylan Arnett and Mark Hays and graphic designs by Andrew Van Fleet as a project of Clohesy Consulting, Cedar Falls, Iowa.
THE EXECUTIVE SUMMARY
EXECUTIVE SUMMARY

MAPPING THE EMERGENCE OF INTEGRATIVE MEDICINE:
A Journey toward a New Medicine

"The point is, if you get your facts wrong, you get your map wrong. If you get your map wrong, you do the wrong thing.” (Peter Schwartz, The Map Rap)

In his essay, *The Map Rap*, Peter Schwartz, a scenario planner and founder of the Global Business Network, explains that mapping is intended “to challenge ingrained perceptions of the present and for questioning how the future will be different from the recent past.”

This report is an effort to challenge and question past and future while also connecting some of the many pieces of the Integrative Medicine (IM) field—pieces that are visible but not yet linked—into a shared picture or navigable map. The report describes numerous points of view, alternative Theories of Change, and optional scenarios for how the future might unfold. It is not intended to be dogmatic in offering a single analysis about the field; instead it is a tool for recognizing landmarks and plotting the best strategic routes for the future. This attempt at mapping the field of Integrative Medicine is intended to help understand how the future will be different from the recent past. It is intended to provide information and also to inform decision making.

Background and Purpose: Why a Map?
This report was commissioned by the Philanthropic Collaborative for Integrative Medicine, a group of philanthropists with diverse interests in bringing about “optimal health and healing for individuals and society by advancing Integrative Medicine . . . and moving American health care to Integrative Medicine.”

In fulfillment of one of its strategic goals to “identify, confirm, organize and document the existing landscape of the rapidly developing field of Integrative Medicine,” the Collaborative commissioned a “concept mapping process” resulting in this report. The mapping process had four main goals:

- Explore the quantity and quality of Integrative Medicine as it is emerging in the U.S.
- Identify both accelerators and obstacles affecting the development of IM
- Communicate the IM story to increase understanding and inspire more interest in IM
- Help guide the Collaborative to understand better how to catalyze and enhance the development of the field of IM.

The study was conducted by:

- Surveying the field through existing documentation, publications, reports and websites.
- Surveying the field through the perspectives of a diverse group of 30 leaders who were interviewed. The leader-interviewees serve as clinical
practitioners both in profit and nonprofit settings. They include researchers, educators, policy makers, and insurers.

The literature review and the interviews were structured and documented according to a matrix of key concepts in the field as well as some basic characteristics about the setting of the person or institution:

<table>
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<th>KEY CONCEPTS</th>
<th>FACILITY TYPE</th>
<th>THOUGHT LEADERS</th>
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The Report is structured in four parts:

**PART I: Description of Findings**—includes data about each of the nine key concept areas from both the interviews and the literature review.

**PART II: Insights for the Future**—a review of Change Theory and how such theory affects the context for IM’s emergence along with eight specific Theories of Change offered by interviewees about the most effective way to achieve the vision of IM.

**PART III: Visual Maps of the Field**—Concept maps of the overall dynamics of the field of IM along with specific maps about specific issues within IM and Complementary and Alternative Medicine (CAM).

**Part IV: Appendices**—Key documents which have helped to define the field of IM and were used as basic references for this study are listed in the Appendices.

**Context: A Moment in Time**
Integrative Medicine—as it is currently recognized—began to emerge about 30 years ago. Of course, like all medicine—conventional and CAM—it is rooted in ancient traditions and does not have an exact starting point. However, the thought leaders and practitioners interviewed for this study attributed the beginnings of the contemporary field of Integrative Medicine to the 1970's and 80's with explorations of mind-body healing and the interest of so many young baby-boomers in Eastern spirituality and energy healing. Many of those young seekers of the 70’s and 80’s have become the physicians, healers,
and researchers who are champions and founders of the ideas and institutions at the leading edge of Integrative Medicine.

The current definition of Integrative Medicine remains controversial but prominent leaders and founders of IM institutions, especially those in centers based in academic health centers, agree that IM is not synonymous with complementary and alternative medicine (CAM). It is a system of health care in which conventional medical options along with CAM therapies are understood and recommended interdependently, according to the needs of the patient. It is relationship-centered and prevention-based, insisting on patients being active participants in their health care with physicians/primary practitioners viewing patients as whole persons: mind-body beings, family and community members, spiritual beings in physical bodies, individual personalities.

The emergence of Integrative Medicine has coincided with a growing crisis in the U.S. health care system. Some would say IM is emerging because of that crisis. The rise of technology in conventional care has driven up costs and the shift to managed care has pressured practitioners to care for more patients in less time, often resulting in the loss of trust between client and practitioner. Consumers in vast numbers have sought out alternative care, challenging the conventional health care system to consider integration.
Taking a historical view of IM’s emergence (USA), the major periods of development could be described as:

**Pre-1970’s:**
Rise of scientific medicine; decreasing tolerance of alternative medicine. “Folk-medicine” is kept alive privately by families, Native Americans, and new immigrants, except for chiropractors and naturopathic doctors who continue to develop and build educational and credentialing institutions.

**’70’s/ ’80’s:**
Mind-body awareness gains intellectual credibility through research, published studies, formation of new journals and organizations etc. (Pelletier, Goleman, Eisenberg, Institute for the Advancement of Health and its publication, “Advances”). Conventional medicine moves toward higher technology. The shifting economy begins eroding accessibility to affordable care and insured health care is a casualty of economic adjustments in many industries. Conventional system begins moving to more cost-effective modes (managed care, etc.).

**Early ’90’s:**
David Eisenberg’s first national survey of the size and scope of consumer usage of complementary and alternative care sparks a first wave of new organizations and clinics. Conventional medicine is said to be “in crisis” and health reform stalls. Bill Moyer’s television series on mind-body health educates millions of viewers.

**Late ’90’s:**
Follow-up survey on complementary and alternative care reveals consumer numbers larger than anyone had expected. Many new integrative health centers are formed; investment capital flows for the start up of Integrative Medicine clinics; associations and networks begin to form (practitioners, schools, philanthropists, etc). Nearly half of all medical schools offer some instruction in CAM. Policy awareness and advocacy heightens; National Center for Complementary and Alternative Medicine (NCCAM) is formed and budgeted for within the National Institutes of Health. The years 1998-99 appear to be a peak period of activity for IM development and advancement.

**2000-2003:**
The economic downturn—especially on East and West coasts—slows down the start up of new clinics and challenges the survival of the first wave of clinics. But strong consumer interest and promising research drives the formation of dozens of new clinics, centers, products, associations, and publications. Conventional medicine is becoming unaffordable; an unprecedented number of people are not insured or covered for care. Web-based information and other technology innovations are changing both conventional and Integrative Medicine.
Part I: Descriptive Findings

The Challenge of Describing or Mapping Integrative Medicine

The dual challenge of this study has been to describe what is happening in the emergence of IM: the definitions, types and categories, numbers, places, people, policies; and also to make sense of the information so that leaders and supporters can make strategic decisions that will support and accelerate the development of IM.

It is clear from the data gathered in this study that the field of IM is no longer in the early start up stage of its life-cycle. IM advocates are building institutions, changing public policy, educating the next generation of practitioners, and looking for the means to grow to scale and sustain the use of IM. Venture capitalists often refer to this level of development as the “mezzanine”, that stage at which an idea or enterprise is beyond start up but not yet at full-scale. Investors understand that at this mezzanine stage the founding idea or product has “caught fire” and now requires persistent and simultaneous support of many aspects of the business along with deep development of the infrastructure or capacity to actually produce and deliver the product. This aptly describes the field of IM as it, too, is a “hot” concept which could fade if capacity and sustainability are not developed.

In addition, this study has brought to the surface some unresolved differences that stand in the way of full-strength strategic growth and development. Some IM leaders see IM emerging as its own field of medicine, a type of practice that builds on and works compatibly with the existing systems but maintains its own long-term identity, institutions, and education. Others see IM as a means to an end: it will be developed as a concept and supported long enough for it to transform both conventional medicine and CAM systems into one new and improved system of medicine. Some see only positive value in thinking about “one medicine” of the future while others see dangers that include the loss of diversity in CAM therapies if CAM is absorbed into the mainstream system. These uncertainties about what the “new medicine” will look like are fueling energy and innovation as the IM field emerges, yet also slowing down progress since not all energy is focused on any one strategic option. There are differing ideas about what will actually “prove” the efficacy and efficiency of CAM therapies and products and these are layered into larger-scale concerns, criticism, and skepticism about the proof of efficacy and efficiency in mainstream conventional medicine.

As this study began, some members of the Collaborative expressed hopes that the mapping process would reveal how close IM is to a “tipping point.” The question has to be interpreted on two levels:

• How close is the development of IM to its own tipping point, that is a widespread belief in and acceptance of its principles; and
• How close is IM to tipping the transformation of the overall health care system into a more integrated and relationship-based system of care?

These questions are not so easily answered, even after months of interviews and poring over others’ research. IM is not a single or small concept: the field is developing on many fronts at once; the mainstream health care system continues to move deeper into its own crisis of accessibility and cost containment; and the very definitions and vision for IM are part of a complex, self-organizing system in which many people are inventing new ideas and adapting to others with little centralized control or information-sharing. There is evidence of steady growth in IM with new centers opening, more educational efforts underway, more national policy attention, and more research being funded. But the growth now is less dramatic than the leaps the field took in 1998-2000. Most IM leaders
observe that the field is stabilizing and deepening with its greatest growth and transformational potential still ahead even though a few have expressed fears that the interest in IM has already peaked.

The intended value, then, of this report will be not only in its breadth of descriptive details about how IM is being developed and practiced but also in the analysis of the possibilities that lie ahead.

**The Concepts:**
The mapping study began with a review of major reports and journals. Out of this first scan of the literature nine dimensions or key concepts of IM were identified and subsequently formed the structure of the study as well as the report. Following are brief descriptions of the nine concepts and a few of the major findings for each concept.

**Concept 1: Founding Vision, Mission, Definition**

By definition, IM clinics are committed to providing care that blends conventional and CAM therapies into a unified approach to care.

Vision, mission, and definitions are similar enough for many clinics and leaders to feel connected to a new network of like-minded innovators; yet there is not yet unanimous agreement about vision or definition for the field.

Nearly all Integrative Medicine (IM) clinics and centers have visions and missions that are satisfying in the ideal but the ideals have not yet been fully operationalized. The clinics are interesting models of providing “new medicine” in a context of clinical care, education, and research but none are working at full scale or in proportion to the communities they serve. Most clinic/center leaders agree that their vision/mission is to transform medicine for the better rather than just delivering a limited amount of better care.

This gap between the ideal vision of IM and the current size and capacity of the IM institutions is significant and calls into question how the IM institutions (clinics, centers, educational programs) can be the system that brings the delivery of IM care to scale.

**Concept 2: Performance**

Founders of IM centers, clinics, services and educational programs have set out to promote health and healing by blending two distinct systems of health services—conventional and CAM—while also restoring the practitioner-patient relationship and motivating patients/clients to accept the responsibilities of self-care.

IM can be delivered by individual practitioners wherever they are located. Increasing numbers of medical doctors are reporting the use of alternative therapies within their own individual practice; and individual or small-group CAM practices are increasingly visible within communities. Nevertheless the emergence of IM is distinctive as IM’s champions and practitioners attempt to create the IM model of care through specifically identified centers and clinics.

Creating these new clinics and centers is comparable to launching any new business or service organization including the start up by visionary founders who are champions of the ideas and/or sources of financial and social capital. The life-stages evolve through growth, the search for appropriate niche and scale, long-term sustainability, and advocacy for systemic change to recognize a “new medicine.”
Because the IM clinics and centers have varying structures operating independently or within numerous systems, this section on “Performance” of IM is one of the most complex parts of the report. The mapping interviewees analyzed their experiences in IM according to:

- Key milestones and major successes
- Missteps, failures, and lessons learned
- Value-added
- Value perceived by clients/patients
- Barriers

In addition the Report analyzes a three-year “Clinics Benchmarking” study conducted by The Integrator. An aggregate summary of the “Benchmarking” data is included along with an analysis of founding patterns and sustainability trends in the 29 clinics included in the “Benchmarking” study.

Looking at both studies combined, some of the major findings include:

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<th>Highlights of Major Findings</th>
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<td><strong>Milestones:</strong></td>
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<td>Substantial financial capital (usually $100,000 to $1 million depending on other supporting infrastructure), defined space, and a dynamic champion(s) are all essential to start up</td>
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| **Success:** |
| “Break-even” is achieved by many in 3-5 years. However, “break-even” can be a combination of patient revenue, product sales, research grants and contracts, and philanthropic income from endowments and/or new donors. |

| **Failures/Lessons Learned:** |
| Trying to do too much (services, education, and research) too fast on too few resources (capital starvation, lack of business leadership on staff and board, staff with no client base to bring to the center) will slow down progress or threaten the viability of a center. |

| **Impact:** |
| IM is not fully accepted as equal but it is no longer seen as quackery; national research grants and studies on efficacy and science are quieting the critics. |

| **Value:** |
| Patients appreciate feeling well listened-to and cared-for. |

**Concept 3: Staffing**

In addition to the perennial challenges of how to find, hire, and compensate the best staff, the greatest staffing challenge for IM centers and clinics is how to structure staff for the best fit with mission. The Study considers one main cluster of questions in the area of staffing:

*How extensively should a Center’s staff be integrated? How important is such integration for the delivery of IM care? Is better medicine provided when a staff...*
team is the “integrator” for an individual’s care? Or is it better (or more manageable) for the staff to simply provide care while the patient integrates their own care plan?

Most of the centers’ leaders said that they believed that the staff teams should be well integrated—meaning that they should work collaboratively and consider themselves to be unified as a mini-system of care for each patient. Most have or are creating thorough intake procedures so that the IM professionals can counsel and guide the client toward an integrated care plan. According to this thinking, the IM staff is the integrator of care for the patient and staff should be integrated to best perform this role.

This section describes the assumption of most clinics that the staff team should be as diverse as possible (i.e. offering numerous modalities of care and treatment) and should be integrated in structure, learning, and service activities. Five models of staffing for integrated care are described and visually depicted; these vary from the stated ideal model of full staff integration to models in which patients/clients take the responsibility for integrating their own care.

Staff credentials and the ways in which staff are hired (i.e. employment or contract) are factors in how well or easily a team can be integrated. While most centers and clinics agree that staff-based practitioners are ideal, the realities of cost and liability result in staffing that is contract-based.

Concept 4: Clients/Patients/Consumers
Consumers have driven and will continue to drive the professional and institutional interest in integration. Therefore the design of integrated care is responsive to what providers perceive that consumers want and is focused on the whole person, present and future.

This focus on the individual means that commitment to self-care is central to the concept of IM; transforming the attitude and behavior of individuals to encompass their own self-care is a consistent priority for all clinics and centers, regardless of their structure or setting.

Marketing of IM clinics and services represents one of the most basic ways in which IM clinics establish their identity and promote their promise of holistic care. Most clinics reported a preference for word-of-mouth trust-building as opposed to commercial or mass marketing (which has been unsuccessful for many).

Trends in insurance coverage that affect clients’ access to care also are described. Trends show a slow growth in insured coverage for IM; the more enthusiastic “bandwagon” effect of a few years ago when many insurers were changing policies seems to have dwindled.

Concept 5: Sustainability
Virtually every IM clinic and center is stretched in imagination and creativity to get to a sustainability formula that works. Most are moving toward a combined income base of fees and other profitable product sales, research grants, philanthropy from patient-donors or from other institutional funding sources.

The Report describes six major sustainability patterns and/or dilemmas:
• Chicken-or-Egg Growth Problem—The small start up scale of IM clinics makes it difficult to make enough revenue to self-capitalize expansion but, without expansion, they cannot achieve enough scale to make a difference in the host system or in the community.

• Hole-in-the-Bucket Problem—Many clinics are losing money on every service they provide due to inadequate pricing or recovery of costs for other patient services and research.

• The Philanthropy Solution—Most centers are moving toward traditional fundraising from individual donors and institutional philanthropies to subsidize start up, innovation, and special programs.

• The Entrepreneurial Solution—in addition to billing for client services, centers are devising business plans for other earned income and product revenues.

• The Cost-Management Solution—Centers are cutting costs, using contract providers, investing in technology, and increasing practitioner-client loads, though some of these measures may be antithetical to the principles of IM.

• Insurance: The beginning or the End of Sustaining IM—Although many believe that IM will never reach scale and transform medicine until insurance providers cover IM care and services, some IM leaders fear that dependence on insurance will destroy the quality of IM that makes it “new medicine.”

Concept 6: External Forces
When asked about the kinds of external forces affecting the progress of IM, the respondents described:

• Cultural and societal shifts, including contradictory trends that both support and impede the growth of IM.
  For example: consumer interest continues to grow in some of the standard CAM therapies such as chiropractic as well as in lesser known therapies such as Reiki. However, many of these therapies cannot be credentialed by the academic medical schools or hospital systems that host IM clinics and therefore cannot be provided through many of the IM clinics. As a result, the attractiveness of the clinics is diminished. More medical doctors are interested in CAM and are getting training and education; but short-term courses for physicians may not be adequate to provide valid treatment, thus increasing availability of care but eroding value.

• Public Policy: interviewees in the study described five major policy areas needing attention and reform:
  o Access and availability of care/insurance
  o Increasing student financial aid, especially for CAM students
  o Re-allocation of research funding to shift from clinical trials to efficacy and efficiency studies of integrated therapies
  o Regulation of supplements
  o Standardize licensing and certification.

The Report also summarizes the findings of the National Policy Dialogue and The White House Commission on CAM Report.
Concept 7: Research
All leaders interviewed described the need for more research to support the growth of IM but the type of research needed is a somewhat divisive issue.

Some believe primarily that clinical trials that will yield science-based evidence about CAM therapies and products are essential, overdue, and more important than other types of research. Some shared concerns that herbs, supplements, and nutraceuticals are the “time-bomb” in IM as they are advertised to deliver more than they can and the effects of their combinations with each other and with prescription medications are unknown.

Others believe that more practical research on “real world” issues of costs, efficiency, and time saved in treatment, etc., are more important for the field’s growth.

Some of the interviewees in the study advocated for a completely different approach to IM research. They argue that IM is based on integrating modalities of care; therefore research, too, must investigate how patients respond to multiple therapies being used together or in succession. Testing therapies or supplements separately has little instructive value when they are rarely used separately. New designs for research will be necessary in order to test multiple and integrated therapies.

Concept 8: Education
Education can mean different things depending upon the institutional or systemic setting. Some IM institutions are most focused on the education of health professionals, especially those in partnership with medical schools; others are focused on the education of clients/patients and the community.

Most leaders in the mapping study said that the “pipeline” of IM practitioners is not yet full enough. There are too few conventional health professionals with a full and working knowledge of CAM therapies and too little conventional medicine being taught as part of CAM educational programs. Although there are a growing number of schools and programs offering education in CAM therapies, there are many areas of the country where there are few, if any, CAM practitioners beyond chiropractors or nutritionists.

However, a few took the opposite position, worrying that there may be a glut of practitioners—both those graduating from short-term programs in yoga, massage, and nutrition as their only or primary education and those conventionally trained health professionals who are being certified after brief courses in acupuncture, massage, etc.

The Consortium of Academic Health Centers for Integrative Medicine was formed “to help transform medicine and health care through rigorous scientific studies, new models of clinical care, and innovative educational programs that integrate biomedicine, the complexity of human beings, the intrinsic nature of healing, and the rich diversity of therapeutic systems.” There are currently 19 members of the Consortium. Their first priority is to develop a shared medical school curriculum in Integrative Medicine.
Concept 9: Future Vision
Mapping interviewees were asked to reflect on several questions:
- How should the IM field unfold over the next several years?
- What are your best recommendations for advancing the field?
- What are the two or three things that could make the most positive difference in integrating conventional and alternative medicine in the future?

There is cohesion and common ground among many leaders about the future of the field as they generally envision a “new medicine” in the future that has survived the current crises of access and costs and emerges as a holistic approach to health care.

At a more granular level of thinking, however, many IM leaders start taking separate paths in their preferences for the kind of institution-building and which priorities will actually achieve a transformation in health care. Some believe that building clinics and demonstrating a care model will bring IM to scale; others believe research is the key. Some want to see only the most rigorously proven CAM therapies integrated into conventional care; others want the greatest variety of CAM therapies. Some believe that IM should and will elevate CAM therapies into broader public acceptance and more systemic payment systems; others believe that all lines between conventional and CAM therapies should blur and disappear.

Some highlights from these leaders’ view of how to achieve the future include:

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PART II: Insights for the Future

Change theory has relevance for understanding the evolution and emergence of Integrative Medicine. Because IM is not a centralized or top-down mandate in any one industry or sector, it is emerging as a complex adaptive system. The essential lesson in complex adaptive systems theory is that “cause and effect” solutions are inadequate. Instead a variety of changes and catalysts—large and small—are required throughout the system. “Harnessing” complexity requires working with it rather than trying to control it.

Five models of change theory are distilled to show the relevance between theoretical thinking about change and the actual dynamics within the field of IM:
- Complex Adaptive Systems and Self-organizing Theory
- Catalytic Change
- The Systemic Change Wheel
- Crossing the Chasm
- The Tipping Point

With these larger theories in mind, nine specific Theories of Change have been developed out of the study. They capture the strategic ideas expressed by interviewees for how IM could best be supported to grow to scale. A growth or value proposition has been created for each of the Theories of Change along with a set of insights and implications for philanthropic strategy.

The nine Theories of Change or Growth Propositions include:

**Theory 1: Nurture Consumers and Consumers Will Sustain IM.** If IM can diversify its appeal to consumers beyond the current dominant profile (white, female, 20-55 years of age; $40,000/year income), then IM will grow to scale and more people will benefit.

**Theory 2: Educate and Train Professional Practitioners.** If more IM practitioners (MDs, NDs, nurses, acupuncturists, energy therapists, etc.) are trained and appropriately licensed and credentialed, they will be able to provide credible services that will then fully unleash the demand of the public for IM.

**Theory 3: Build Centers that Successfully Demonstrate the IM Model.** If clinics/centers are designed to model the principles of IM and successfully deliver their services, then patients will get “better medicine” documented both through patients’ perceptions and outcomes research, and the model can then be replicated or adapted by others to meet the demand for better medicine.

**Theory 4: Clinically Prove the Value of Services and Products.** If IM care, particularly alternative treatments and products (herbal remedies, nutraceuticals) can be proven effective through clinical trials, then patients will feel confident about seeking such treatments, insurers will be able to issue coverage, centers will be able to offer the services, demand will increase, and IM will be accepted.

**Theory 5: Practically Prove the Efficacy and Efficiency of IM.** If IM care can be proven to be cost effective and efficient in reducing pain/healing time and helping to lower costs of care, then clients, insurers, and employers will prefer IM over the more limited options of either conventional-only or CAM-only treatment plans. This proof of efficiency will open “floodgates” of demand, which will ultimately transform the system.
Theory 6: Confidence of Insurers. If insurers are pressured to offer IM—or understand and positively respond to the benefits of IM—then the increasing numbers of people insured for IM will increase demand for services and stimulate demand for more IM options in many communities.

Theory 7: The Self-Care Revolution. As a model of care, IM emphasizes the importance of the client-practitioner relationship and shifts more responsibility to the client/patient. If IM practice can successfully persuade clients to accept the responsibility of self-care, it will revolutionize preventive health care and diminish the occurrence of chronic illnesses.

Theory 8: Policy. Policy making can guarantee that IM is accessible and safe. If policies are advocated and successfully implemented, there will be more research, more public spending, more insurance coverage, fair and thorough regulation, standard certification and licensing, and product safety. As a result, patients will know that they can get and trust a basic standard of care and will seek IM in order to have the options of safe CAM along with safe conventional medicine.

Theory 9: Merger or Acquisition. If conventional medical schools add educational options so that all doctors understand IM, recommend it, and are qualified to deliver it (e.g., MD acupuncture, etc), then CAM practices and practitioners will be certified and standardized through the conventional health care system. Patients will trust it more, and this will lead to growth in the use of IM and ultimately better health outcomes.

Resistance to the Growth of IM
Advocates of IM will be able to use this Mapping Study, including these Theories of Change (or Growth Propositions), to plan strategy that will lead to the desired transformation of medicine and health care. However, their efforts will be met with resistance—both subtle and direct. Some of the centers and clinics reported in their interviews that their host agencies (hospital systems and academic centers) are “mixed” environments for IM. Some people are champions while others are detractors and even strong resisters to the vision of IM as the integration of conventional and CAM services.

The National Council Against Health Fraud collects and distributes papers that critique CAM ideas and therapies. The National Council’s website has a prominent link to Quackwatch.com which also issues occasional papers and opinion documents about what they see as the inadequacy of CAM therapies.

A 1999 debate between Arnold S. Relman, editor-in-chief emeritus of the New England Journal of Medicine, and Andrew Weil, director of the University of Arizona Program in Integrative Medicine, laid out the “sides” of the argument for and against IM. Relman described his beliefs that alternative treatments are based on “irrational or fanciful thinking, and false or unproven factual claims, and are at odds with modern knowledge about the human body. Weil presented the interests of consumers for CAM and the consumers’ own proof for what had worked for them.

The 2002 White House Commission included a “minority” report from two of the Commissioners who went on record as saying that the Commission’s recommendations don’t acknowledge appropriately the limitations of unproven and unvalidated CAM interventions and doesn’t adequately address the minimization of risk. They claim that the Report is too inclusive of all CAM practices without appropriate nuance.
Although the interviewees in the Mapping Study did not talk about these resistors as being high-level threats or barriers to their work, the resistance is “out there” and will demand acknowledgement and attention.

PART III: Visual Maps of the Emergence of Integrative Medicine
The emergence of IM is a dynamic process engaging players from both the conventional and CAM systems of health care, along with mainstream political, industrial, scientific, and community leaders. The emergence of IM is happening amidst turmoil in the overall health care system. The lack of affordable care, the accelerating development of high-tech medical interventions, the aging of the population and rise of chronic pain and illness, and the consumer demand for greater choices of care are all factors in a system perceived by many to be in crisis.

The emergence of IM requires the construction of collaborative relationships between the large, conventional health care system and the less formal system of CAM institutions and practitioners. IM will require transformation of both systems so that everyone can benefit from any/all services and interventions appropriate for their need. Although leaders in conventional, CAM, and IM institutions all can articulate an ideal health care future in which “one-medicine” effectively enables and provides optimum care, there is little agreement on how such a unified system should be created; who will be in charge; who will be the gatekeepers; and who will pay.

Distilling the current situation and its likely future into visual mental-models can help to “check” analytical assumptions and strengthen strategic discussion and decision making. Several visual models are offered as a way of depicting the situational analysis and the possible future scenarios for the emergence and maturing of IM.

There are five visuals that describe the overall dynamics in the emergence of the field of IM:

- Integrating Asymmetrical Systems Into “A New Medicine”
- Mapping IM—Current Realities and Propositions for Growth
- IM: A Gateway to A New Medicine
- Four Scenarios for the Emergence of IM and A New Medicine
- The Stakeholders of IM

In addition, there are 12 visuals that describe some specific aspects of both conventional and CAM therapies and professions.

The Central Challenge
Ultimately those desiring to support the full emergence of IM and bring it to scale are facing the challenge of how to integrate asymmetrical systems.

Conventional medicine is a large and complex business system of major educational, research, care-giving, government, and private sector institutions with well-established standards and procedures for licensing of people, treatments, and products. It is focused on science-based treatments and products for curing illness and disease.

On the other hand, CAM is an informal and relatively small system of individual practitioners, small institutions, and associations providing health care practices that often derive from diverse cultural traditions and are in demand by consumers but lie outside of defined conventional care.
Most IM leaders believe that the development of IM will create a “new medicine” by transforming and moving the entire system toward the values of holistic, person-centered care without losing access to the science-and-technology-based cures of conventional medicine. But integrating an institutional system on one hand with an informal and small system on the other could easily mean that conventional medicine is modestly transformed while much of CAM becomes controlled through conventional institutions and agencies. How can integration truly combine the best of both?

Philanthropic leaders are challenged to hone their insight about the dynamics of change within the field and then to fund those strategies and activities that achieve their ideal vision.
Conventional Medicine - USA
A large and complex business system of major educational, research, care-giving, government and private-sector institutions with standardized credentialing, licensing and powerful peer associations. Primarily focused on science-based treatments and products to care illness and disease.

Complementary and Alternative Medicine - USA
An informal and relatively small system of individual practitioners, small institutions and associations providing health care practices that often derive from diverse cultural traditions and are in demand by consumers but lie outside of the defined conventional care and financial systems.

The Gateway Challenge
Can Integration happen if IM sees its primary significance as a portal or gateway to other systems? The Conventional Healthcare System and the CAM System are asymmetrical and not easily merged or fully integrated. Consumers have made it clear that they want both and would prefer "safe" and "guided" choices. As a "Gateway" IM could provide primary interaction with consumers/patients and use a network of systems to find and deliver the best of conventional and CAM care.
Four Scenarios for the Emergence of IM and a New Medicine

**Big Medicine Gets Bigger**

*HIGH Transformation* of Conventional Systems

*LOW Expansion* of CAM

Conventional institutions may expand their own ideas about prevention, public health, and patient education. A few CAM therapies may be grafted onto the system. The dominance of the Conventional System’s transformation may starve resources and attention from CAM so that its expansion is stalled.

**E Pluribus Unum**

*HIGH Transformation* of Conventional Systems

*HIGH Expansion* of CAM

An integrated system emerges in which conventional medicine is highly transformed by IM/CAM and CAM therapies are proven and accessible. The “new” system recognizes the different traditions of conventional and CAMS but accepts both and enables the patient to find all options. While accepted as different from each other both are vigorous and interdependent care systems that form the larger healthcare system.

**Stalled on the Bridge**

*LOW Transformation* of Conventional Systems

*LOW Expansion* of CAM

The Conventional System does not change and the momentum for CAM/M stalls. This could happen for many reasons: research outcomes on CAM therapies turn out to be inconclusive; insurance coverage shrinks as employers cut back on employee benefits; clinics and small practitioners struggle to survive in harsh economic conditions.

**Networked but Not Integrated**

*LOW Transformation* of Conventional Systems

*HIGH Expansion* of CAM

Conventional medicine “draws the line” on integrated care, credentialing/licensing and referrals; conventional medicine stays basically the same. At the same time CAM/M research and outcomes/data further define the value of CAM in basic and specialized healthcare. IM and CAM institutions flourish. Partnerships with conventional medicine are likely but they do not veer towards integration.
THE REPORT:

Introduction and
Part I: A Description of Findings
“Nine Concepts”
INTRODUCTION

I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person’s family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick. I will prevent disease whenever I can, for prevention is preferable to cure.

Except from the Modern Hippocratic Oath Written in 1964 by Louis Lasagna, Academic Dean of the School of Medicine at Tufts University,

Context and Purpose

In 1990 and again in 1997, David Eisenberg, MD completed national surveys of complementary and alternative medicine (CAM) that provided irrefutable evidence that growing numbers of people in the United States were turning to CAM in place of or to supplement conventional medical care. Some of the numbers were surprising, if not shocking. The findings overturned many assumptions about American preferences for health care and captured considerable media attention among medical professionals and the general public. For example the surveys found that:

- The total visits to CAM providers (629 million) exceeded total visits to all primary care physicians (386 million) in 1997.
- Out-of-pocket expenditures for CAM professional services in 1997 were estimated at $12.2 billion. This exceeded the out-of-pocket expenditures for all U.S. hospitalizations.
- Out-of-pocket expenditures for herbal products and high-dose vitamins in 1997 were estimated at $8 billion.
- An estimated 15 million adults in 1997 took prescription medications concurrently with herbal remedies and high-dose vitamins.

Subsequent surveys by Eisenberg and others have shown that the majority of CAM therapy users:

- Perceived the combination of CAM and conventional care to be superior to either alone (79%).
- Typically saw a medical doctor before or concurrent with their visits to a CAM provider (70%).
- Did not disclose their CAM therapy to their medical doctor (63-72%).

It was clear to many people—following the publication of these surveys—that the health care system in the U.S. was nearing a critical shift. Decades of small changes in personal behavior, along with advances in mind-body research and wider availability of diverse cultural ideas about health were adding up fast to a new consciousness among patients/consumers. Demand for a different kind of health care had outstripped the capacity of conventional medical institutions, and practitioners and consumers were self-styling their health care without much input or counsel about the compatibility of different therapies. The data established a new picture of the health care consumer as inventive, willing to choose and pay for extra options, and not interested in settling for either/or options.
Between 1990 and 2003 numerous associations, networks, institutions, and programs were founded and/or enjoyed new growth to further comprehend and advance an emerging new model of health care that would blend the best of conventional medicine with the best of complementary or alternative care.

- Nationally, there are more than 20 Integrative Medicine centers or clinics with close ties to medical schools and teaching hospitals, as well as dozens of smaller clinics in private physician offices. (AMNews staff. Nov. 13, 2000.)

- In 2000-2001, more than 90 of 125 allopathic medical schools reported that they include CAM in required conventional medical courses and 64 offer CAM as a stand-alone elective.

- About 15% of U.S. community hospitals offered alternative or complementary therapies in 2000, according to the most recent survey by the American Hospital Association, nearly double the number just two years earlier. The clinics are typically run by family practice physicians or internists and are closely monitored by the affiliated hospitals.

- Numerous professional associations have been created and are available to the IM practitioner including:
  - Acupuncture and Oriental Medicine Alliance (AOMA)
  - American Association of Naturopathic Physicians (AANP)
  - International Chiropractors Association (ICA)
  - The American Alternative Medical Association (AAMA)
  - American Holistic Medical Association (AHMA)

The term “Integrative Medicine” was coined to signify the value of this blending. While definitions of “Complementary,” “Alternative,” and “Integrative” Medicine remain controversial, there is a basic understanding among health practitioners and consumers that health care can mean one type of intervention or the other (Conventional or Alternative or Complementary) and that the efforts to blend them or to use them together (without assumptions of the dominance of any one modality) are known as “Integrative Medicine.”

In 2000, a group of philanthropists with diverse interests in conventional and alternative medicine established a collaborative structure and agenda to:

**Bring about optimal health and healing for individuals and society by advancing Integrative Medicine...and moving American health care to Integrative Medicine.**

*The Philanthropic Collaborative for Integrative Medicine* (the Collaborative) launched its work with a “Declaration for a New Medicine,” committing to ten principles that express an overall belief in the interconnections of mind, body, and spirit as well as the “sacred and healing nature of relationships” between patients and health care providers.

Briefly summarized, these ten principles include:

- Value the sanctity of life, the treatment of the individual in a holistic manner, and the fulfillment of the needs of mind, body, and spirit.
- Recognize the sacred and healing nature of the relationships between patients and health care providers, and acknowledge that humanism, compassion, and caring are central to healing and health.
• Believe that the empowered patient is the responsible central actor in healing, self-care, and prevention.
• Work for a health care system that supports healing relationships and recognizes that, in order to be healing and empowering, healers themselves must be restored and whole.
• Support truly Integrative Medicine, which offers the highest standards of excellence in a full and complete array of care modalities.
• Embrace the spiritual dimension of life and acknowledge the importance of context and intention in the healing process.
• Acknowledge that the risks of many serious illnesses such as cancer, cardiovascular disease, and diabetes can be reduced with scientifically-based nutrition, exercise, and mind-body interventions.
• Give voice to the patient.
• Support the efforts of healers to develop the integrity and spiritual qualities that are as important as medical knowledge and technical skills to the process of healing.
• Dedicate ourselves to bring about the new medicine in an optimal healing environment.

These values are intended to guide the strategic decisions of the Collaborative, along with the gathering and synthesis of information about the unfolding of the field of Integrative Medicine.

In fulfillment of one of its strategic goals to “identify, confirm, organize, and document the existing landscape of the rapidly developing field of Integrative Medicine,” the Collaborative commissioned a concept mapping process resulting in this report. The mapping process had four main goals:

1. Explore the quantity and quality of Integrative Medicine as it is emerging in the U.S.
2. Identify both accelerators and obstacles to the development of IM.
3. Communicate the IM story to increase understanding and inspire more interest in IM.
4. Help guide the Collaborative to understand better how to catalyze and enhance the development of the field of IM.

Design of the Mapping Study
This mapping study was envisioned as “Phase I” of a process that would likely continue over time, growing more complex as the Integrative Medicine field grows. the Collaborative wanted a “map” that would:

• Connect many pieces of knowledge about the field,
• Collect first-hand information and wisdom from field-leaders, and
• Yield new insights into the dynamics of IM’s growth and development.

Ultimately, the Collaborative members wanted a study that would help them to think about and make better strategic decisions concerning how to support IM.

The mapping process was designed to be straightforward, gathering existing data and directly questioning leaders in the field in order to yield useful information for the funders’
decision making. The mapping did not begin with a hypothesis to “prove.” Instead, it
began with questions and a desire for discovery. It was not intended to update major
surveys like the 1997 Eisenberg study or to summarize research about the efficacy of
specific alternative therapies. Instead, it was intended to provide a “bird’s-eye” view of
the shift underway in the health care system and to gain insight into IM practitioners’ own
experiences and their perceptions/advice about what is needed to sustain and increase the
momentum for change toward a “new” medicine.

The Mapping was conducted in two parts:

1. **Surveying the Field—Existing Documentation**

   Initially, the project team assumed a need to organize a fairly extensive data base
   of journals, articles, news media coverage, etc., both for identifying critical
   questions to guide the mapping process and also for providing the Collaborative
   with a data resource for the future. While more than 170 key articles and
   publications have been entered into the project’s database, it became clear that
   CAM on PubMed, a searchable database of more than 220,000 publications now
   open to the public, should be used as the knowledge base for this work. CAM on
   PubMed is a partnership between the NIH-based National Center for
   Complementary and Alternative Medicine (NCCAM) and the National Library of
   Medicine (NLM), creating a subset of NLM’s PubMed that automatically focuses the
   search on Complementary and Alternative Medicine (CAM).

   However, the mapping process has also resulted in a collection for the
   Collaborative’s use of reference copies of most of the major reports influencing the
   development of IM (e.g., National Policy Dialogue Report; The White House
   Commission Report; NCCAM Five Year Strategic Plan, etc.).

   In addition, the mapping included a thorough reading of more than four years
   (1998-2003) of The Integrator, a monthly publication which monitors, reports, and
   analyzes clinic, educational, and industry ideas, innovations, policies, and
   collaborations related to IM. Part I: The Description of Findings (Section 2—
   Performance) includes an analysis of The Integrator’s findings over three years
   from a group of 29 clinics. Other stories and reports from The Integrator are
   quoted and credited throughout the report.

2. **Surveying the Field—Insights and Ideas**

   A series of 30 interviews was conducted with thought leaders in the field as well as
   leading clinical practitioners—including profit and nonprofit researchers, educators,
   policy makers, and insurers.

   The interviews were based on nine key concepts that emerged from the literature
   search as being critical to the development of ideas, practices, and institutions in
   IM. These included:

   - Vision/Mission and Definition of IM
   - Performance (of Clinics/Centers)
   - Staffing
   - Clients/Patients
   - Sustainability
The interview data might be best grasped as a matrix:

<table>
<thead>
<tr>
<th>KEY CONCEPTS</th>
<th>FACILITY TYPE</th>
<th>THOUGHT LEADERS</th>
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<td></td>
<td>Hospital-Based Center</td>
<td>Academic-Based Center</td>
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<tr>
<td>Vision Definition</td>
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<td>Performance</td>
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<td>Staffing</td>
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<td>Sustainability</td>
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<td>External Forces</td>
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<td>Research</td>
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<tr>
<td>Future Vision</td>
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**Structure of the Report**
Beyond this Introduction, the Report is structured into four parts:

**Part I: Description of Findings.**
Data about each of the nine major Concept Areas are summarized and attributed as much as possible to the type of institutional or leadership source. This descriptive section is intended to convey the information about various centers and programs as well as key ideas and insights.

The interviews on which these findings were based were purposely structured for qualitative input from the interviewees and most questions required the synthesis of personal and institution experience or the creation of future vision and ideas. In each section the interviewees’ insights are blended with or set into the context of ideas scanned from the literature review.

**Part II: Insights for the Future.**
The data from interviews and from the literature search are interpreted into Theories of Change and implications for philanthropy. These were written specifically for the Collaborative and its members; but this analysis may be useful as well to other decision makers or funders who are interested in IM.

**Part III: Visual Maps of the Field**
Several types of information collected or synthesized during the project are depicted through visual diagrams. An overall synthesis and concept map of the emergence of the field also is included.

**Part IV: Appendices**
PART I: DESCRIPTION OF FINDINGS

A bypass has its place but patients need nutrition information and assistance in how to get and stay healthy...I had no idea where to send my patients after surgery...Risk factors for heart disease can be prevented so we've built a facility that incorporates both Alternative Medicine and Western Medicine...We look at heart patients from every aspect - Mind, Body, and Spirit, training patients through lifestyle change, nutrition, QI chi, yoga, meditation. Profound changes have resulted...We sought to create a prevention umbrella looking at real nutrient-based information not just substituting a low fat hot dog for a high fat one.

Erminia Guarneri, MD, on the creation of the Scripps Clinic - Torrey Pines

Overview: Deciphering the Pattern of Emergence of IM

Mapping the field of Integrative Medicine sounds like a simple thing to do. After all, the field is perceived as young, just emerging, and far from being fully established.

In reality, the field of IM is well beyond the earliest “start up” life-stage and is maturing into a stage of greater expectations and accountability. Accelerating and deterring factors influencing the growth pattern include:

Accelerators:

• Demand by consumers is strong for “more than” conventional health care.

• Results of a national research on many specific CAM therapies are enabling greater acceptance by the public and by conventional practitioners.

• Creation of IM studies by other federal agencies with some responsibility for health care (Institute on Medicine; White House; National Cancer Institute).


• Creation of new partnerships between CAM insurers and networks of service to include CAM in health care plans for large and traditional employers (e.g., General Motors, John Deere).

• Stakeholders/advocates for IM are growing and diversifying: hospitals and health systems, conventional and CAM practitioners, managed care organizations, academic medical schools and centers, private integrative clinics, public health and policy organizations, Internet/e-health educators/providers, natural products industry, venture capitalists, employers, and the employee benefits industry.

Deterrents:

• Definition of IM and vision for the transformation of health care: what is the baseline for claiming to provide IM?

• Access to IM vs. the current availability of only bits and pieces of CAM.

• Efficacy and efficiency data about what IM is lacking; better information would persuade insurers and more practitioners to provide it.
Financial backing is tenuous. Public financial deficits and the tightening of funding for public universities and hospitals and their IM programs. (One interviewee described the financial outlook for his center as: “Fragile at best. We break even with a supplement from the university; but the university now has a deficit and is dependent on a state budget that now has a huge deficit and the state is dependent on a federal budget that now has a huge deficit.”)

These push-pull tensions are typical of an emerging field. Leaders and advocates still feel they are pushing their rock “up the hill” and they are searching for the additional momentum that will carry their ideas into full acceptance and appropriate scale in the health care system and the society.

The following nine sections provide an inventory of the field and a “listening post” for what many of the leaders are saying about the current situation and the future possibilities.

[See Part III, the Visual Maps, for some depictions of the scale, momentum, and change process underway in the IM field.]
1. Founding Vision, Mission, Definition

Over the last 30 years, increasing numbers of Americans, particularly those with chronic and life-threatening illnesses, have begun to look for health care answers in complementary and alternative approaches. They are not turning their back on conventional medicine—it is, in fact, those who have had all the benefits of modern scientific medicine who have led the search—but they are very much aware of its limitations and side effects. They are exploring approaches that would complement this medicine - or in some cases, be alternatives to it. And, most often, they are exploring these approaches without valid scientific information to guide them.

James Gordon, MD, Chairman of the Whitehouse Commission on CAM Policy

Founding myths or stories can often explain the focus, direction, and dynamics of institutions, programs, and even individual life paths. Discovering and understanding the founding ideas and developmental patterns of IM are crucial because they are part of the defining process in an emergent field.

Personal and Institutional Catalysts for IM

Respondents consistently identified one or more of six common catalysts for their individual motivation and institutional interests in providing IM services and advocating for IM as a health care concept and option.

- **Perception of consumer demand.** The 1990 and 1997 Eisenberg studies confirmed for many people their own every day observations, hunches, and intuitions about the changing attitudes and openness of Americans about their health care. The surprisingly large numbers of users of alternative health products and services alerted health care professionals to both an unmet need as well as the potential dangers of self-styled health care.

- **Disgruntled frustration about the present; idealism for the future.** Some MDs and conventional and alternative health care practitioners are dissatisfied with the overriding disease-intervention model of medical care and the hurried services necessitated by the business structure of conventional health care. They desire a more open and holistic concept of health “care” as well as the access to more diverse “tools” when conventional care isn’t the answer.

- **Positive personal experience.** Many of the field leaders and institutional founders have had their own positive results with mind-body healing or an exposure (usually in early adulthood) to a completely different cultural mindset about health (most often Asian systems).

- **Leadership: Top-down interest.** The action and support by a top-level leader or administrator who has been transformed by one of the above (i.e., “market” perception, frustration, positive first-hand experience) has helped in the creation of many of the institutions and service programs.

- **Practitioners: Bottom-up organizing.** The organizing actions by a group of faculty or practitioners who see opportunities to serve and innovate through a new field of ideas have catalyzed change.
- **Visionary philanthropy or capital.** Individual donors and/or venture capitalists—often also transformed by personal experience or persuaded by the growing market numbers—are part of the founding formula.

Some or all of these catalysts are present in the formation of virtually all IM services—clinics/centers, educational programs, insurance coverage, and policy innovations (e.g., the formation of NCCAM), etc. Among the clinics/centers, there are some small but interesting differences in the catalytic process. The diagram below shows the types of catalysts mentioned by those in this study and the text that follows analyzes some different patterns.

**Catalysts Driving the Formation of IM Services & Institutions:**

For hospital and/or academic centers, the most important catalysts were:
- An administrative/leadership level champion.
- A group of faculty members and/or practitioners committed to changing the practice of medicine.
- A visionary philanthropist and/or other source of capital.
- Positive personal experience of founders/champions with complementary or alternative care.
The free-standing/independent centers, both profit and nonprofit, emphasized these catalysts:

- An empowered leader, disgruntled with the current disease-intervention model of medicine.
- Positive personal experience of founders/champions with complementary or alternative care.
- Consumer demand.
- A visionary philanthropist or source of capital.

Definitions and Terms

In response to questions about their theory or value system about “integration,” the respondents in this Mapping Study articulated a congruent core vision and definition about IM. Most of them proposed that, at a minimum, IM means:

- The availability and use of both conventional and alternative therapies to meet the needs of the patient without a strong bias for one modality over the other.

Most agreed that IM also means:

- The empowerment of patients to participate fully in their own healing and ongoing care.

- Collaborative process and mutual respect among diverse practitioners.

For some, the definition requires more qualifiers about the type of care:

- The availability and use of both the best of conventional medicine and the best of alternative therapies, based on the best available evidence.

- A few wanted “best” to be determined by “clinically proven data” or “evidence-based science.”

For some, the ultimate value of developing IM is to ensure a collaborative health system that includes many and diverse options from which to pick and choose appropriate combinations of care. For others, there was a vision of IM being a link in a larger evolutionary force toward a different concept of medicine. Some referred to a future “world medicine.” Others spoke of a “transformation of medicine” in which lines between
conventional and alternative care are invisible—a single medical system rather than collaboration among such differentiated parts.

While many of the MD-leaders tended to describe their founding vision in “blended” and “one-world” vocabulary, the NDs and other alternative practice leaders—while wanting equal acceptance (insurance, etc) and credibility of CAM practices—expressed concerns that “one-world” visions would result in the “takeover” and domination of CAM by conventional leaders and institutions. “One-world” would not imply a “merger” of ideas, but rather an “acquisition.” A few of the alternative practitioners went so far as to suggest that IM is only a creation of conventional medicine.

**Practical Definitions**
Within the IM Clinics, the concept of integration was defined on deeper levels in addition to the “IM Vision.” Some of the defining characteristics mentioned included:

- The diversity of services available to a patient, i.e., can you claim to be an IM clinic or an insurer of IM if you have only one or two alternative therapies available to a patient? This issue is likely to increase in importance as the field moves toward standardizing a level of diverse services that can be called IM.

- The Collaborative approach among diverse practitioners to overall understanding of the value and efficacy of various treatments and the shared care of individual patients, e.g., the clinic practitioners are integrated as a team and therefore they help the patient to obtain a “seamless” array of necessary treatments.

- Integration with host-systems/conventional care providers e.g., IM clinics with primary care clinics, other specialized departments of hospitals and/or universities.

- Integration of mind-body concepts into both the conventional and CAM care models.

Most of the clinics also admitted that the definitions of IM remain an ideal rather than the reality as few are strong enough or big enough to provide integration at all levels: services, practitioner approach, and integrative network with other clinics/services. And most raised doubts focusing too exclusively on creating their own separate models of integration as the goal rather than using the centers/clinics to help make way for larger systemic change.

The White House Commission Report on Complementary and Alternative Medicine Policy states its agreement with a 1998 editorial in *The New England Journal of Medicine*: “There cannot be two kinds of medicine—conventional and alternative. There is only medicine that has been adequately tested and medicine that has not, medicine that works and medicine that may or may not work. Once a treatment has been tested rigorously, it no longer matters whether it was considered alternative at the outset. If it is found to be reasonably safe and effective, it will be accepted.”
Mission

All of the centers’ missions and service structures contain three basic elements: education/information, clinical care, and research—though they differ in purpose and proportionality.

The Academic IM centers commonly share a commitment to:

- **Education**—particularly of health care professionals (new and/or established) through a formal partnership with a medical school and teaching hospital.

- **Clinical Care**—direct services for multiple or specialized health needs and usually limited to those few CAM practices that can be credentialed through the academic “parent.” The five most common are: acupuncture, chiropractic, homeopathy, herbal medicine, and massage.

- **Research** (beyond patient feedback) that proves the efficacy and efficiency of IM care.

Some respondents claimed that an academic center could not be truly useful without a commitment to all three. However, there are some centers that emphasize education and research or specialize in a specific area of pain or illness.

For Hospital IM centers the structure usually emphasizes:

- **Clinical Care**—direct services, but usually limited to a few practices for which there are reimbursements and the services are minimally controversial, e.g., healing touch, massage, and chiropractic.

- **Education**—primarily of the consumer/patient and the community. Cooperation with nursing and medical schools to host rotations for practitioners.

- **Research**—primarily feedback, documentation, and analysis of patient experiences; some have more strategic research agendas similar to those of academic centers and/or academically-affiliated hospitals.

For Free-Standing Centers the structure emphasizes:

- **Clinical Care**—diverse services from primary conventional care and nutrition to naturopathic medicine, massage, acupuncture, energy therapies (Reiki, polarity, etc.), hypnotherapy, shamanic healing, movement, mindfulness, etc.

- **Education**—primarily of the consumer/patient and the community; some also facilitate practitioner-education for medical students, nurses, and other disciplines. Most free-standing centers have experimented in marketing, public education, and broad community education.

- **Research**—primarily the analysis of patient feedback and patterns of care. A few have affiliations with academic centers or hospitals and their patient data are part of a larger data set being tracked and analyzed.

Again, like their visions, the centers’ mission statements, especially regarding clinical services—all overshadow their current scale and capacity to deliver services. All those interviewed have held fast to their values and founding vision in the design and quality of their services but none are working at the scale foreseen by their mission statements.
2. Performance

Fear doesn't serve. Be creative, and trust your gut. When there is no role model, you have to be a pioneer. There was no literature at the time we started—especially from an operational standpoint...just 4 peer-reviewed journals in 1996. Now there are more than 40. Use the community development model—listen to stakeholders, go for the 60% perfection rate initially, and understand that you have to change as you evolve.

Barbara Findlay, RN, BSN, Tzu Chi Institute for Complementary and Alternative Medicine

The creation of IM centers for clinical services and/or research and education is one of the main hives of activity in the overall landscape of the field of IM. There are differing opinions about the design, structure, potential for sustainability, and longevity of the centers. Some people believe that the centers are the future of health care institutions. Others imagine that the IM clinics and centers will be “portals” of the future, providing the entrance to a world of health care with the many options available from all systems. Others believe that IM centers will be short-lived experiments that will be unnecessary and redundant entities once the integration of CAM becomes commonplace throughout mainstream medical practice.

Regardless of the differing points of view, the IM centers right now are important sources of learning about how the ideals of integration can take shape in the practical everyday reality of health care. Therefore the design of this Mapping Study focused considerable time and resources on talking directly to center directors and questioning them about the “performance” of their programs. The information from the directors is both simple and complex: in the short-term and on a small scale, the centers are exciting ventures with high patient satisfaction and promising outcomes. Over time and imagined at a larger scale, the centers all see looming financial problems linked to bigger problems of equity, access, and sustainability. One director, speaking frankly, shared that the business plan is built on projections for marketing its services to the “worried wealthy,” even though the founders and leaders are all advocates of IM as a health care improvement that should be available to all.

Both the successes and the barriers experienced by the centers are instructive about the long view of the emergence of IM care. Interviewees responded to questions about their centers:

- Key milestones and major successes.
- Missteps, failures, and lessons learned.
- Value and impact to patients and affiliated institutions.
- Perceived value by clients/patients.
- Local barriers and barriers to the IM field as a whole.

Of the 30 interviews conducted for this mapping process, 19 were with current or former directors of IM centers.

In addition to reporting on this information from the “Mapping” interviews, this Performance Section also includes an analysis of the “Clinic Benchmarking” done by The Integrator between 1998 and 2001. The Clinic Benchmarking study is important because it adds 29 clinics for a combined review of nearly 50 clinics and centers. Intentionally, the
designs of this Mapping Study and the Clinic Benchmarking study overlap so that some results are comparable. In fact, both studies come to many similar insights about clinic sustainability, models of operation, staffing, etc. However, in some aspects, the two studies are also quite different. The Mapping Study tries to reveal insights about the overall field of IM as it is unfolding now and what is required in the future. The Clinic Benchmarking study concentrates only on the clinics and their profile data so that size, start up capital, service delivery, and structure can be described and compared.

The performance indicators and experiences vary somewhat depending upon the center's structure and place. For example hospital-based centers voiced the most concerns about the adequacy and identity of their space. In contrast, free-standing centers took the attainment of space as a mere necessity but worried about its ambiance and quality, desiring that the health care experience begin for the client the moment they walk in the door. Credentialing is one of the most worrisome parts of the hiring process for hospital and academic centers; free-standing centers have more freedom in hiring but expressed concerns about being able to afford and attract the “right mix” of practitioners. Overall, the performance issues were more similar than they were different among the different types of centers.

Performance was described by most of the interviewees through six dominant aspects of institutional development:
- Fiscal health and sustainability
- Space and infrastructure
- Personnel
- Education
- Research
- Identity

Some of the main ideas repeated throughout the interviews follow.

**Fiscal health and sustainability:**

**Success factors:**
- Starting a center requires start up capital. Some have begun on as little as $100,000 in seed money. Several more received start up grants of $1 million or more.
- Most are diversifying their funding bases to include research grants, earned income, and philanthropic gifts.
- The best streams of earned income (in addition to client fees) come from the sale of herbal products and dietary supplements. Some clinics have launched pharmacies as part of the center or clinic.
- Some centers have succeeded in raising endowment funds; philanthropic gifts primarily come from visionary philanthropists who believe in IM and also from grateful patients.
- Operate on a cash-only policy with patients.
- Be attentive to the return visits of clients as return visits have more cost benefit than a first or only visit.

**Failures:**
- Not being proactive enough on fundraising resulting in capital starvation; centers need substantial cash on hand in unrestricted operating funds.
- Trying to do too much too fast on too few resources, e.g., trying to launch research, education, and clinical services all at once.
• Inability to recruit practitioners with existing clients who will follow them to the center; hiring too many young or beginning practitioners builds in too much lag-time on profitability.

**Space and Infrastructure**

• Space is important. It needs to be adequate in size, identifiable as being “special” for the IM program, and visibly designed for holistic and mind-body healing. The healing begins with the space. Patients are vocal about valuing such a healing space. Centers that have compromised on space have reported it as a failure, especially those centers based inside hospitals or academic institutions as they needed to be distinct from the host institution.

• Centers/clinics based inside larger institutions also urge others to avoid underestimating the difficulty of establishing an innovative structure inside a conventional health care system. None of the existing systems are an exact fit and the adaptation process is demanding.

**Personnel**

• Staffs vary greatly in size and differ in their composition. Some staff are all employees; other staff configurations include more contract people and consultants.

• The more integrated the staffing design and structure, the more important staff management, coaching, and development becomes.

**Research**

• All centers are doing some level of research; academic centers are most intense in their commitment to competing for research funding at the national level.

• The academic centers see research success as winning the highly competitive national research grants and having the capacity to do evidence-based research. Failures in research are about the inability to conduct rigorous research or not prioritizing the collection of day-to-day data.

**Education**

• Clinics and their clients value the intensity with which IM clinics and centers transmit education and information to their clients.

• The academic centers and the hospital-based centers prioritize the teaching of IM practitioners as part of their structure and services.

• Free-standing clinics reported the necessity of building in dialogue with the community in order to make sure that learning happens in a loop: center to patient to center.

**Identity**

**Successes:**

• Creating a “signature” program that clients identify with the center (e.g., cancer programs or stress reduction, etc.).

• Holding leadership roles on NIH, White House, or other national committees.

• Publish a journal, online health advisory, or newsletter to establish identity and communications routine with clients and other stakeholders.

• Strive to be a resource to mainstream media; this changes the perception of IM from marginal to mainstream.

• Host national or regional conferences on issues that need dialogue and learning.

**Failures:**
IM leaders and physicians have not maintained visibility and credibility with conventional peers; this can leave the IM clinic in danger of “quackery” accusations or shunning by other parts of the institution.

The interviewees reported that clients value:
• Comprehensive services (both primary medicine and CAM therapies) in one facility.
• Space that is a healing sanctuary.
• Intensive self-help and education efforts (one center offers more than 36 different classes to its clients/patients).
• Practitioner-patient partnership.
• Feeling well-cared for; experiencing a culture of attentiveness to the whole person.
• Comprehensive health testing and evaluation using conventional and CAM testing modes.
• Open access to providers on e-mail.
• Generous amount of time allocated to visits
• High quality of practitioners.

Finally, the interviewees described the barriers they encounter in their own settings and in the IM field as a whole:

<table>
<thead>
<tr>
<th>FOCUS AREA: Barriers</th>
<th>Hospital-Based Center</th>
<th>Academic-Based Center</th>
<th>Free-Standing Center</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Grant money—private and public—goes to universities before hospitals and free-standing centers.</td>
<td>Lack of insurance reimbursement system and standard for CAM.</td>
<td>Lack of clear estimates of what it takes to launch a center.</td>
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<tr>
<td></td>
<td>Many clinics are reaching the transition from start up to sustainability and it appears that many are on the edge and in danger.</td>
<td>The financial structure of centers is impossible: Fees don't cover services; research doesn't break even even if the university demands too much of the overhead income; education doesn't break even for most; entrepreneurial income generation is possible but not a widespread practice.</td>
<td>Networking with other independent physicians as well as those in hospital and university settings.</td>
</tr>
<tr>
<td>Space/Infrastructure</td>
<td>Lack of autonomy when housed in a larger institution.</td>
<td>It saps creative time to try to make ends meet.</td>
<td>Clinics have to prove their outcomes and their costs.</td>
</tr>
<tr>
<td>Personnel</td>
<td>Surrounded by bureaucracy.</td>
<td>98% of NCAM $$ goes to conventional medical schools.</td>
<td>Definition of Integrative Medicine.</td>
</tr>
<tr>
<td></td>
<td>Overcoming the reluctance of physicians to refer.</td>
<td></td>
<td>Credentialing and setting state standards.</td>
</tr>
<tr>
<td>Research</td>
<td>Low availability of high quality staff.</td>
<td>Lack of evidence of outcomes and efficiency.</td>
<td></td>
</tr>
<tr>
<td>Identity</td>
<td>A “big-business” mentality is emerging among IM centers; “celebrity” centers dominate and this leads to a strategy of most resources invested in too few institutions.</td>
<td>Lack of uniform standards for licensing and credentialing.</td>
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THOUGHT LEADERS’ VIEWS about PERFORMANCE:

In addition to the centers’ operational leaders’ insights (summarized above and in the appendices), the thought leaders interviewed in this study had opinions and insights on the performance and institutional value of IM services. Some of the thought leaders had been early founders of centers; others interact with the centers through their current roles in industry, policy, etc.

Their opinions and ideas are captured here in their own words:

**Insurers:**
- We, as a country, don’t train providers for wellness and we don’t train people to take care of themselves; IM offers a change in this direction.
- Employers value a healthy workforce so they want services that get people feeling better and back to work quickly; insurers are getting better and clear data on utilization and outcomes of IM. Although these data are available to employers, many don’t pay attention and don’t want to know; insurers can’t advance IM without the employers.

  Interestingly, even with good data (CIGNA’s studies; Ornish data on heart disease) employers are still reluctant to include IM coverage. They are concerned with the short-term health of employees, not what will benefit them for the long-term. One insurer said: “As long as we have an employer-run health care system, from the insurance point of view, we’ll have a sick system.”

- Consumers want medical care they can understand; they don’t want any more barriers in the system; we can help get more options to the consumer.
- A shift in how health care is structured in the U.S. is required to meet the mission of making IM benefits available to as many people as possible.

**Pharmaceutical Science:**
- We need to educate new scientists and new leaders; without them this work will not get done.
- For the most effective training of medical professionals in academic centers, you must catch them young, when they are interested in making a name for themselves. The Pharmacology area lends itself to this.
- Patients are vocal about valuing the inclusion of women in clinical studies and the future credibility of health products will depend on distinguishing their value for men and women.
- The University of Illinois at Chicago’s NAPRALERT Database on medical plants is valuable as more nutraceutical research is being done in more universities and hospitals. The database is available to scientists and nonprofit organizations in developing countries, free of charge. In addition, they provide research training for scientists from developing countries in the area of medicinal plants (Botany, Chemistry, Pharmacology, Toxicology, and Clinical Evaluation).
Founders/Early Innovators:
  • Key milestones in the field have been the engagement of important legislators (Harkin, Hatch, Kennedy, and Feinstein).
  • The increasing and diverse research and the centralization of retrievable information online (e.g., PubMed, etc.) is having an important impact.
  • Training leaders as agents of change in the culture, clinical, and academic centers is key. Education is the basis for change but education is never self-sustaining and there is no money for it.
  • IM is not a subspecialty but should be part of all training in medical school.

Policy:
  • Evidence, cost patterns, utilization, and cultural attitudes all must be documented to continue to build credibility both in policy and practice.
  • Reach business leaders with concerns about health care costs and policies—they must be educated on the options.
  • More resources are needed to level the playing field. A quasi-underground system can’t compete with the large investments in the current medical system. Why aren’t we wiser in the way we invest our research dollars? New conventional research may achieve a 10% gain at the margins of advancement where we haven’t scratched the surface of CAM therapies and how they can be effective.

Note: Tables showing the details of interviewees’ comments about performance factors are available in Part IV-Appendices (Appendix A)


The initial report of The Integrator’s Clinic Benchmarks Study was published in 1998 just prior to the release of Eisenberg’s updated report “Trends in Alternative Medicine Use in the United States, 1990-1997.” The $28 billion cash-out-of-pocket that consumers were spending on CAM in 1997, as reported by Eisenberg, painted a cash-rich image for this growing field. Interest had been growing since the initial study in 1990, providing the incentive for hospitals and health care systems to develop, or get to market, their integrative clinics. The first group of IM clinics to be formed and studied was created in this eye-opening context of the unexpected size of the IM/CAM demand.

Due to the cash-rich image of consumers prevalent in this period, supporters and founders of IM clinics did not see the need for third-party contributions or philanthropy, though this initial impression has been revised.

In The Integrator’s first survey of clinics (1998), respondents stated that the critical changes for supporters and founders involved achieving increased trust in the IM relationships: greater openness in conventional practitioner referral patterns must be supported, and clinic operators must be invited into the system of fundraising. These were the two key changes that leaders felt must occur to secure the financial integration of CAM into the care delivery system.
These and other key questions around the financial model have not changed and have not been resolved. Questions about the viability/sustainability of the centers are central from the first survey in 1998 to the last in 2001 in the Clinic Benchmarking study.

The following paragraphs summarize several aspects of the Benchmarking study.

**The Variety of Structural Models**

There is no common model for the 29 clinics in the Benchmarking study. In this sampling, there were diverse operating strategies: nonprofits, for profits, some part of larger health care system ranging in size from 850-26,000 ft\(^2\). Leadership is provided by diverse professionals: MDs, NDs, PhDs, entrepreneurs, and health care administrators. *The Integrator*’s report attempted to identify trends, shared features, and common denominators.

Over the five years, *The Integrator* codified four distinct categories for IM Clinic models:

**Complementary Health Services.** In this model services are typically limited to education, massage, body work, and some energy therapies such as therapeutic touch. Common characteristics:
- Services are part-time but only generate $45 to $65 per visit.
- Third-party payment is typically minimal or non-existent.
- Revenue from these practices cannot support overhead.
- High patient satisfaction with services.

**CAM-centric Services.** In this model the centers include services of distinctly licensed providers (acupuncturists, chiropractors, naturopathic physicians). Direct involvement of any medical doctor is limited, even in a part-time, salaried, non-clinician medical director capacity.

**Integrative, CAM-centric Service Delivery.** In this model the typical leader is an MD or DO (Doctor of Osteopathy); but most services are provided by non-MD/DO practitioners. The medical director may not have extensive clinical experience in integrative care but is considered to be the team leader, providing clinical strategy guidance, clinical program development, outreach to the system, intake, or management of complex patients. The MD provides reassurance to the system’s more conservative conventional physicians. Respect for the distinct skills of the CAM provider team is critical. Often the CAM providers are relatively low-cost and productivity-based providers; MD-DO is salaried.

**Integrative MD/DO-centric Service Delivery.** This model bases most care provision on services of “integrative physicians,” MD/DO practitioners who have skills in one or more CAM modalities, typically acupuncture and some therapeutic nutrition, botanical medicines, homeopathy. The potential for revenue in these clinics is high but overhead may also be high. A challenge to this model: managed care contracting does not typically have payment categories which reflect the diversity, individualization, and time intensity of integrative treatment.

Some institutions may be looking to integrative clinics as a new source of revenue, but little evidence was found over the five years of the study that these clinics are making direct financial contributions to the parent organizations.

Some thought that one area of growth lies in the support for inpatient services, i.e., earning revenue from services provided to patients referred from the system’s conventional physicians.
Clinical Services
Consumers’ growing interest in relaxation and mind-body approaches is strongly reflected in the offerings of clinics surveyed. General education services (93%), group-focused mind-body programs (70%), yoga (70%), and multi-week condition-specific programs (67%) are all widely available.

Chiropractic, in spite of its general acceptance by consumers and the insurance industry, is offered in just 19% of the clinics surveyed. Acupuncture, used by only 1 to 3% of consumers, ranks third highest in these clinics. The 1997 NIH Consensus Conference on Acupuncture, and a similar conference in 1995 on mind-body approaches to pain, is widely acknowledged as the evidence base that supports inclusion of these services. Yet the evidence for chiropractic, captured in clinical practice guidelines from what was then the Agency for Healthcare Policy and Research, has not shown the same ability to influence inclusion decisions. The relative absence of chiropractic in these clinics is typically attributed to opposition from conventional medical staff rather than to lack of evidence for its efficacy.

Choice of Practitioners/Practitioner Credentials
An ongoing issue in the integration debate involves selection of practitioners to provide a particular CAM modality. The question is whether acupuncture, manipulation, or massage should be provided by a distinctly trained and licensed acupuncturist, chiropractor, or massage therapist or whether these services should be provided by conventionally trained practitioners who have developed some skills in a specific treatment option.

For some sponsors, the initial experiment is only with integrating complementary services into their clinics. While 74% of the clinics have MDs on staff as clinicians, in roughly one-quarter of the clinics surveyed, there is no integrative-oriented medical doctor on staff or acting as medical director. Respondents from most of the clinics without this type of active medical director noted that this absence creates a significant void, particularly if the clinic is seeking to build referrals from the health systems' staff physicians. The claim that medical doctors listen to medical doctors is certainly confirmed in the CAM integration environment.

Developing Clinical Integration
Clinic operators find that both CAM practitioners and conventional practitioners tend to operate independently and they have little experience, awareness or skill when it comes to knowing when cross-referral to a distinct practitioner in the clinic makes the most sense. The most popular strategy for building an integrated team is a weekly meeting of 60 to 90 minutes. Many view the team meetings as possibly the best clinical education in the value of CAM for medical doctors in the US today.

Salaried or Contracted?
The clinics are diverse in their approach to contractual relationships. Just over half of the clinics say they have both salaried practitioners and those who are on incentive-based contracts. Conventional medical personnel, in particular medical doctors, are significantly more likely to be salaried than are distinctly licensed CAM providers.

The experimental nature of these operations accounts for some of this double standard. CAM practitioners on split-fee incentive contracts are told, in effect, that they must earn their keep.
Most of those interviewed agreed that from a business perspective, linking payment to production in integrative services makes sense, just as it typically does in most conventional business models.

**General findings that apply across these models are the following:**

- Large clinics (6,000 or more square feet) are not likely to achieve operational break-even without a core of integrative MD/DO providers.

- Chiropractors, while controversial, can prove to be significant patient draws, even in MD/DO-centric models.

- Thorough integration into hospital or health system clinical programs is unlikely to be accomplished without the involvement of an MD/DO ambassador from the clinic.

- Systems that only offer complementary health services should anticipate needing an ongoing system subsidy.

**Business Models: Referral and Income**

The national dialogue around consumer-use of CAM typically notes the grass roots source of this interest. In the emerging “alternative medicine” of the 1980s and early 1990s, patients typically paid cash and were self-referred or referred by family members or friends.

One of the most significant findings of this survey is that, while owned by mainstream delivery organizations, the business model of these hospital and health system-sponsored clinics remains largely “alternative.” Word-of-mouth is still the top source of new clients. Revenues reflect little third-party payment.

**Some sample findings:**

- 75% receive less than one quarter of their referrals from conventional physicians.

- Nearly two-thirds (65%) of the clinics receive 90% or more of their revenues as cash.

- 87% obtain 30% or less of their payment from managed care.

- Almost none do any direct contracting with employers.

- Word-of-mouth is viewed as the most successful marketing strategy.

From a business standpoint, the potential for profitability is enhanced by direct patient access to CAM services. As the conventional medical staff becomes more comfortable with CAM, access is more readily facilitated.

Another potential for referral is from CAM providers in the community who may come to view an integrative clinic as a supportive place to send patients who may either need to see a medical doctor or for services the community provider does not offer. However, few of the clinics have successfully positioned themselves as partners with the community CAM providers.
Model is Non-Integrated
Typically, in the first stages of clinic development, the model that emerges is remarkably non-integrated into either mainstream payment (via third party compensation) or mainstream delivery (via routinely utilized referral from conventional MDs/DOs).

The clinic operators underscored the laborious nature of developing referrals from conventional physicians. Moreover, only a few reported successes in developing special relationships with managed care firms. Many link economic sustainability of integrative clinics to the integrative services’ penetration into the health system’s conventional practice. One example of a recent success is a relationship with a breast cancer specialist who routinely refers her patients to an integrative clinic for supportive, integrative care. The clinic is now developing integrative programs designed to piggy-back on other existing health system clinical initiatives.

Marketing Strategies
More than half find that promotion by word-of-mouth is their most successful approach. An additional “mouth” that has played an important role for 16% of respondents is the free advertising gained through media reports.

In general, the clinics do not report significant value from direct mail, newspaper, television, or radio advertising. By comparison, the free media gained through news reports seems to grant the clinic internal legitimacy by creating visibility within the health system. As one medical director said, “It put us on the map.”

Clinic Strategies for Data Collection and Research
Most of the surveyed clinic operators realized that because they were called pilot or demonstration projects, the integrative clinic had something to prove. Research, for most clinics, is considered a core part of their mission. Over 80% of clinics surveyed report routinely gathering quality-of-life information and measuring patient satisfaction. A similar percentage state they are using standardized forms for intake. A rich body of data appears to be accumulating in these clinics. Two-thirds announce a formal research intention, with half of these planning to explore the question of how research provides some cost-offsets in the clinic.

Looking to the Future: Money, Marketplace, and Mission
These clinic profiles are what may be considered some of the generation of health system-sponsored integrative clinics. The system motivations have typically been threefold: money (creating new revenue streams), marketplace (besting or matching competing health systems), and mission (using CAM to build a more healing-oriented, patient-centered care). The models portrayed here are non-integrated into either third-party payment or referral practices of conventional providers accumulating in these clinics.

Outcomes to date, based on the interviews with the clinical developers, are poor on money, uncertain on market advantage, but resoundingly upbeat on patient care. The question for the next generation, and for many present sponsors, is whether shortfalls on the revenue end will allow these explorations to continue.

These models provide numerous tips on how to create sustainable CAM clinics inside conventional delivery systems:
- Don’t over commit.
- Provide incentives to practitioners.
• Expect relatively low margins on CAM labor-intensive delivery structure.

• Keep system overhead low.

• Seek philanthropic support.

• Finally, expect creation of significant value to take time. Growth will be through word-of-mouth from experience-based relationships.

Present experience suggests that the focus should be on the relatively unexplored areas of relationships (programs with employers and insurers) and on creating value among the health system’s conventional physicians. Short of engaging these critical elements of a more substantive integration, these facilities have an uncertain status in mainstream payment and delivery.

NOTE: A Table summarizing the details of The Benchmarks Study is available in Part IV—APPENDICES (Appendix B).

3. STAFFING

If you look at the larger system you see a large number of MDs leaving medicine now: they are miserable; they don’t see a concurrency of values of health and wholeness. The current health care system can’t meet MD’s ideals. Many students feel that through CAM and/or IM they can reclaim what they want medicine to be about.

Tracey Gaudet, MD, Duke Center for Integrative Medicine

In addition to the perennial challenges of how to find, hire, and compensate the best staff, the greatest staffing challenge for IM centers and clinics is how to structure staff for the best fit with mission. The Study considers one main cluster of questions in the area of staffing:

How extensively should a center’s staff be integrated? How important is such integration for the delivery of IM care? Is better medicine provided when a staff team is the “integrator” for an individual’s care? Or is it better (or more manageable) for the staff to simply provide care while the patient integrates their own care plan?

Most of the centers’ leaders said that they believed that the staff teams should be well integrated—meaning that they should work collaboratively and consider themselves to be unified as a mini-system of care for each patient. Most have or are creating thorough intake procedures so that the IM professionals can counsel and guide the client toward an integrated care plan. According to this thinking, the IM staff is the integrator of care for the patient, and staff should be integrated to best perform this role.

Some centers, however, favor a model in which the patient is the integrator of his/her own care. In some of these models there are backup systems to assist the patient. Several centers keep integrated records; others have a conference system among the practitioners so that periodically all of the practitioners gather to share information about
each patient. Another center with the patient-as-integrator model also offers PODs (Patient Oriented Delivery System) or a group appointment in which multiple patients meet as a group with one or more practitioners. This is, of course, a common practice for delivering certain therapies such as yoga and nutrition education; but some practitioners are also experimenting with the group model to deliver physical therapy, counseling, and energy therapies.

A few centers have an either/or or both/and approach in which an integrated team exists but the client also can take the integrating role, depending on the client’s individual needs.

While all of the centers are striving for a comprehensive model of care for each patient, some are also willing to offer what one called “wellness a la carte,” meaning that a patient might use the clinic to obtain treatments as needed without ever having a comprehensive care plan. For others, the intake process is so intense (often a 90-minute interview and assessment) that occasional or isolated services would be discouraged.

Expense is the greatest problem described by the center directors in implementing integrated team models. In order to have integration, practitioners must devote at least one or more hours per week for conference and consultation with other practitioners. It is difficult to recover the costs of this kind of coordination and shared learning and problem-solving. Some clinic directors said that building such costs into the price of office visits makes the visits too expensive, especially when the client is not reimbursed through insurance. Some are using their start up capital to cover the costs of integration in the early stage of a center’s life but are puzzled about how to make the transition to sustaining this level of care.

Some clinics are experimenting with a “concierge” or patient-advocate model in which a nurse or nurse practitioner becomes the integrator for both the patient and the practitioners. This concierge or advocate “works” the system to create a care plan, helps the patient navigate the system, and enables all the health care practitioners to be aware of the others. The advocate facilitates the integration.

The ability of a center or clinic to integrate also is affected by the conventional and CAM balance in the staff and the mix of salaried employees and contractors on the team. Most of the centers interviewed include both salaried employees and contractors.
The staffing integration models that seem most dominant in the clinics and centers are described below. Each of these models includes a mix of employees and contractors on the IM team:

**Advantages:**
- The whole person is recognized.
- Usually beneficial for the person to have exposure to/availability of multiple modalities.
- Practitioners learn from each other and get exposure to new ways to think about how modalities work together; it can be a learning high.
- Feedback and research on effectiveness/outcomes of care can be designed collaboratively.
- Increases the "patient visit volume" for the clinic by having multiple practitioners interface with the client. These multiple relationships guarantee follow-up visits with several practitioners rather than with just one.

**Disadvantages:**
- Costs: paying staff for collaborative time and the opportunity cost of losing patient services time while practitioners are in collaborative meetings/conferences.
- Resulting patient cost due to high cost practitioner/patient interface.
- Requires integrated records and technology that may be too expensive for start up efforts.
Advantages:
- The patient feels secure about diversity and quality of recommended care because care is coordinated/integrated.
- The patient has access to more diverse care options than most centers can offer under one roof.
- Center-based practitioners can learn from practitioners outside of their center and vice-versa.
- Expanded learning as a larger network of practitioners can share records and documented results.

Disadvantages:
- Some loss of control of quality.
- Difficult to maintain a network of appropriately credentialed colleagues.
- Integrated staffing and shared responsibilities for guiding the patient to care beyond the center is costly. The center-based practitioners need to know the services available in the community and feel confident in recommending them.
- Turf issues may arise, affecting overall care.
- Coordinating a network of practitioners requires shared technology and record-keeping so that integration is possible.
Advantages:

- Reduces collaborative costs among practitioners.

- An integrative records system can aid both the patient and the various practitioners. If all practitioners can easily get to the patient record and if the patient can easily get to the record in order to authorize it for others to use, then the entire knowledge base about an individual is more transparent and usable.

- Patients may learn more and be more assertively responsible for their own care.

- Patient can seek out diverse practitioners within the center or from any other institution or practitioner in the community.

Disadvantages:

- Practitioner learning is less intense.

- Patient may not be as well informed as desirable.

- Loss of continuity of care.

- Patient may become frustrated with coordination and lose interest due to the extra effort.
Advantages:
- One designated person integrates care for both the patient and the practitioners; there is an advocate coaching both the patient and the practitioners.
- The costs for concentrating integration in one person are less than constantly sparing practitioners for the integration/collaboration process (still appears to be an assumption, not proven).
- The costs for a concierge or advocate can be billed to patients or patients can hire their own consultant who interfaces with the center and other providers.

Disadvantages:
- Additional costs for the patient.
- Patient may feel limited to the network of the selected advocate.
- There are no accepted standards at this time for the selection or role of a consultant/advocate/concierge.
Advantages:
- Patients learn from each other as they all share same or similar issues.
- Practitioners have greater patient exposure, increasing learning.
- Cost of educational/consultative care is reduced.

Disadvantages:
- Works primarily for problems that benefit from group process rather than single one-on-one treatment (e.g., does not work for acupuncture).

Integration Models Used by Mapping Study Clinics:

<table>
<thead>
<tr>
<th>Integrator Models</th>
<th>Percentage</th>
</tr>
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<tbody>
<tr>
<td>Both</td>
<td>22%</td>
</tr>
<tr>
<td>Patient as the Integrator</td>
<td>39%</td>
</tr>
<tr>
<td>Team as the Integrator</td>
<td>39%</td>
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</table>
• Seven centers use the Patient as Integrator model; the practitioners are administered through a center and some do have a system for consulting with each other but they are not a collaborative team.

• Seven centers use the Team as Integrator for the patient and in which various methods are used to enable collaboration, information sharing, and learning. Some of these also explicitly value a collaborative model that recognizes all practitioners as equal and does not favor MD-domination.

• Four centers use both/and or either/or.

Of these 18 centers:
  • One also explicitly organizes its services to encompass a network of community-based practitioners.
  
  • One also is experimenting with a concierge/consultant model of integration.
  
  • Two centers are trying to use PODs whenever possible.
  
  • Most are working with some contract staffing. Contract-practitioners have space in the clinic and are coordinated through the integrating model in place in that clinic. Administratively, each practitioner is an individual entrepreneur, seeing his/her own clients and billing/collecting fees individually. One center reported collecting rent and fees from the practitioners who are based in their space, thus making the staffing structure an income-producing activity.
4. Clients/Patients

The patient is the most important person in their health care.
Joseph Pizzorno, ND, former President, Bastyr University

Client/Patient Self-care
The emphasis on self-care may be one of the most powerful assets that IM brings to the health care marketplace. IM leaders express the belief that self-care will transform the life of an individual patient and ultimately will transform the health care system. As a result, most of the IM clinical programs as well as IM medical school education curricula focus on empowering the individual patient and making them a partner in their own care.

The White House Commission on CAM Report (2002) points out that approximately 75% of all health care spending in the U.S. currently is for the treatment of chronic disease. Conventional as well as CAM leaders recognize that most chronic disease is tied to lifestyle choices and therefore preventable. Conventional medicine does include prevention strategies. But IM leaders believe that the IM combination of conventional and CAM approaches and its defining commitment to empower the client will prove to be critical factors in IM effectively dealing with chronic disease. Successful prevention of or intervention in the care of chronic disease would make IM a force for change in the overall systems of medicine and health care.

The commitment to provide intensive information about and coaching to achieve self-care is the strongest common characteristic across all IM centers, regardless of their setting or structure. Most of the centers believe in similar formational components for self-care:

- Access to information
- Nutrition
- Exercise
- Contemplative practice
- Relationships

Ken Pelletier, an IM thought leader noted in his interview, “The message about self-care needs to happen right at the moment of intake; it is the first attempt to communicate the culture of self-care and it is the test of how the patient is listened to. I can’t think of a single more important therapeutic function.”

Some of the examples of self-care programs and services include:
- Carefully building the practitioner-patient relationship as a partnership.
- Providing fact sheets and information searches for a patient’s specific concerns.
- Improving food shopping, cooking, and offering “eating out” classes.
- Opening access to electronic medical information system.
- Integrating medical records that are open for patient reference.
• Making available reference library and resource room for patients.

• Teaching take-home skills (energy work, yoga, etc).

• Offering seminars, retreats and classes that provide community education and enable potential clients to make appointments for services.

Some centers begin the self-care education process before the patient ever arrives by sending advance packets of information and self-assessment materials. Duke, for example, is using a specific model or protocol for discussing self-care options and is conducting research to understand all factors affecting self-care, including the patient’s self-perceptions about the efficacy of self-care. For most of the centers, a careful first visit and intake process is designed to make clear—upfront—that outcomes will be dependent upon the patient’s commitment to self-care.

Some directors observed that while the centers are clear and ambitious in their efforts to persuade their patients about self-care, it is easier said than done and rarely is accomplished through single interventions.

Health in New York City—for example—developed a three-part approach:

1. Fact sheets. Forty different fact sheets were developed for client education prior to opening and are used to prepare clients for their care.

2. Follow-up calls. Practitioners follow-up with clients on a regular basis to reinforce the information from their visit and the written material.

3. Library resources. Reference library available to clients with extensive number of books, magazines, medical reference books, dictionaries, etc.

[Note: Health closed in 2003 as this Report was being completed.]

Client Population and Marketing
National survey data about those seeking alternative and integrated care are reflected in the patient populations of most of the centers interviewed. In general that population tends to be:

• Predominantly women
• Early middle age (mid-40s)
• Highly educated
• Dealing with chronic conditions
• Of sufficient income to pay for services (often middle to top level incomes)

Those clinics with specialties in pain management are seeing increasing numbers of men, often referred by employers. Other centers specialize in aging and mid-life changes and tend to see older populations, especially when they accept Medicare.

While some clinics are interested in diversifying their base of patients, others wish to specialize in a particular type of injury or illness. A few are intentionally trying to build their reputations as women-friendly clinics.

Most of the clinics have had mixed or little success with traditional marketing and advertising; and some have learned this the hard way after spending considerable money and time. Some have held back on marketing since they are still too small and have too few practitioners to respond to a surge in demand but are planning to move into
marketing in the future. (Also, the lack of know-how is a stumbling block since medicine is not a business that is traditionally marketed.)

Some of the lessons learned from marketing:

• Word of mouth is powerful and positive because a new person comes with pre-existing trust.

• Marketing is important to educate the community and to serve increasing numbers of people since most centers’ missions include the intent to help change the health care system in their communities and nationally.

• Creative marketing methods are needed (use of volunteers, getting information to people who are looking for the services) since word of mouth is not fast enough for the job.

• The use of public service announcements is a beneficial method of marketing that positions the centers as credible community resources.

The centers are aware of the messages they wish to send to the community. In the interviews the center leaders were asked to imagine the messages they believe would be effective with the public and would actually be used in marketing their own center. Not all the leaders used exactly the same phrasing or words, but there was considerable overlap in the messages they articulated. Some will build their marketing campaigns around these messages:

• Find relief from long-term or lifelong pain.

• Take charge of your health care, i.e., “There’s a lot more you can do for yourself.”

• Prevent the illnesses of carelessness or aging.

• Improve your life.

• Enjoy the benefits of relationship-centered care.

• Heal the whole person.

The centers also hold similar ideas about how to position themselves in the marketplace:

• Credible and innovative.

• Effective health care delivery.

• A place for education, research, and care.

• Helping to move the community to support healthy living.

• Clinical and scientific grounding for familiar as well as new therapeutic options.

• Many and diverse therapies are available; the center provides access to numerous credentialed practitioners under one roof.

Some of the barriers to marketing:

• Lack of financial resources.
• Lack of direct experience and therefore lack of confidence about managing a marketing process.

• Attitude of some (especially in parent institutions) that marketing health care services is unsavory or a waste of money.

• Convincing people to try IM is often an emotional process and is not data driven; most people don’t have an emotional experience through marketing, therefore marketing that is only rational and not sensitive about appropriately getting to emotional experience will have lackluster results or fail altogether.

Some of the concerns regarding the centers’ accessibility:
• Lack of access to care by low-income individuals.

• The self-pay system means that most centers will emphasize their marketing efforts for the wealthy and/or insured.

Health Insurance
The availability of insurance reimbursements for IM and the ease with which centers can deal with insurance affects the willingness and ability of individuals to seek out care that goes beyond the familiar and customary options.

The Mapping Study did not document state-by-state rules for insurance of IM or the actual rates of coverage. The centers’ experiences as reported through this mapping process indicate that reimbursements to their patients are “small and few” rather than comprehensively available and generous. Nevertheless, the trend in insurance coverage of CAM is one of slow and steady expansion and growth, not retraction. Some of the evidence of this includes:

• Several credentialed networks of alternative providers began as networks only for chiropractic and are now diversifying beyond chiropractic and into other forms of alternative care; new networks are forming specifically to cover diverse forms of complementary and alternative care.

• In 1999, The Integrator reported a Landmark health care study which found that nearly 70% of HMOs offered some CAM service or coverage, primarily chiropractic (66%) and acupuncture (31%).

• In June, 2002 the AARP formally partnered its Alternative Health and Wellness Network with American WholeHealth, Inc. AARP has a membership of 30 million and American Whole Health has partnerships with over 25,000 practitioners throughout the U.S. (chiropractors, acupuncturists, massage therapists, registered dietitians, and nutritionists, and mind-body therapists, e.g., guided imagery, yoga, personal training, Tai Chi, Chi Gong, etc.).

Despite these signs of growth in coverage, the centers in this study reported that few (less than 10%) of their patients collect reimbursement for care, though the majority of the centers don’t really know since they do not specifically collect this information.

Only 10 of the 17 centers reported taking direct reimbursement and two of these plan to stop the practice since the reimbursements are too small to cover the costs and the required administrative staffing is too complex for them to sustain.
This means that most of the centers are or will be primarily structured for self-payment by clients. Susan Folkman, of the Osher Center at UCSF, reported that Osher conducted its own survey of IM centers’ best practices during their start up planning process. The single strongest recommendation they received from other centers was to structure the Osher Center for self-pay: cash only!

Some of the clinics admitted forthrightly that the self-pay system—even when clients can claim reimbursement—leaves them with the dilemma of limiting their marketing to the wealthy even though people of every class and income need their services. Some of the clinics have business plans that include serving people of all income levels but they don’t yet know how to get there.

The Employer/Managed Care Working Group of the Collaboration for Healthcare Renewal Foundation has pledged to work for expansion of existing CAM products and services into major health systems. They have defined expansion as:

- New customers among major health systems and employers.
- An accelerated transition to embedded benefits and supplemental riders from affinity programs.
- Increased access to CAM services by customers of health plans.
- A greater scope and increased menu of available CAM products and services.
- More meaningful and substantive integration with conventional medicine.

**Malpractice Insurance**

For most of the centers and practitioners, malpractice insurance has not yet become an issue. Some fear it is an issue that is coming, especially as the centers deal more in pharmaceuticals and nutraceuticals. Others believe that malpractice insurance will never get out of hand for IM because the therapies are gentle and not traumatic and also because of the time and attention-intensive, relationship-centered partnership between the practitioners and patients. A 1998 *Journal of American Medicine* article based on a Harvard School of Public Health survey on the medical malpractice implications of alternative medicine found that alternative care practitioners have fewer claims and for less severe injuries than physicians. However, in some situations physicians are liable for negative consequences of their referrals to alternative practitioners, should those arise.

In reality, little is known about the malpractice experience of complementary and alternative practitioners and it is an area needing more documentation. If the field of IM does become more litigious, the negotiation of malpractice rates will be difficult because IM will be an unfamiliar concept for insurers. Moreover, the intrinsic quality of integrative medicine means that no single intervention or therapy is the sole cause of or the deterrent to recovery; rather it is the combination of efforts, including those of the patient. This integrative model itself will likely challenge current rules and standards of malpractice coverage.
5. Sustainability

The mundane should never be covered. Insurance should be for the catastrophic illnesses and needs. The sore throat is bankrupting the system. Chris Foley, MD, Integrative Care

Deciding whether the cup is half full or half empty is a dilemma when thinking about the sustainable future of IM.

Thinking at the level of IM as a field of thought and practice, it is easy to be optimistic and see the cup as half full. Consumer interest in CAM and in the integration of CAM into conventional medicine is growing steadily.

- Through 2001, naturopathic medical schools such as Bastyr, acupuncture and chiropractic colleges, and massage therapy and energy healing programs were reporting growing enrollments. For some, 2001 was a record enrollment year. In 2002, Bastyr and others reported a downturn in enrollments but current interest in these professions is higher than it has ever been.

- More medical schools are creating and offering IM courses and sub-programs to meet the increasing interests of medical students and the continuing education interests of practicing physicians.

- American Specialty Health, one of the companies that aggregates alternative health services for employee group insurance plans, has grown substantially with interest coming from traditional and mainstream companies like General Motors.

- Most hospitals offer some basic CAM therapies, usually healing touch services, therapy, and massage.

- At the level of mass culture, bits of alternative health care are embedded everywhere, e.g., community recreation centers commonly offer yoga, supermarkets are expanding their health products to include health foods and nutraceuticals, and popular magazines advocate for meditation.

A general notion about the value of IM seems to have enough momentum to continue increasing in importance for years to come. Short of disastrously negative research about alternative therapies and supplements, the consumer commitment to IM appears firm. The aging demographics along with evidence of increasing aging-related illnesses (chronic pain and syndrome illnesses like fibromyalgia) in the U.S. are a combination likely to stimulate IM’s growing importance. In this sense of commitment to an idea, the field itself has momentum and staying power.

However, when looking more locally at the delivery of IM services and specifically the individual IM centers, the sustainability glass appears to be half-empty. All centers—nonprofit and for profit—and in all settings are facing sustainability challenges. Most of them are relatively young (less than 10 years-old) and they see themselves in the early start up or entrepreneurial stages of development and therefore they accept the uncertainty of sustainability (at this point) as a natural part of the evolution of an institution. All expressed optimism about finding a way to thrive and grow; yet in the six months of this study’s interviews and writing, two of the centers in the study announced that they would close (Tzu Chi Institute for Complementary and Alternative Medicine and Health).
The financial viability and sustainability problems of the centers are not exactly the same in each one as they all have different strengths and weaknesses, different strategic advantages and disadvantages in terms of how they were founded, and different structures and institutional parents and partners.

The sustainability problems described by the centers included:

**Chicken or Egg Growth Problem**
Many of the centers—both profit and nonprofit—have started out small in scale in order to model the concept of IM and to test their ability to deliver. Most are undercapitalized. Because they are small, they are not making enough revenue to hire more practitioners. In order to attract more patients to have more income, they need to first hire more practitioners. Some are filling out their staff and consulting positions on venture investments, philanthropic, or government-assisted start up capital but are then finding that patient revenues don’t always break even with the costs of providing services in an IM model. Most are not doing marketing because they cannot afford the costs and, as a result, they are not fully using the capacity they do have. At the same time their start up capacity—even at full utilization—is too small to get the cost advantages of scale. And the capacity of most centers is much too small in proportion to the size of their communities and the consumer demand.

**The Hole in the Bucket Problem**
For some centers, the more business they get, the less sustainable they become. In other words, the more patients they see and the more research they do, the poorer they become. They are losing money on each service.

For those clinics that accept direct insurance payment, this is especially true since insurers—private and government—do not reimburse the full costs of IM consultations and therapies. It is the reason why most of the centers have policies about providing services for cash-only patients. At the same time, even cash-only centers believe they have yet to devise a fee scale for services that covers the true cost of service without scaring away patients. Some centers (UCSF, Scripps, and Thomas Jefferson) believe they will meet their business plan goals of breaking even within three or four years of opening their doors; but all are still working with philanthropic start up capital.

For some centers, investment in research, especially under federal grants that carry overhead allocations, provides the “give” in the system and enables break-even budgets. But some centers in academic settings are required to turn over all the overhead to the general university fund. The university then returns a small portion of the collected overhead to the center but it is not enough to cover the true overhead costs of the center itself. As a result, the more successful they are at winning coveted research grants, the poorer they get.

**The Philanthropy Solution**
Most of the nonprofit centers, regardless of setting, believe that the development formula for their center’s sustainability is “Thirds:”

- 1/3 revenue, primarily from patient care or income-producing education and training,
- 1/3 research grants (primarily federal grants), and
• 1/3 philanthropy from individuals and foundations. Some are receiving development assistance (grant writing, donor research, etc.) from their parent institutions and some plan to hire their own development professional.

**The Entrepreneurial Solution**
In addition to billing for services, most centers are devising business plans and exploring options for earned income. The entrepreneurial ideas being explored by the centers include:

- Developing training and continuing education institutes for health professionals.
- Creating information systems and information products.
- Developing signature products identified with the center: vitamins, supplements, therapeutic oils, etc.
- Charging for community education (e.g., public speaking, workshops, training).
- Creating “satellite” clinic sites.
- Improving the strategic value of research outcomes for the field.
- Do more research and use it to serve and lead the field.
- Creating a retail operation to sell related products on site, such as an herbal pharmacy.

**The Cost-Management Solution**
Without sacrificing the vision of an IM model built on relationships, time, and empowerment of the patient, the centers are seeking ways to contain costs. Some of the ideas include:

- Minimize full-time staff/faculty appointments and retain practitioners on consulting arrangements.
- Conceptualize the center as a “mall” and contract with each practitioner to rent space as an individual entrepreneur. The center gets rent plus income; the practitioners bill and collect fees directly from patients.
- Create a uniform fee for office visits so that choosing the right practitioner is not a financial choice but a medical one; this levels the field for clients and creates better cash flow for the center.
- Invest in sophisticated cost management/business management software and/or consider outsourcing some administrative services.
- Reduce employee/practitioner turnover.
- Hire practitioners with a following so that their work is profitable as quickly as possible.
- Move to or incorporate a POD or client-cluster model to increase patient visits while utilizing a lesser number of practitioners.
• Increase practitioner workloads, though this is difficult to do without violating the 
time commitment to each patient, a distinctive characteristic of IM care. (One clinic 
director reported hearing about practitioners such as acupuncturists and 
chiropractors pushing their schedules—or being pushed—to include 25-30 visits per 
day.)

Insurance: The Beginning or the End of Sustaining IM?
Center directors and thought leaders alike are divided over the issue of insured care 
for IM and its importance for the future of IM centers. There is a continuum of 
opinion:

At one extreme:
Practitioners/leaders who believe that insurance (especially direct-pay to the provider) 
distance the patient from their own care and diminish the value of care to the patient. 
Moreover, the terms of insurers begin to dictate the standards of service.
• If insurers decide that a 90-minute intake visit is luxurious instead of good 
  medicine and refuse payment, will patients agree to do it anyway and pay the 
  difference?
• Or will practitioners be forced to take short cuts in building the relationships on 
  which IM care is based?

While these leaders would not stand against the availability of reimbursements that 
can be claimed by patients from their own insurer, they would prefer a system in 
which care is affordable and people simply pay for it.

At the other end of the spectrum:
Some practitioners/leaders believe that IM will never fulfill its promise if it cannot be 
delivered via direct pay insurance. IM will not be a viable part of the health care 
system unless it can be available at scale and the only thing (other than the 
availability of practitioners) that can get IM to scale is the financial capacity of people 
to get the care. Medicare, group and individual insurance, and HMO arrangements all 
need to encompass IM within their care model.

The President of American Specialty Health, a for-profit aggregator of alternative care 
services for insurance groups and also an insurer, confirmed that it is unlikely that 
insurance will ever pay fully for the premium level of service envisioned as essential at 
IM centers. “There will have to be compromise,” he said. But compromise on rates 
and/or some standards of care may be more desirable than shutting out most people 
from getting integrative care.

In between these extremes:
In the middle are practitioners/leaders who believe in and are actively working for 
policy that will broaden the insurers’ coverage of diverse modalities of alternative 
care. These practitioners also believe that it is possible to devise a standard for office 
visits and therapy sessions that meet IM standards for relationship-based care and yet 
can qualify for insurance reimbursement.
At the same time, most of these leaders in the middle ground still do not want their clinics to move to direct reimbursement. They wish to maintain cash-only systems at the clinic while increasing the numbers of patients able to collect a reimbursement.

**Sustainability Conundrums**

Insurance is one critical element of the system of viability and sustainability issues but there are many other thorny and sometimes paradoxical issues related to sustainability.

- **“Dis-integrated care.”** As many as 70% of Americans say they have used some form of alternative health care; yet most of these same people (63%) do not tell their primary care physician or specialist about their use of alternative therapies or supplements.

- **Who Pays for Integration?** IM provides a way to bridge alternative and conventional therapies but the bridging or collaborative process is a service that must be paid for and that effectively adds costs to either form of care. In some clinics, care is subsidized by philanthropists who believe in the future good that will come of demonstrating the IM care model, and the wealthy few who can afford to pay all the costs associated with IM, are subsidizing the gap. Many clinic leaders fear that charging clients for the “invisible” collaborative process will push their prices too high both for individual clients and any insurers that might cover the services.

- **Is IM a Powerful Enough Force to Transform Health Care?** Some IM leaders believe their ultimate value will be to blend back into the main health care delivery system but only when the system can change enough to accommodate the values and innovations of IM. Otherwise, IM innovations will disappear into the dysfunction of the current system.

- **Evidence for Insurers.** Widespread availability of insurance and reimbursements for alternative care might allow centers and networks of practitioners to achieve economies of scale. However, the insurers say they won’t support IM until there is evidence of both medical efficacy and cost benefit. But even in areas where there is proof (pain relief, heart disease intervention) there appears to be no rush by insurers to cover the treatments.

Realistically, these issues likely mean some centers will continue to research and innovate and offer gold-standard service in a private enterprise model: people who have insurance and cash flow will receive the best versions of integrative service that they can afford; others will have access to bits and pieces of alternative and conventional care but not a seamlessly integrated care plan until the whole system is transformed.
6. External Forces

While funding for the National Center for Complementary and Alternative Medicine increases each year, commensurate with the multi-year doubling of the overall NIH budget, it is critical that other federal agencies charged with programs relative to health resources and services, primary care, health professions, training and workforce development, consumer education, health services, research, and other areas be brought to bear on the important challenge and opportunity of Integrative Medicine. Public support together with private innovation has been the hallmark for medical advancement in the twentieth century and should continue to be the case for Integrative Medicine in the twenty-first. 

Marc Micozzi, MD, PhD, Thomas Jefferson University Hospital Policy Institute for Integrative Medicine

The emergence of any new field is driven by its champions and available resources but even the most dedicated perseverance is influenced by external forces over which champions and advocates have little direct control. Two main external forces were explored through the mapping interviews:

- Cultural, societal, and economic shifts
- Public policy issues

Cultural, Societal, and Economic Shifts
IM is emerging in the crosswinds of a consumer revolution toward IM/CAM and institutional reluctance to fully accept it. Individuals are using everything from scientifically valid information to rumors to decide on and gain access to alternative therapies and supplements. An established conventional medical profession and system that remains mostly resistant to IM are moving at a much slower pace than consumers to integrate alternative care. Business trends are also mixed as producers of supplements and herbal products continue rapid growth while the expansion of insurance to cover IM is growing, but slowly.

A sampling of press reports and studies about the societal shift toward IM/CAM includes the following:

More Evidence of Powerful Consumer Behavior
- The Journal of Family Practice (2000) noted that 33% of the patients seeking health care used a complementary medicine practitioner as their primary health care provider.

- In 2002, Newsweek reported some 83 million Americans—more than 40% of the adult population—sought out herbalists, chiropractors, and other unconventional practitioners.

- The majority of Americans say they are actively involved in not only treating, but also diagnosing, their own health-related problems. More than nine in ten are confident about these decisions; 58% are very confident. For the first time, the number of consumers who took an OTC drug (77%) for minor illnesses outnumbered those who decided to “wait to see” (69%) and 50 million consumers used a dietary supplement to treat a condition in the last six months (Roper Starch Worldwide/Consumer Healthcare Products Assn., 2001, New York, NY).

- Approximately 50-60% of the general public personally view herbal therapies as effective, while 70-80% believe that since herbal medicines are "natural" they are safer
than conventional drug therapy (The UIC/NIH Center for Botanical Dietary Supplement Research in Women's Health).

- Recent surveys of U.S. consumers indicate that approximately 42% of Americans have tried some type of alternative therapy in the past year, and 17% use herbal medicine preparations on a regular basis (Eisenberg, 1998).

According to a soon-to-be-released updated report from Business Communications Company, Inc. (www.bccresearch.com) RGA-085R Evolving Nutraceutical Business:

- The global nutraceuticals market grew from $38.2 billion in 1999 to $46.7 billion in 2002, an average annual increase of nearly 7%.

- Most of this growth occurred between 1999-2000, when nutraceutical sales grew by 17.5%. The market growth rate slowed to 2% annually in 2001 and 2002. This slowdown resulted from a number of factors, including the slowdown in the world economy. Other factors behind the slowing growth rate include the publication of studies that question the effectiveness of several high-profile nutraceuticals such as ginkgo biloba; the lack of any new "blockbuster" nutraceuticals that caught consumers' interest; and competition among nutraceutical producers that drove down average prices.

- Over the five-year period 2002-2007, nutraceutical sales are projected to grow at an average rate of 9.9% annually, reaching $74.7 billion by 2007.

Demand for nutritional supplements is expected to continue to be strong, as baby-boomers interested in leading active lives swell the ranks of 45- to 64-year-olds by 51% over the next decade. Consumers are likely to increasingly seek out physicians and pharmacists who develop expertise in vitamins, minerals, herbs, and other specialty nutritional supplements.

- According to USA Today, February 2001, the 76 million U.S. boomers, dubbed "the pig in the snake" by demographers, will reshape our youth-oriented society. By 2030, a fifth to a quarter of Americans will be 65 or older

- "You're going to see more and more 'nutraceuticals,' foods infused with nutrients like vitamin E and beta carotene, anything thought to fight aging," says consumer behavior psychologist Ross Goldstein of BRS Group, marketing researchers in Mill Valley, Calif.

**Changing Attitudes: Physicians**

- A study reported in Archives of Internal Medicine (1998) showed 43% of U.S. medical doctors refer patients to alternative or complementary medicine providers.

- Based on a 2000 study Kaiser Permanente (Mid-Atlantic Region) concluded that conventional health providers are increasingly interested in using and learning more about CAM therapies, particularly those forms having the strongest scientific evidence of efficacy. In the Kaiser Permanente study, 48% of respondents said they used some form of CAM to treat patients. Respondents expressed strong interest in Kaiser Permanente providing (or increasing) CAM services to patients, mainly for acupuncture, acupressure, and biofeedback. Respondents also expressed greatest interest in CME
courses about these three types of CAM therapies.

**Changing Marketplace: Employers and Insurers**

- The 2000 Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans found that in 1998, 49% of survey respondents (representatives of employers’ insurance plans) indicated that chiropractic was covered. By 2000, the number had risen to 70%. Over the same time period, coverage of acupuncture rose from 12% to 17%, and coverage of massage therapy increased from 10% to 12%.

- The survey also found that large employers (those with more than 20,000 employees) were more likely to offer CAM benefits than smaller employers. PPOs and indemnity insurers were more likely than HMOs to offer health plans that include CAM benefits.

- The study, “The Effect of Cost Sharing on the Use of Chiropractic Services,” found that insurance and HMO coverage of CAM will very likely have an impact on use of CAM services. It has been reported that fully covered persons made twice as many visits to chiropractors as individuals with no health plan coverage or those required to pay 25% of costs.

- In a recent survey of over 2,000 households, “Insurance Coverage, Medical Conditions, and Visits to Alternative Medicine Providers,” health insurance coverage was found to be the strongest correlate for frequent use of CAM practitioners.

**Education: Problems and Opportunities in the Pipeline**

- One of the major stumbling blocks to the advancement of botanical science in the U.S. is the lack of adequately trained PhD-level scientists needed to address issues related to quality, safety, and efficacy of botanical supplements. Over the past 35 years, basic science and pharmacognosy have decreased in importance and emphasis in both the undergraduate and graduate curricula of most pharmacy schools in the U.S. (Mahady 1997, 1998).

- Only 12 of the 75 schools of pharmacy in the U.S. have a department of pharmacognosy, although some have combined pharmacognosy with other departments (Holt 1996).

An article in *JAMA* in 1998 reported that 75 out of 117 U.S. medical schools offered elective courses in alternative medicine, or included alternative medicine topics in required courses.

**The Business of Pharmacology: Trends**

- Wall Street continues to support pharmaceutical stocks. A recent front-page article in the *Wall Street Journal* assailed a $100-million-a-year nutritional supplement company, which is growing at the rate of 20% per year, for having a one-man R&D department while pharmaceutical companies require huge outlays for R & D as well as FDA clinical studies. The *Wall Street Journal* reporter felt it was unfair for nutritional supplement companies to be able to make health claims on their products while drug manufacturers have to undergo extensive studies for the same right.

- According to the *IMS World Review*, in 2002, global audited sales of pharmaceuticals rose 8% (at a constant dollar rate) to reach $400.6 billion. North America was again the strongest performer, growing 12% at a constant dollar rate to reach $203.6 billion —51% of the world’s total.
Drug companies choose many of the drugs that are prescribed, not doctors. Celecoxib (CELEBREX), the heavily promoted COX-2 drug for arthritis, sold over $1 billion before a single study was published in a medical journal comparing it to another arthritis drug (Public Citizens, OnLine).

The drug companies claim they put most of their revenues back into finding new drugs. But recent reports reveal that more than half of the research and development funds for new drugs come from taxpayers who underwrite the costs of many private pharmaceutical companies (New York Times, April 23, 2000; Associated Press, July 24, 2001).

The Office of Technology Assessment indicates more than half of the R & D money spent by drug companies goes to "me-too" drugs that represent little or no treatment advance over pre-existing products. Furthermore, for every dollar pharmaceutical companies spend on research and development of new drugs, they are spending 50 cents for advertising currently available drugs, says The National Institute for Health Care Management Research Institute.

Regulation and Safety

• The federal Food and Drug Administration estimates that 38 million Americans have used a fraudulent health product or treatment within past years, and have spent billions of dollars a year on quack products and treatments.

• The overall cost of prescription drug-related side effects now exceed $177 billion annually, says a 2001 report in the Journal of the American Pharmaceutical Association. This figure far exceeds estimates made in 1995 which indicated annual drug-related morbidity and mortality costs were around $76 billion. Frank R. Ernst, PharmD of the College of Pharmacy at the University of Arizona, lead author of the report, indicates the total cost of drug-induced side effects far exceeds the cost of the medications themselves (Journal American Pharmaceutical Assn. 41: 192-99, 2001).

• According to a study in the HerbalGram, the peer-reviewed journal of the American Botanical Council, only 28% of the public that uses herbs say they consult with their doctors about taking them, and only 23% ask pharmacists for information.

Public Policy

In the mapping interviews conducted for this study, leaders from every setting have hopes for a progressive policy agenda that will stimulate and support the development and acceptance of IM.

Overall, those interviewed described policy concerns that fall into five main categories:

• Policies that allow access to a broader range of alternative therapies and also require or incentivize insurers to include coverage for preventive and “well-being” health care, including IM. Medicare/Medicaid already provide coverage for some basic therapies (e.g., massage and chiropractic) but should be broadened to include more modalities. (The Access to Medical Treatment Act of 2001 had wide support in the various integrative and CAM health networks of providers and practitioners. However, both the House and Senate bills—HR1964 and S1378 died in the 107th Congress and are awaiting new sponsors and reintroduction.)
• **Student financial aid.** Students training in alternative medicine institutions, such as naturopathic, acupuncture, massage, etc. schools, can borrow much less than other medical, dental, and chiropractic students (Stafford Loans). The President of Bastyr University, Thomas Shepherd, DHA, cited that students can borrow nearly 35% less. Loan policies need to be more equitable.

• **Allocation of research funding to enable more research on IM.** More research is needed in both basic sciences as well as on the efficiency and efficacy of IM.

• **Regulation of supplements,** including herbs.

• **Licensing and certification** for CAM services and practitioners should be nationally standardized.

Thirty-one states, for example, have massage practice laws: the oldest has been on the books since 1916 in Ohio and the most recent is Mississippi in 2001. Even in states where massage practice laws exist, there is little standardization of how the licensing ties back to educational programs.

Similar disparities exist for acupuncture: 38 states and the District of Columbia and California require passing their own exam. Louisiana licenses only acupuncture assistants. In the case of MDs, the [World Health Organization](https://www.who.int) and the [World Federation of Acupuncture and Moxibustion Societies](https://www.wfas.net) (WFAS) have promulgated acupuncture training and education standards for Western-trained physicians. These are considered to reflect the minimum level of training necessary for a Western-trained physician to enter the practice of medical acupuncture. For MDs, training in acupuncture can be accomplished following a course devoted to acquiring the knowledge and skill in acupuncture as well as the related basic theory for at least 200 hours of formal training followed by an examination given by health authorities to ensure “safety, competence, and efficacy.”

<table>
<thead>
<tr>
<th>Category of Personnel</th>
<th>Level of Training</th>
<th>Acupuncture (ACU) Core Syllabus</th>
<th>Modern Western Medicine (MED) Core Syllabus</th>
<th>Official Examination</th>
<th>Certificate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Theory</td>
<td>Supervised Practice</td>
<td>Theory + Clinical</td>
<td></td>
</tr>
<tr>
<td>Acupuncture practitioners (non-medical)</td>
<td>Full course of training</td>
<td>1000 hours</td>
<td>500 hours</td>
<td>500 Hours</td>
<td>500 hours</td>
</tr>
<tr>
<td>Qualified physicians</td>
<td>Full course of training</td>
<td>500 hours</td>
<td>500 hours</td>
<td>500 Hours</td>
<td></td>
</tr>
<tr>
<td>Qualified physicians</td>
<td>Limited training in ACU as a technique for their clinical work</td>
<td>Not less than 200 hours</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other health personnel</td>
<td>Limited training in ACU for use in primary health care</td>
<td>Varies according to application envisaged</td>
<td></td>
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</table>

*State examination in acupuncture and modern Western medicine (at appropriate level).*

Naturopathic doctors are licensed in 12 states plus the U.S. territories of Puerto Rico and the U.S. Virgin Islands. In these states, naturopathic doctors are required to graduate from a four-year, residential naturopathic medical school and pass extensive post-doctoral board examination (NPLEX) in order to receive a license.


**Other Perspectives on Policy: The National Policy Dialogue and the White House Commission**

Beyond the interviews conducted for this study, there are broader views of IM policy issues on the public record, articulated through policy forums and reports self-organized through IM networks and also organized through federal agencies.

A National Policy Dialogue was sponsored in 2001 by the Integrated Health care Policy Consortium (IHPC), a working group under the umbrella of the Collaboration for Health care Renewal Foundation. Co-hosted at Georgetown University, with the American Association for Health Freedom, the Dialogue included stakeholders from conventional academic medicine, complementary and alternative academic medicine, insurers, and
professional organizations of CAM providers, researchers, and consumers. As a result of the Dialogue, IHPC published a Report, “National Policy Dialogue to Advance Integrated Health Care: Finding Common Ground,” describing the seven key recommendations agreed-upon by the Dialogue participants:

1. Establish a federal office to foster the creation of an integrated health care (IHC) system focused on health promotion and disease prevention.
2. Significantly increase federal research allocations for health promotion and disease prevention, and examine the role of CAM/integrated approaches in these areas.
3. Establish a national consortium of conventional and CAM educators and practitioners.
4. Assure widespread access to CAM/IHC in rural and underserved communities.
5. Achieve regulatory recognition for each profession seeking it, in every state and within federal programs, based on competency standards set by the profession.
6. Develop a national agency that acts as a clearinghouse for defining the qualifications and scope of practice for health care providers in each discipline, system, or modality.
7. Ensure that CAM is effectively integrated into the Healthy People 2020 development and implementation process.

The White House Commission Report on Complementary and Alternative Medicine Policy took two years, $2 million, and thousands of people to create. Based on a series of 14 hearings and town hall meetings as well as written submissions, the Report’s purpose is to offer legislative and administrative recommendations that would help public policy to maximize potential benefits to consumers and American health care of CAM therapies. The Report makes 29 recommendations and each of these recommendations included several proposed actions. The recommendations are clustered into six areas:

- Coordination of Research (Nine Recommendations)
- Education and Training (One Recommendation)
- CAM Information Development and Dissemination (Seven Recommendations)
- Access and Delivery (Five Recommendations)
- Coverage and Reimbursement (Six Recommendations)
- Coordinating Federal Efforts (One Recommendation)

(See Appendices for a summary of all 29 recommendations.)

Policy Roles of Professional Associations
Interviewees for this study did not identify the professional associations as having a major role, power, or clout in determining public policy, even in standards of care and practice. Yet many thought it would be beneficial if all professional medical and health associations would recognize the value of Integrative Medicine and advocate for its place in the health care system.

Some examples:
- The National Board of Medical Examiners could add IM questions on National Boards which would alert students to study it and be aware of it in their training.
- The Institute of Medicine is in the process of creating an expert panel to review the impact of CAM practices in the U.S.

There are some associations that exist specifically to bring alternative practices into conventional medicine. For example The American Holistic Medical Association certifies MDs and DOs for holistic practice. (See Appendices for a listing of the numerous organizations and associations that have some role in standards and credentialing.)
7. Research

What should be funded? Health policy and translational policy research is key; NCCAM is being pushed toward basic research and large clinical trials. What are needed are practical outcome assessments, clinical outcomes, and efficacy-based outcomes. This research is relatively inexpensive, answers the questions that people want, provides the cost outcomes that companies and insurance companies need.

Kenneth Pelletier, MD, Ph.D

A lot of people are concerned that research will find that many of the things we now believe in aren’t as effective as we assume. That doesn’t worry me; the field will become stronger as we verify what works and what doesn’t. In conventional medicine, the research trials throw out tons of products. That’s the process of science. I’m an optimist and I believe in exploring the science of what we are doing in IM.

Susan Folkman, Ph.D, Osher Center for Integrative Medicine at UCSF

The formation in 1992 of the National Institutes of Health Office of Alternative Medicine and its successor in 1998, the National Center for Complementary and Alternative Medicine (NCCAM), responded to the growing use of CAM and subsequently has been a significant driver in its expansion.

In particular, the CAM research agenda has become more strategic and extensive. The 2002 appropriation to NCCAM was $104,644,000. This figure reflects a 17.3% increase over the FY 2001 appropriation of $89.2 million. In FY 2002, the Research Project Grant (RPG) portion of the NCCAM budget represented 42% of the total budget or approximately $44M. The remainder of the NCCAM budget is allocated to infrastructure development in CAM Institutions, supporting Centers of Excellence for Research on CAM (CERC), and support of education and training. Since FY 1999, there has been a 22-fold growth in grant applications received by NCCAM.

Although not all CAM research is sponsored by NCCAM it is the single largest resource for research. Other sources come from private philanthropy, university, and hospital endowments, corporate, and the operating budgets of all centers as they conduct practical research and evaluation with their clients.

NCCAM, and the setting of its annual research agenda, is advised by a diverse network of stakeholders. The NCCAM strategic plan outlines a research agenda through 2005 with five areas of focus:

- Mechanisms of CAM intervention
- Cancer
- Botanicals
- Health disparities
- Integrative Medicine and research training

NCCAM research grants are prized by the academic medical centers for the seriousness of the commitment (multi-year awards, budgets that parallel other health research grants, and overhead costs for the centers and/or the parent institutions) and for the prestige they bring. All academically-based IM centers include in their strategic plans specific goals to increase their NCCAM research awards.

At the same time, the NCCAM strategies are controversial. Some believe that the size and force of the NCCAM research resources in an emerging field like IM may force it into the same mold as conventional medicine, thus diminishing its unique characteristics. IM thought leaders and practitioners are particularly critical of the dominance of clinical trial research.
Clinical trials are intended to prove the efficacy of a single, particular intervention (a treatment or supplement). NCCAM has favored clinical trials, arguing that the same scientific rigor be applied to CAM therapies and substances as is given to conventional pharmaceuticals and treatment procedures requiring FDA approval. The assumption by the public that conventional therapies are actually “proven safe and effective” before approval and distribution is controversial since there are numerous instances of already-approved substances being removed from the marketplace due to bad effects.

However, IM practitioners and leaders argue to expand the research concept beyond clinical trials for more substantial reasons. They point out that the purpose of IM is to blend therapies and to use multiple modalities to enable a person to overcome pain or a particular health condition. It is rare in IM to utilize one type of treatment or substance; it is the mixture of modalities: nutrition, herbs, mind-body work, etc. that provides healing over time. Isolating any one element and proving its efficacy alone would not, then, be seen as proof for its practical application. The value of integration can not be proven by disaggregating the treatments and testing them separately.

Many IM practitioners believe that public popularity of CAM is based on assumptions among consumers that alternative approaches are safer, better, or more personally suitable than conventional therapies and “just as effective.” Without fully understanding the principles of Integrative Medicine, many IM consumers expect cause and effect medicine—and preferably quickly! There is constant anecdotal evidence in the popular press about fast results from alternative therapies and relief when nothing else has worked. This fuels consumer interest in CAM, but at some point such consumer-assumptions add pressure onto researchers to try and prove outcomes through clinical trials. While some researchers believe this pressure for “proving pills” is growing, they also acknowledge that many other consumers come to IM with knowledge and insight about the principles of integration and an appreciation for proving the efficacy of multiple modalities over time.

In 2002, NCCAM publicly recognized its “heavy investments” in clinical trials and responded to criticism from its advisory council by increasing its research emphasis on “the mechanisms underlying CAM approaches.”

Due in March and April of 2003 are applications from IM centers to be designated Centers of Excellence or Developing Centers. Both designations and the grant awards will help to expand research agendas for those centers.

Most of the centers interviewed in this Mapping Study—including some who specialize in science-based trials—also advocated for practical research, based on direct clinical experience that would document the efficiency and efficacy of IM. Anecdotal evidence among many IM practitioners implies that injuries heal faster and better and people miss less work and costs are less when IM is used. However, there are few studies large enough to prove these observations. Some practitioners believe that simpler and straightforward documentation of costs and outcomes of specific care approaches will be more useful in refining best practices and in convincing employers to offer alternative care and to persuade insurers to cover it.

Some of the specific ideas on research voiced by the participants in this study included:

Today’s Practice: Tomorrow’s Standards for IM
• IM centers—including the free standing and for-profit centers—cannot stop at collecting patient feedback. The outcomes of actual clinical care are the source for knowledge and learning in this field. Some expressed the need for a knowledge system—an online database—where many clinics could enter and share data about care patterns, results, best practices, etc.

• Specialized centers should systematically monitor outcomes in order to document specific therapeutic relationships, e.g., acupuncture in treating strokes, asthma, fertility, etc.; use of imagery for low back pain, etc.

• The model of integration needs to be researched, not just the particular components of IM.

**Cost Effectiveness Data are Essential for Increasing Acceptance of IM**

• Insurers have access to large sets of data and outcomes. American Specialty Health, for example, has a forthcoming study that will show that the costs of treatment are less overall when a chiropractic benefit is available. AHS believes that clinical safety is a must, but that cost effectiveness will be the essential information needed for future decision making.

• Duke University is conducting a study of cost effectiveness of several CAM practices. The results are 12-24 months out. The information is expected to help the field make a case for more IM.

• Some of the information needs of the IM field include practical outcome assessments, clinical outcomes, and efficacy-based outcomes. Documenting this data should be relatively inexpensive and yet answer the questions that people have while also providing the cost outcomes that companies and insurers need.

**Education also Relies on Research for Direction**

• Research is needed about education and training in IM, especially in understanding how beliefs motivate student interest and how new beliefs are formed through training. The beliefs students already have will affect the education they seek and at the same time training will influence and change their beliefs.

**Mind-Body-Spirit Connections Are Essential to a Model of IM**

• Some of the best research in IM is on mindfulness. This is research that is rooted in other scientific and medical disciplines and also has been researched at very practical levels

• IM research methodology needs to bridge both science and spirituality.

**Botanical Research Is Urgent**

• Standardization of botanicals is an urgent for research. Product lines are increasing; more companies are putting substances and products on the market.

**More Resources**

Despite the size of NCCAM more resources are needed. To put it into perspective, one respondent described one medical school’s research resources: the medical research enterprise received more than $120 million in funding in FY 2002. Approximately 57% of this funding is from NIH and 29% is from other government sources The remaining 14% is from foundations, individual, and other sources. The CAM-related research accounts for
$1 million or 1/120th of this total. The Report of the White House Commission on CAM (2002) deals extensively with research issues and includes nine major recommendations that urge increased funding for CAM/IM research especially in disease prevention and health promotion; providing incentives for private sector research (especially on dietary supplements and CAM products); engaging more federal and state agencies in CAM research (e.g., NIH Office of Dietary Supplements, National Library of Medicine, National Cancer Institute’s Office of Cancer Complementary and Alternative Medicine, etc).

8. Education

*Those who train together, practice together.*

Thomas Shepard, MS, DHA, President, Bastyr University

*Medical students are participating with faculty leaders to learn CAM techniques—meditation, biofeedback. It’s a new experience for them to learn this way, especially the self-discovery. It has been a transforming experience for the students...a profound connectivity for them with their classmates, learning together to reconnect to why they went into medicine.*

Aviad Haramati, Ph.D., Professor and Director of Education, Department of Physiology and Biophysics, Georgetown University School of Medicine

There are a variety of opinions among IM thought leaders on education and training in IM. Some emphasize the education of CAM professionals about conventional medicine; others stress the education of conventional practitioners about CAM; some focus on basic medical or health professions education; and still others are concerned with the continuing education of well-established physicians and other health professionals. And for some, the most important focus of education is on the client/patient.

Ultimately all these dimensions of education will be needed to achieve the full vision of IM.

In the interviews conducted for this study, differences in educational focus among types of centers/clinics were apparent:

**Free-standing Centers** work with a wide range of education clients: their patients/clients, the community, and a variety of health care professionals.

**Hospital-based Centers** work with diverse health care professionals during their formal educations: nurses, doctors, technicians, health administrators; and they do so in a wide variety of roles from informal internships to more conventional rotations of service. Some hospitals serve an important educational role for students but they are not teaching hospitals. Some would like to have deeper relationships with educational institutions, especially with medical schools. One hospital in the survey reported that while nursing schools had been enthusiastic about sending students to the IM center for training and exposure to IM, the university’s medical school (which does not yet have an IM program) has been reluctant and less than cooperative.

**Academic-based Centers** have the most direct links and responsibilities to their affiliated medical schools. Depending on how advanced the IM center is in its development, the role can vary from helping to create medical school curriculum to formal medical internships and residencies. In some settings, the creation of a center/clinic is being used as a way to formalize the curriculum changes and locate clinical responsibility for medical school curriculum changes.
For example, the Osher Center for Integrative Medicine at the University of California–San Francisco (UCSF) sees education as one of its three main service areas in addition to direct clinical service and research. The center’s faculty are also medical school faculty and are mentors to medical students. The students are required to spend 23 hours in CAM curriculum and the center provides an opportunity for hands-on learning. Within the next six months, the center will engage medical students and residents in formal rotations through the center.

In a similar structure, the Duke Center for Integrative Medicine is engaged in designing medical school curriculum; the IM physicians teach in the main residence clinic and residents also can rotate through the IM center.

The Bastyr Center for Natural Health has a substantial role in the education of Bastyr naturopathic medical students and runs 15 different educational programs serving undergraduates as well as graduates.

While academic centers do not yet have a single model in Integrative Medicine education that they are trying to create with their medical schools, they do share similar thinking about their roles as educators for physicians, nurses, and other allied health professionals whose knowledge and skills in IM would help to build the field. Their greatest area of disagreement is over the formation of medical fellowships in IM. Some of the centers are eager to create IM fellowships as a way to further advance the field and identify a specialized set of skills that are unique to practicing IM. Others are resisting the creation of fellowships because they do not believe in creating IM as a specialty within medicine; their goal is to merge IM into all other specialties.

Most of the issues to be resolved about educating medical doctors and other health professionals in IM are just in their infancy, though the demand is building from two sides: centers, clinics, and communities want more practitioners who know both alternative and conventional care; and more students entering medical school want access to IM curriculum and practice. Some of the observations shared by interviewees for this study included:

- UCSF administrators have observed that some students are attracted to their medical school because of the CAM curriculum.
- At Georgetown, where CAM therapies/teachings have been integrated into the conventional curriculum, administrators believe that IM is more “on the radar” but students are still making more traditional choices and not “flocking to” IM offerings.
- At Duke, and at some of the free-standing centers, the leaders note that increasing numbers of MDs are leaving medicine now. “They are miserable because they don’t see a concurrency of values of health and wholeness. The current health care system can’t meet MDs’ ideals. Many students feel that through CAM and IM they can reclaim what they want medicine to be about.”
- Centers in New York City and San Francisco cautioned that there may be a glut of practitioners forming as so many people are applying to and graduating from short-term educational programs in massage, yoga, exercise, and nutrition. “Self-appointed experts are coming into the system with no credentials.”
Some of the interviewees’ recommendations about education and training priorities included:

- Create national and state-based credentialing and standards.
- Standardize processes/criteria within medical schools for bringing CAM practitioners into IM clinics.
- Improve credentialing requirements for MDs who expand their practice into CAM (e.g. acupuncture, Oriental medicine and herbology, etc).
- Devise more and better strategies for how nurses should be educated and trained in IM.
- Subsidize IM education. IM will not be lucrative in the same way that elite medical specialties are; student debt needs to be alleviated in some way or students won’t be able to afford ND’s and other CAM/IM training.
- Establish a core curriculum for IM in medical schools for the foreseeable future; eventually CAM information should be part of all courses and the IM label should disappear from medical education.
- Develop teaching prototypes drawn from real patients’ cases that can be used as teaching tools in medical schools; approximately 100 teaching cases need to be developed.

In 2002, supported by a grant from the Philanthropic Collaborative for Integrative Medicine, a group of 12 academic centers came together in the “The Consortium of Academic Health Centers for Integrative Medicine”. The purpose of the Consortium is to “help transform medicine and health care through rigorous scientific studies, new models of clinical care, and innovative educational programs that integrate biomedicine, the complexity of human beings, the intrinsic nature of healing, and the rich diversity of therapeutic systems.”

Consortium members are committed to sharing information and ideas, and meeting challenges in a process grounded in the values of Integrative Medicine. They also seek to support member institutions and provide a national voice for Integrative Medicine. The Consortium provides opportunities for prioritizing research topics and collaborations and for sharing curricula, clinical policies, and strategies for meeting the challenges of research. The Consortium provides the cohesion necessary to maximize individual institutional efforts and to move the field forward in ways that no individual institution could.

The initial project of the Consortium, funded by The Philanthropic Collaborative for Integrative Medicine, is the development of a shared medical school curriculum in Integrative Medicine. The Consortium is gathering existing curricula from member institutions and making them available to all schools within the Consortium; and a synthesized core curriculum also will be created and shared. The core curriculum will be advanced in later stages by adding teaching cases, experiential learning opportunities and other features.
In 2000-2001 more than 90 of the United States’ 125 allopathic medical schools reported that they include CAM in required conventional medical courses; 64 offer CAM as a stand-alone elective. However, courses in CAM offered at conventional medical schools are not standardized. The work of the Consortium should help medical schools move toward some shared standards for curriculum.

9. Future Vision

Many people are hanging the future hope for this industry on the Integrated Clinics; but you can't put all the eggs in this basket. It is too small, too limited. Integrated Clinics will be part of the future but they won't be THE system.

George Thomas DeVries III, Chairman, President & CEO American Specialty Health

The mapping interviews included several questions about the future of IM. The intent was to elicit from leaders in various "hot spots" in the field their ideas for how IM should grow and what innovations or resources would help to advance the field.

Among these leaders are both some solid common ground and also worrisome fault lines.

Common Ground and Shared Vision

- **Self-care** is the central idea and drives all else for IM.

- **Collaboration is essential for integration.** Large-scale IM cannot be a takeover of alternative medicine by conventional medicine. Day to day, we need collaborative thinking among practitioners; collaboration is not optional within an IM institution.

- **Healing the whole person** is a central concept. IM should heal the way we live rather than being about the specific modalities of treatment.

- **Evidence and persuasive** communications are needed to convey the beliefs of the IM care model. Most IM practitioners believe that their experience shows that IM will help people to get better faster! But this is not yet a commonly communicated message.

- **More resources** are needed to “level the playing field.” Despite the presence and growth of NCCAM, IM is still being financed in a quasi-underground system.

- **Integration of data** across all stakeholders will help everyone understand the patterns and ideas forming through practice and research. A whole picture would require patient outcomes, employer data about absenteeism; and patient feedback.

- **Information technology/knowledge systems** are needed for IM (shared patient records, common data, and statistics files, etc.).

- **More networks and more convening opportunities** are needed to bring IM leaders and institutions together to continue envisioning and planning the full implementation of IM.

- **A stronger definition of the field** should be widely accepted.
• **Indicators of progress and success** should be linked to the definition and used by all clinics, centers, and practitioners to track and share results and learning.

**Fault Lines and Divergent Vision**

• **Be aware that the health care business in the U.S. means making money first;** helping people is not the primary business and this affects the vision and plans for how IM can transform the bigger system.

• **Stop insuring and covering “the mundane.”** Reserve insurance for catastrophic illnesses and needs. The sore throat is bankrupting the system.

• **Mainstream IM education** into all health professions’ education.

• **Run IM care like a business** with pragmatic guidelines and standards in place, but without sacrificing the unique qualities of IM.

• **Divide the centers** of practice from those centers that are primarily research organizations; develop them accordingly.

• **Include undergraduate schools** in a vision of IM education and training.

• **Do not separate the IM department** in medical schools; IM must be part of the overall curriculum and system.

• **Engage CAM institutions—especially accredited medical schools** (ND, acupuncture, Oriental medicine) to have a bigger voice in the IM dialogue.

• **Create good medicine; lose the names** (conventional, alternative, IM). If IM institutions and practitioners can successfully provide good medicine, IM won’t exist in the future as a separate idea; there will just be a different and better system of medicine.

• **Enable and support the organizing of a community IM model.** Individual IM centers will never be able to be the IM system; there would need to be too many centers to handle the demand. More effort is needed to help independent practitioners to join together with IM and other medical institutions in a community network that can be seen as and used as the IM system.

• **Increase the dialogue** at the practitioner level; if IM remains an intellectual exercise it will remain a fringe idea.

• **Create a universal payment model** and the necessary legislation to achieve it.

**Good Ideas/Good Practice**

• **Practice integrated rounds** in hospitals—MDs with CAM practitioners.

• **Create integrated pharmacies**—“fish oil” next to Tomoxifin.
• **Educate** all stakeholders.

• **Promote the value of the mind-body connection.**

• **Teach doctors to become healers;** promote courage rather than fear of litigation.

• **Respect other cultures** and the knowledge they bring to the healing process.

• **Engage more private foundations;** most are not funding IM.

• **Make powerful partnerships with business leaders.** IM practitioners and research leaders need to reach out to business leaders and build more shared understanding about health care costs, efficacy of IM, etc.

• **Encourage more venture capital funding** for clinic start up.

• **Compare outcomes of profit and nonprofit centers.** Does the legal status make a difference? What other factors make a difference?

• **Build centers and services in a contextual vision:** don’t just bring acupuncture to the center...work to transform the staff, the client, the institution, and the community.

• **Transform the payment system** for treatment as IM is adopted into the conventional centers—currently, university medical centers are not doing well financially on providing health care services so why should IM be expected to do so?
THE REPORT

PART II: Insights for the Future

How Change Happens
Theories of Change/Growth Propositions
PART II: Insights for the Future

When you pick up one piece of this planet, you find that, one way or another, it is attached to everything else—if you juggle over here, something is going to wiggle over there...We need this sense of the continuing interconnectedness of the system as part of the common knowledge...

Sylvia Earle, PhD, Marine Biologist

1. How Change Happens

The mental concepts and beliefs that people hold about how change happens drive both planning and action. In the last two decades, contemporary Theories of Change have moved away from cause and effect notions and, instead, derive meaning from more fluid ideas like systems theory, complex adaptive system theory, chaos theory, unified field theory, and particle physics theory. Rather than being far-fetched, these theories provide a rationale for the participatory and decentralized world in which we live and offer a framework for analysis of ideas and strategic decision-making.

This section of the report opens with a brief review of five examples of change theory that are relevant to the emergence of IM. These slight glances into change theory provide a context for thinking about IM and how it can influence the larger practice of medicine as well as insights for generally understanding the dynamics of the change.

This is followed by Theories of Change, which draw out specific value propositions for how to develop IM so that it is a strong lever for change and transformation in the health care system.

Health care: A Complex Adaptive System

The health care system—while highly regulated—also is a decentralized system. It is a complex adaptive system in which seemingly random and unrelated acts such as...

- individual consumer choices in food, lifestyle, or health care,
- health career and educational decisions by 20-year olds,
- the marketing decisions by private businesses,
- the youthful experiments in mind-body thinking by baby-boomers 20-30 years ago

...have as much or more power to catalyze change as more central decision making like government regulation or coordinated planning by major institutions. The health care system is a world in which many players—both individuals and institutions—are all adapting to each other and where the emerging future is is difficult to predict. Adaptive change and self-organizing go hand-in-hand. Self-organizing is a characteristic of the activity within an adaptive system: when there is no central control for a change process, people and institutions form new networks and alliances to catalyze or respond to other changes.

In their book, Harnessing Complexity (The Free Press, 1999), Robert Axelrod and Michael D. Cohen describe “Complex Adaptive Systems” as: “...worlds where there are many participants, perhaps even many kinds of participants.” They go on to say that these participants:

...interact in intricate ways that continually reshape their collective future. New ways of doing things—even new kinds of participants—may arise, and
old ways—or old participants—may vanish. Such systems challenge understanding as well as prediction. These difficulties are familiar to anyone who has seen small changes unleash major consequences. Conversely they are familiar to anyone who has been surprised when large changes in policies or tools produce no long-run change in people’s behavior.

Most advocates for a particular change in society would like to believe that there is a single best approach to control the complexity of their context and achieve goals. But the very nature of a complex system means that a simple cause-and-effect strategy is not a likely option. At the same time the inability to control complexity means that small changes often have unexpected energy and ripple through a system causing change that is disproportionate to effort. Axelrod’s and Cohen’s concept of “harnessing complexity” lays out a concept for working with complexity rather than trying to control it.

Complexity itself allows for techniques that promote effective adaptation. When there are many participants, numerous interactions, much trial-and-error learning, and abundant attempts to imitate each other’s successes, there will also be rich opportunities to harness the resulting complexity. And there will be things to avoid...Even though one action seems best, it usually pays to maintain variety among the actions you take so that you can continue to learn and adapt.

In *System Effects* (Princeton Paperbacks, 1997), Robert Jarvis states:

*The effect of one variable frequently depends on the state of another, as we often see in everyday life: Each of two chemicals alone may be harmless, but exposure to both could be fatal; patients have suffered from taking combinations of medicines that are individually helpful.*

He then proposes that Gulf War Syndrome may have been caused by the simultaneous exposure to two or more of the insecticides or drugs even though none of the chemicals alone caused a problem.

When many players in a system are trying to adapt to each other, it makes it difficult to predict the consequences of any one set of actions. And, this makes it difficult to choose an absolutely best course of action. If everyone in the system is constantly adapting to each other, then every new experience prompts revisions of strategies and actions. This means that everyone’s context is constantly changing. The best way to have an impact on such an environment is to initiate a variety of approaches that will eventually saturate the system or accumulate toward a tipping point of change.

**Catalyzing Change**

Integrative Medicine is only one of many forces catalyzing changes within the larger health care system. Stan Davis (*Lessons from the Future*, Capstone Publishing, 2001) contends that the transformation of health care is still focused on “risk as a problem rather than health as an opportunity.” Davis describes the old model of medical care as having risk “lodged upstream with providers, doctors, and hospitals. In managed care, the risk migrates a bit downstream to payers, the insurance companies.” In the future (the “connected era” of real health care) the risk “will migrate progressively downstream to patients. but with risk will come reward, the chance to become a lifelong monitor and caretaker of your own well-being. Doctors and insurance companies see managing risk as a problem to minimize and control, whereas consumers will see their health care risks as opportunities to maximize and proactively manage in order to create value.”
Under managed care, "Power has migrated from large central hospital facilities to smaller neighborhood clinics and health maintenance organizations. In the new health care model, it will continue to migrate further from the center and into the home itself. This is made possible by connecting technologies that are stepping forward to fulfill new market needs. Home products that allow consumers to test themselves for everything from pregnancy to blood sugar counts, prostate-specific antigens, and vitamin and mineral deficiencies, for example, will continue to flood into the marketplace."

Changes in the overall health system are being driven by forces bigger than IM: economics, new technology especially home-based technology, the availability of online information, and the ability of patients to form themselves into electronic support groups. As this shift happens and people have more and more capacity to diagnose and analyze themselves at home, power within the health care system shift from providers to payers to customers.

Davis offers the example of pacemakers as a symbol of such shifts. For years, if something went wrong with a pacemaker, the patient had to call the doctor for an appointment to clear the device, make insurance adjustments, etc., a process that could take a week or more. Since 1973, Medtronic has made a pacemaker that a computer analyzes by phone. Soon, the computer will both read the pacemaker and adjust it. Medtronic already has in development another transplantable pacemaker that can be read continuously by a wireless monitoring box. Davis comments:

> As the locus of power migrates from provider to payer to consumer, value and wealth will migrate to use the businesses most ready to empower consumers medically, just as it had migrated under managed care to those businesses most ready to put the payer in charge."

The IM movement is congruent with these changes in that it also seeks to transfer power to the client/consumer.

Within Integrative Medicine there are many players competing, collaborating, and adapting to each other to form the IM field. Within the larger health care system, the reform movement for IM is also a “change system.”

And, within each of the players in the IM movement are mini-systems of change. For example, each clinic is faced with changing the system within which it works: a hospital or academic center or community. The graphic below depicts the systems within systems and their waves of change.
Change in Context of the System

The Change Wheel

At the institutional level, Rosabeth Moss Kanter is one of the leading theorists about change. In a recent book, *e-volve* (HBS Press, 2001) she focuses on the changes and adaptations required by organizations to survive in a digital world. She offers a model for enabling leaders to "get systemic change rolling." The model, The Change Wheel, illustrates the nature of change as circular, meaning that no one element automatically comes first; there can be many starting points. But all elements must be designed and implemented to reinforce the change:

The Change Wheel

- Common Theme, Shared Vision
- Symbols and Signals
- Rewards and Recognition
- Measures, Milestones, and Feedback
- Policy, Procedures, System Alignment
- Communications, Best Practice Exchange
- Quick Wins and Local Innovations
- Guidance Structure and Process
- Education, Training, Action Tools
- Champions and Sponsors
Crossing the Chasm
Near the end of 2000, John Weeks, editor of The Integrator, wrote an article in which he attempted to put the evolution of IM into the context of adaptive change theory. He reasoned that a useful roadmap for IM’s next steps could be fashioned from a technology adaptation model and so he used Geoffrey Moore’s 1990 book, Crossing the Chasm about marketing high tech products. Moore’s concept of a bell curve of technology acceptance divides the adaptation process into “early adopters” who push momentum and demand up the bell curve toward the “early majority.” But between the two there is a chasm since the first stage is characterized by decisions and actions taken by risk takers and visionaries while the decision makers in the more mature stage are managers, technocrats. In the first stage, the risk takers will make decisions based on belief, mission, impressionistic cases, and intuitive reasoning. In the second stage, the decision makers will require hard evidence of efficiency and efficacy.

In his article, Weeks proposed that IM is pushing toward the “chasm” in Moore’s model and that the bridge across the chasm is not yet possible. In his view, the IM/CAM community is busy doing research and proposing priorities for appropriate research to develop the needed evidence for the early majority. But he also perceives that the mainstream institutional partners for IM (the necessary abutment on the far side of the chasm) “continue to treat CAM as little more than a marketing ploy with few if any studies on CAM economics. He calls for CAM champions (the early adopters), all IM/CAM institutions as well as government and philanthropy to think about and help create the chasm-crossing evidence that will be necessary for IM/CAM to move to majority influence in the system.

In a subsequent book, The Tornado, Moore explores the challenges of meeting demand once it is unleashed. He observes that most organizations or companies are so focused on gaining acceptance of their idea that they usually are not prepared to meet the demand once it is created. This stage of growing and stabilizing systems to provide what has been promised opens yet another stage of a field’s development. Planning for demand needs to go hand-in-hand with building the bridge across the chasm.

Tipping Point
The tipping point is that dramatic moment in an epidemic when everything can change all at once. Often called the moment of critical mass, the threshold, or the boiling point, it is a place where the unexpected becomes expected and where radical change is more than a possibility. It is a certainty. The tipping occurs usually because of the efforts of a few select carriers.

From this theory of epidemiology, several thinkers have noted that ideas and products and social messages and behaviors spread like viruses. They follow a geometric progression of doubling, and doubling again and again. Often the first stages of change (the first sets of doubling) are imperceptible. The average observer can’t even detect that change is happening. And then suddenly the change seems fast and engulfing.

Those seeking to catalyze social change are fascinated by tipping point theory. Malcolm Gladwell’s book, The Tipping Point, has helped to create a new vocabulary for change theory. Gladwell proposes in a concept he calls the “Law of the Few” that there are
exceptional people in our midst that are capable of starting epidemics; they just need to be found and supported. They are the people with a special gift for bringing the world together; they are the social glue and they spread the message.

Gladwell also has coined the term “stickiness factor,” which means that there is a simple way to package information that, under the right circumstances, can make it irresistible (“sticky”) and compels a person into action. In order to spark an epidemic or a tipping point, ideas have to be memorable and move us into action.

Ultimately, Gladwell believes that “a world that follows the rules of epidemics is a very different place from the world we think we live in now.” He observes that most people still believe deeply in cause-and-effect process rather than contagiousness of ideas and behaviors. Shifting to an epidemic model means that little changes can have big effects and vice versa. Although there is often some proportionality between the effort made and the results achieved, this is not always true in larger systems.

Strategists seeking to lead change need to consider tipping point theory. Gladwell proposes, “The virtue of an epidemic, after all, is that just a little input is enough to get it started and it can spread very, very quickly. I’d like to show people how to start ‘positive’ epidemics of their own.”

**IM’s Dynamic Life-Stage and the Importance of Understanding How Change Happens.**

The attempt to put IM into the context of several contemporary and popular change theories is helpful because it can yield insight about how to detect leverage and energy points in the process. Using some diagnostic tools to determine the positioning of IM in the change process helps to imagine appropriate strategies for enabling additional movement and growth.

IM is no longer in the earliest stage of vision and start up and therefore will not benefit from basic start up support. Instead, it is moving from being a good idea to trying to be a good system or part of the transformation of a larger system. Definitional issues, proof and evidence, partnerships, institutional relationships, policy, and interactions with mainstream systems are all now part of the scaling-up process for IM.

**Theories of Change for Accelerating the Progress of Integrative Medicine**

In the “mapping” of a self-organizing movement like Integrative Medicine, various theories or models of change become apparent. Advocates and innovators of IM see its potential through their own “lens”; their analysis of the situation along with their ideas for how to make change follow from their point of view.

This section of the report is intended to chart the various Theories of Change and value-propositions that were expressed through the mapping interviews. In effect, these are “propositions for growth” and can be used as the basis for dialogue and strategic decision-making by the Collaborative.

Those interviewed for the Mapping Study were all credible and important leaders in IM. So it stands to reason that their ideas for how to support and accelerate the evolution of IM are insightful. Among this group there are no “wrong” ideas. Many Theories of Change were articulated in the context of desiring the growth and scaling up of IM to evolve into widespread availability and accessibility.

At the same time, philanthropists cannot support everything that the leaders of the field believe in or everything that is truly needed. Ultimately the Collaborative members need to look at the field and find the place(s) where they perceive the best fit of ideas or values and where they feel best able to make the greatest difference.
2. Nine Theories of Change/Growth Propositions for IM

Theory 1: Nurture Consumers and Consumers Will Sustain IM

The Proposition:
Consumers are driving the formation of IM as well as changes within both the conventional and CAM systems. These are consumers who don't want conventional or alternative care alone but see the value of the integration of both. The majority of these consumers are 20-55 years of age, white, female and making more than $40,000/year. If IM institutions can successfully educate more consumers and more diverse consumers about IM benefits, then more people will seek care and the additional growth in numbers of people seeking IM will sustain further development and expansion of IM.

Implications for Philanthropy:
- Collaborate with IM leaders (researchers, clinic directors, policy makers, and consumers) to craft messages that convey the value of IM and fund the development/implementation of marketing.
- Consider a five-year update of Eisenberg’s research (1997-2003).
- As part of a marketing study, assess the actual capacity of the centers/clinics. If marketing builds consumer interest, can the clinics handle it? If not the clinics, then who? How?
- There is an assumption that the price the consumer market “will bear” is $45-$65 per treatment. Can this be verified? What is the price point?

Theory 2: Educate and Train Professional Practitioners

The Proposition:
If more IM practitioners (MDs, NDs, nurses, acupuncturists, energy therapists, etc.) are trained and appropriately licensed and credentialed, they will be able to provide credible services that will then fully unleash the demand of the public for IM.

In other words, education and the supply of practitioners must be attended to first and these will be the drivers of growth and adaptation of IM—and ultimately the transformation of the larger system.

Implications for Philanthropy:
- Create a strategy focused primarily on educating practitioners.
- Decide whether or not such an education strategy would emphasize changing conventional education to include more CAM; or changing CAM education to be more knowledgeable and open about conventional; or creating a simultaneously symmetrical process in both conventional and CAM educational systems and programs. Once this decision is made then appropriate partnerships could be established.
- Investigate the models of licensing CAM practitioners and decide which model to follow and support (i.e., the Washington model in which CAM practice is regulated
in a parallel way to conventional medicine; or the Minnesota model, which is almost unlimited freedom to practice).

- Learn more about the supply/over-supply controversy. Are professionals needed in certain specialties but not others? How can schools/students be given incentives?

### Theory 3: Build Centers that Successfully Demonstrate the IM Model

**The Proposition:**
If clinics/centers are designed to model the principles of IM and successfully deliver their services, then patients will get better medicine documented both through patients’ perceptions and outcomes research; the model can then be replicated or adapted by others to meet the demand for better medicine.

This proposition relies on demonstrating that integration is possible and that its positive impact on health care will make it worth replicating or adapting.

**Implications for Philanthropy:**
- Gain a deeper understanding of the various models and ranges of capitalization of clinics [See Part I, Section 1 on Performance].
- Help establish standards for how many services can justifiably distinguish a clinic as an “IM center/clinic”. (Existing centers vary widely on this and some are calling themselves IM when they offer only two or three CAM modalities.).
- Decide whether the locus of the center or clinic matters in terms of its “change” value (i.e., academic, hospital or hospital system, free-standing).
- Weigh strategic advantages of funding more start ups of additional clinics or focus on strengthening the models that exist.
- How can private philanthropy best complement the public support of center and clinic formation? NCCAM favors a “centers of excellence” model. Should private philanthropy intensify the development of these elite centers of learning or push out to more community-based models that may serve more people day to day?
- If clinics/centers are not sustainable through income-based self-sufficiency, what is the appropriate share for philanthropy to capitalize the centers for long-term sustainability?
- If clinics/centers are not sustainable long-term, what is their value as a transitional part of IM evolution?
- How can shared learning among clinics be intensified? Document best and promising practices so that they can be replicated or adapted.
- Help determine what types of technology support (especially a knowledge management system) can enable clinics to share learning and enhance delivery of services and development of the institutions.
Theory 4: Clinically Prove the Value of Services and Products

The Proposition:
If IM care, particularly alternative treatments and products (herbal remedies, nutraceuticals) can be proven effective through clinical trials, then patients will feel confident about seeking such treatments, insurers will be able to issue coverage, centers will be able to offer the services, demand will increase, and IM will be accepted.

Implications for Philanthropy:
The value of some clinical trials is shared across conventional and CAM proponents of IM; yet the concept of clinical trials also is held by many IM champions as being oppositional to the concept of integration. Directly testing a single component or modality contradicts the concept of integration. Therefore a commitment to clinical trial evidence will pull a funder into one of the fundamental controversies of the field. But supporting clinical trials might be a best strategy if:

- The funders agree on a particular disease or illness that is the focus of their own interest.
- The funders agree on a particular area of products or treatments (i.e., a specific herb or type of treatment) that is of the greatest interest.
- The funders are willing to help develop appropriate research methodology so that a clinical trial concept can be applied to an integrative process rather than a single substance or treatment.

One issue that stands out in the clinical trials debate is that of the growing use of herbs, vitamins, and nutraceuticals. One IM leader referred to these products as the “time-bomb” lurking within the IM field. Another suggested that scientific testing, including clinical trials, should be vigorously supported and expanded. The sooner some substances are tested and then either confirmed as useful or rejected, the sooner the field can support the development and testing of additional new ideas and products. “The field should not be afraid to learn that some products are not as useful as suspected; reducing the emphasis on some favorites will make room for others to become available.”

Complicating the situation with herbs, vitamins, and nutraceuticals is the profitable advantage that these products bring to both institutions and people in the field. Leaders throughout the field (practitioners in clinics, academia, policy roles, etc.) are owners of for-profit companies supplying these products or are in key governance roles on boards of directors.

Philanthropists active in the IM field will need to articulate their own strategic position about the safety, accessibility, and regulation of IM products. It is an issue of major significance in the field and should be dealt with directly and strategically or avoided in an open and deliberate way (not by accident).

Theory 5: Prove Efficacy and Efficiency

The Proposition:
Even if clinical trials prove value or remain indeterminate about the value of specific modalities, IM will only be accepted if there is proof that IM care can be cost-effective and efficient in reducing pain/healing time and helping to lower costs of care. Then clients,
insurers, and employers will prefer IM over the more limited options of either conventional-only or CAM-only treatment plans. This proof of efficiency will open floodgates of demand, which will ultimately transform the system.

**Implications for Philanthropy:**
- This is an area where less research has been funded through NCCAM—at least to date. A more detailed map of practical research projects underway would be useful; then research priorities can be chosen.
- Enlightened self-interest of industry should be tapped through partnerships, research co-ventures, and collaboratives.
- Enlightened self-interest of government-based entitlement programs should be tapped for research partnerships and co-ventures (Social Security; WICS; Veterans Administration; Medicare, Medicaid; etc.).
- A shared data base through which many clinics/practitioners could register patient data and outcomes would create a system-wide data base and measurement system (e.g., similar to how practitioners and communities register data with the Center for Disease Control for epidemiological research).
- Define efficiency and efficacy issues to include real world issues such as productivity, quality of life, cost, and cost offsets.
- Support outreach and education of employers and insurers to stay in touch with and responsive to the type of information or proof that would enable them to broaden coverage to include IM.

**Theory 6: Confidence of Insurers**

**The Proposition:**
If insurers are pressured to offer IM—or understand and positively respond to the benefits of IM—then the increasing numbers of people insured for IM will increase demand for services and stimulate demand for more IM options in many communities.

**Implications for Philanthropy:**
Philanthropists cannot control the insurance industry; however, philanthropy can help to create a favorable policy environment, educate the public, and assist advocates in making their voices heard. Some of the strategic actions that philanthropy might consider:

- Documenting in detail the status of coverage for IM—through traditional insurers, networks of services, managed care, and defined benefits trends in corporations.
- Catalyzing/supporting industry-wide dialogue.
- Work with IM clinics to discover if and how insurance can work for IM—beyond self-pay and individual insurance reimbursements.
- Enable advocates to craft and support coherent policy changes in insurance and regulation of IM.

**Theory 7: The Self-Care Revolution**
The Proposition:
As a model of care, IM emphasizes the importance of the client-practitioner relationship and shifts more responsibility to the client/patient. If IM practice can successfully persuade clients to accept the responsibility of self-care, it will revolutionize preventive health care and the management of chronic illnesses.

Implications for Philanthropy:
- Many IM clinics get chronic illness referrals when there is nothing more that conventional medicine can do. Although IM can be successful at this point, it is not the strongest point in the health care process to make the greatest impact on prevention or early interception of chronic illness. How can IM clinics work with more diverse age groups? Many assume that the aging of the baby-boomers will “make” the IM field in years to come. This assumption needs to be examined in the context of other age-related strategies that could embed IM and effective self-care into the health care system.

- Preventive care and self-care are areas of overlapping interest between conventional medicine and CAM. More research is needed on the behavioral aspects and motivators for self-care.

- Habits of self-care develop early in life and compliance issues shift rapidly as children move into teen and young adult years; yet none of the IM clinics in the Mapping Study have a specific interest or specialty in pediatric or young adult care. What bridges need to be built between IM and the conventional medical care of children and youth?

- Explore the promise of “digital medicine” (i.e., online education, video-game and simulation education etc.) and its potential for motivating and sustaining self-care.

Theory 8: Policy

The Proposition:
Policy making could guarantee that IM is accessible and safe. If policies are advocated and successfully implemented, there will be more research, more public spending, more insurance coverage, fair and thorough regulation, standard certification and licensing, and product safety. As a result, patients will know they can get and trust a basic standard of care and will seek IM in order to have the options of safe CAM along with safe conventional medicine.

Implications for Philanthropy:
The policy agenda that affects the evolution of IM is substantial and includes everything from public funding to licensing and standards of care. The IM field also has been active in envisioning a policy agenda (National Policy Dialogue, 2001). In addition, the White House Commission Report (2002) lays out a comprehensive array of 27 major policy recommendations. And, in 2003, a new commission sponsored by the Institute of Medicine got underway. The challenges for philanthropists will be to:

- Choose an area(s) of policy making for focus and action as the agenda is too big for any one foundation or collaborative to work on all issues all at once.

- Concentrate all or most resources on policy making. Find and fund credible partners who can organize effectively and achieve policy gains on many fronts at once.
• Help create new networks and collaborations if the existing ones do not have sufficient capacity to carry the policy agenda

Theory 9: Merger or Acquisition

The Proposition:
If conventional medical schools add educational options so that all doctors understand IM, recommend it, and are qualified to deliver it (e.g., MD acupuncture, etc.), then CAM practices and practitioners will be certified and standardized through the conventional health care system and patients will trust it more. This will lead to growth in the use of IM and ultimately better health outcomes.

If conventional medical schools add educational options in CAM, then they will use the power to own the field of CAM and will be perceived and accepted as the gatekeepers of CAM.

Implications for Philanthropy:
This, of course, is a highly controversial Theory of Change and almost nobody would publicly state this as a preferred strategy. Yet some of the ideas for research, regulation, and education imply or could be interpreted as meaning that the goal is for conventional medicine to expand itself to include proven CAM practices, but not necessarily to transform the health care system.

In order to either support this theory of change or to intervene to make sure that it does not inadvertently become the reality, philanthropy should be attentive to:

• Enlivening and nurturing the dialogue about what will make integration transformative rather than just expansive.

• Engaging IM leaders to agree on how such transformation (via integration) will be evaluated and measured. How will we know when we have integrative care?

• Monitor and advocate for symmetrical development of CAM institutions so that there is a two-way integration of care.

• Support the open dialogue about the vision for integration: a future of three systems/options (i.e., all conventional, all CAM, or integrated); or a future of one system (all “good” medicine in an interrelated and interdependent system); or a future of two systems (an expanded conventional system that includes some CAM and a separate and more diverse CAM system that continues to exist).
### 3. The Theories of Change at a Glance

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**• Engaging IM leaders to agree on how such transformation (via integration) will be evaluated and measured. How will we know when we have integrative care?**  
**• Monitor and advocate for symmetrical development of CAM institutions so that there is a two-way integration of care.**  
**• Support the open dialogue about the vision for integration: a future of three systems/options (i.e., all conventional; all CAM; or integrated); or a future of one system (all “good” medicine in an interrelated and interdependent system); or a future of two systems (an expanded conventional system that includes some CAM and a separate and more diverse CAM system that continues to exist).** |
| If conventional medical schools add educational options so that all doctors understand IM, recommend it, and are qualified to deliver it (e.g. MD acupuncture, etc.) then CAMS will be certified and standardized through the conventional health care system and patients will trust it more, and this will lead to growth in the use of IM and ultimately better health outcomes.  
If conventional medical schools add educational options in CAM then they will use their power to own the field of CAM and will be perceived and accepted as the gatekeepers of CAM. |
These Theories of Change or patterns of IM development reveal the many layers of field-building that are underway in the emergence of IM. All are important and all will help to yield either a new field of medicine or the transformation of the existing systems. But the art of philanthropy requires choices that satisfy the souls of the donors while working toward the greatest possible positive change that is envisioned and desired.

The strategic answer for the Collaborative may be one of these theories, a combination of some of them, or the invention of new ones that are stimulated after considering those presented here. The opportunities are enormous as the field continues to need work at the vision and definition level as much as it does at the practical delivery of services and the ultimate replication of IM models and/or the transformation of health care. Moreover, all the modern theories of systems change imply that no single strategy can be isolated as the magic answer; instead many areas of change—large and small—need to be nurtured so that enough change is sparked in enough places in a complex system so that it accumulates and tips the prevailing notions and practices.

4. Resistance to Change and the Growth of IM

Advocates of IM will be able to use this Mapping Study, including these Theories of Change (or growth propositions) to plan strategy that will lead to the desired transformation of medicine and health care. However, their efforts will be met with resistance—both subtle and direct.

Some of the centers and clinics reported in their interviews that their host organizations (hospital systems and academic centers) are "mixed" environments for IM. Some people in the organization are champions while others are detractors and even actively block the concept of IM and its vision for integrating conventional and CAM services. This resistance shows up in the form of intellectual criticism, barriers to credentialing CAM practitioners in IM centers, and withholding resources. Those interviewed were aware that they are often fighting the "quackery" label and discussed the need to maintain frequent and open communications with leaders up the ladder.

The National Council against Health Fraud (NCAHF) collects and distributes papers that critique CAM ideas and therapies. The National Council’s website has a prominent link to Quackwatch.com which also issues occasional papers and opinion documents about the inadequacy of CAM therapies. Both sites post papers “on the record” that criticize nearly all CAM therapies, both those that are licensed and regulated and those that are not.

A 1999 debate between Arnold S. Relman, editor-in-chief emeritus of the New England Journal of Medicine and Andrew Weil, director of the University of Arizona Program in Integrative Medicine, laid out the sides of the argument for and against IM. Relman described his beliefs that alternative treatments are based on “irrational or fanciful thinking, and false or unproven factual claims,” and are at odds with modern knowledge about the human body. Weil presented the interests of consumers for CAM and the consumers’ own proof for what had worked for them. Relman denied that the studies about CAM therapies are rigorous enough to be clinical proof; Weil countered with growing
evidence that CAM therapies are positive and useful, often because they make the mind-body connection.

The 2002 White House Commission on CAM, while overwhelmingly positive and encouraging about moving forward on IM/CAM, did include a minority report from two of the Commissioners who went on record as saying that the Commission’s recommendations don’t acknowledge appropriately the limitations of unproven and invalidated CAM interventions and don’t adequately address the minimization of risk. They claim that the Report is too inclusive of all CAM practices without appropriate nuance and they outline their objections section by section.

The NCAHF has gone on the record with a statement against the Commission’s Report. While applauding the inclusion of the Minority Report, NCAHF members accuse the White House Commissioners of being mostly aligned with CAM, including some with economic interests in the growth of CAM/IM. They accuse: “Throughout the report, the Commission implies that ‘CAM’ is a well-defined medical discipline rather than a marketing term used to promote unproven methods….The Commission falsely assumes that CAM research is cost-effective and that CAM methods have been sufficiently developed to integrate into every aspect of our educational and healthcare delivery systems. The report does not identify a single CAM practice that should be considered improper.”

Although the interviewees in the Mapping Study did not talk about these resistors as being high-level threats or barriers to their work, the resistance is out there and needs to be acknowledged and countered as part of any strategy for IM growth.
THE REPORT

Part III: The Visual Maps
PART III. Visual Maps of the Field

The emergence of IM is a dynamic process engaging players from both the conventional and CAM systems of health care, along with mainstream political, industry, science, and community leaders.

Distilling the current situation and its likely future into visual representations of mental models can help to check analytical assumptions and strengthen strategic discussion and decision making. The visual models help to clarify points and quickly communicate information that is described in great detail in the first parts of the report. The visual models are an effort to simplify some of the key issues:

- What is happening in the world around the IM field/movement; how is IM related to the systems it intends to integrate?
- What is happening in the field itself—both descriptive data and ideas for change?
- How might change in this field unfold? What are some of the likely scenarios?
- How can these scenarios help to identify which descriptive data are essential and potentially of high influence to the field and which data represent forces that are of little influence in how the field will continue emerging?

Several visual models are offered here as ways of depicting the situational analysis and likely future(s) of IM.

There are five visuals that describe the overall dynamics in the emergence of the field of IM:
- Integrating Asymmetrical Systems into "A New Medicine"
- Mapping IM—Current Realities and Propositions for Growth
- Four Scenarios for the Emergence of IM and a New Medicine
- IM: A Gateway to a New Medicine
- The Stakeholders of IM

In addition there are visuals that describe some specific aspects of both conventional and IM/CAM institutions, therapies, and professions:
- Profile of the clinics/centers in the Mapping Study
- Profile of the clinics/centers in the Integrator’s Benchmarking Study
- Profile of the Consortium of Academic Centers for Integrative Medicine
- Geographic maps of CAM licensing and credentials (4)
- Operations and clinical characteristics for the clinics/centers in the Mapping Study
- Graph of the U.S. health care dollar
- Fact map (Physician Office Visits in minutes)
- Insurance Facts (A-G)
Part III: Visual Maps of the Field

Integrated Asymmetrical Systems Into "A New Medicine"

The Challenge
How can a highly formalized and large-scale system of institutions and a small-scale informal system of individual practitioners integrate the best of both to form a better overall health care system? Inherent in the integration process is the possibility that the more powerful partner will acquire the other and overwhelm the identity and unique qualities that the smaller system represents.

Integrative Medicine - USA
An emerging network of people, associations, and institutions advocating for and practicing the combining of proven conventional medicine and CAM therapies while emphasizing patient-provider relationship, health promotion, prevention and self-care.

Conventional Medicine - USA
A large and complex business system of major educational, research, care-giving, government and private-sector institutions with standardized credentialing, licensing and powerful peer associations. Primarily focused on science-based treatments and products to cure illness and disease.

Complementary and Alternative Medicine - USA
An informal and relatively small system of individual practitioners, small institutions and associations providing health care practices that often derive from diverse cultural traditions and are in demand by consumers but lie outside of defined conventional care and financial systems.
Mapping IM: Current Realities & Propositions for Growth

**Description of the Field**

1) Founding Vision, Mission, Definition
2) Performance (including Key Milestones, Major Successes; Failures and Lessons Learned; Impact; Perceived Value; Barriers)
3) Staffing
4) Clients/Patients/Consumers
5) Sustainability (6 major syndromes)
6) External Forces
7) Research
8) Education
9) Future Vision

**Growth Propositions**

1) Nurture Consumers & Consumers will Sustain IM
2) Education and Training of Professional Practitioners
3) Building Centers that Successfully Demonstrate the IM Model
4) Clinical Proof of Services and Products
5) Proof of Efficacy and Efficiency
6) Confidence of Insurers
7) Self-Help Revolution
8) Policy
9) Merger or Acquisition

**EXTERNAL FORCES**
Affecting the Overall Health System

- The Efforts of Health Reform
- Prevention, Managed Care...
- Inequities and Lack of Access
- Spiraling Costs
- Age Demographics
- American Lifestyle
- High Tech Medicine
- Consumer Demands for CAM
Conventional Medicine - USA

A large and complex business system of major educational, research, care-giving, government and private-sector institutions with standardized credentialing, licensing and powerful peer associations. Primarily focused on science-based treatments and products to cure illness and disease.

Complementary and Alternative Medicine - USA

An informal and relatively small system of individual practitioners, small institutions and associations providing healthcare practices that often derive from diverse cultural traditions and are in demand by consumers but lie outside of defined conventional care and financial systems.

Integration Medicine - USA

An emerging network of people, associations, and institutions advocating for and practicing the combining of proven conventional medicine and CAM therapies while emphasizing patient-provider relationship, health promotion, prevention and self-care.
THE AXIS of TRANSFORMATION
This diagram shows possible scenarios for integration. This axis does not encompass all of the possible factors of integration but shows two major lines of change in the integration process.

Four Scenarios for the Emergence of IM and a New Medicine

**Big Medicine Gets Bigger**
**HIGH Transformation** of Conventional Systems
**LOW Expansion** of CAM

Conventional institutions may expand their own ideas about prevention, public health, and patient education. A few CAM therapies may be grafted onto the system. The dominance of the Conventional System’s transformation may starve resources and attention from CAM so that its expansion is stalled.

**E Pluribus Unum**
**HIGH Transformation** of Conventional Systems
**HIGH Expansion** of CAM

An integrated system emerges in which conventional medicine is highly transformed by IM/CAM and CAM therapies are proven and accessible. The “new” system recognizes the different traditions of conventional and CAMS but accepts both and enables the patient to find all options. While accepted as different from each other both are vigorous and interdependent care systems that form the larger healthcare system.

**Stalled on the Bridge**
**LOW Transformation** of Conventional Systems
**LOW Expansion** of CAM

The Conventional System does not change and the momentum for CAM/MM stalls. This could happen for many reasons: research outcomes on CAM therapies turn out to be inconclusive; insurance coverage shrinks as employers cut back on employee benefits, clinics and small practitioners struggle to survive in harsh economic conditions.

**Networked but Not Integrated**
**LOW Transformation** of Conventional Systems
**HIGH Expansion** of CAM

Conventional medicine “draws the line” on integrated care, credentialing/licensing and referrals; conventional medicine stays basically the same. At the same time CAM/MM research and outcomes data further define the value of CAM in basic and specialized healthcare. IM and CAM institutions flourish. Partnerships with conventional medicine are likely but they do not veer towards integration.
THE STAKEHOLDERS OF IM

- Industry:
  - Pharmaceuticals
  - Vitamins/Supplements
  - Employers
  - Venture Capital

- Educators:
  - Medical Schools
  - MDs
  - Acupuncture, Chiropractors, etc.

- Care Providers:
  - Hospitals
  - Health Systems
  - IM Centers

- Consumers:
  - Online Services

- Professional Associations
  - Networks

- Phialanthropy:
  - Individual and Institutional DONORS

- Government:
  - NIH, CDC, HHS

- Politicians / Regulators:
  - Congress, State, Medical Boards, FDA,
    Licensing Associations
## Mapping Process Interviewee Sites

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<thead>
<tr>
<th>Organization</th>
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<th>State</th>
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<td>American Specialty Health</td>
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<tr>
<td>California Pacific Medical Center</td>
<td>San Francisco</td>
<td>CA</td>
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<tr>
<td>Center for Mind Body Medicine</td>
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<td>BC</td>
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### Integrator Benchmarking Sites

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<tr>
<td>Organization</td>
<td>City</td>
<td>State</td>
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</tr>
<tr>
<td>Center for Natural Medicine</td>
<td>Portland</td>
<td>OR</td>
</tr>
<tr>
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<td>WA</td>
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<td>Cypress Center for Alternative Medicine</td>
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<td>East-West Health Centers</td>
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<td>The Tapestry Group</td>
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<td>Bastyr University Bastyr Center for Natural Health</td>
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<td>Beth Israel, Albert Einstein Continuum Center for Health &amp; Healing</td>
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<td>North Hawaii Community Hospital</td>
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<td>Osher Center for Integrative Medicine at UCSF</td>
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<td>The center for IM (CIM) U of MD School</td>
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<td>U of MA Center for Mindfulness in Medicine, Health Care and Society</td>
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<td>U of AZ Program in Integrative Medicine</td>
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*Organizations were viable during the course of mapping the process. At the end of this quarter, they are closing their doors due to financial constraints.*
## SITE OVERVIEW: CLINICAL

<table>
<thead>
<tr>
<th>Organization</th>
<th>Array of Conditions Treated</th>
<th>Array of Services Provided</th>
<th>Information Resources for Clients</th>
<th>Natural Products Pharmacy/Dispensary</th>
<th>Integrator Role</th>
</tr>
</thead>
</table>
| Basyr Center for Natural Health | All conditions as natural health care are particularly effective for the prevention of and relief from chronic and degenerative health conditions. It can help provide relief from fatigue, depression, and relationship issues, cold and flu, menopausal symptoms, stress-related conditions, allergies and asthma, cardiovascular disease, high blood pressure, digestive problems, ulcers and HIV/AIDS. | • ACUPRESSURE  
• AURICULAR  
• ACUPUNCTURE  
• CHELATION THERAPY, ORAL ONLY, DIETARY SUPPLEMENTS  
• NATUROPATHIC MANIPULATION  
• HOMEOPATHIC  
• MASSAGE  
• NATUROPATHIC, OSTEOPATHIC  
• QI GONG  
• REIKI | Yes | Yes | Staff |
| Beth Israel, Albert Einstein Continuum Center for Health and Healing | General practice with specialties in gynecology, nutrition, with diabetes as a specialty, broadly overlaying the work. | • General family practitioners, psychologists, homeopaths, nutritionists, mind-body, chiropractors, massage, gynecology, pediatric.  
• AYURVEDA, traditional Chinese medicine, Native American medicine  
• Plant-based medicines  
• Optimized nutrition  
• Nutritional supplementation  
• Manual therapies and healing movement forms like chiropractic, massage, craniofacial, T’ai Chi and yoga  
• Energy medicines, like homeopathy, Reiki and therapeutic touch  
• Relaxation techniques, such as meditation, biofeedback, hypnotherapy and guided imagery | Conventional medicine | Both |
| Center for Mind Body Medicine | Cancer | • Relaxation therapies, hypnosis, meditation, acupuncture, nutrition, music and dance, herbalism, musculoskeletal manipulation, yoga | Yes | No | Patient |
| Division for Research & Education in Complementary & Integrative Medical Therapies Harvard Osher Institute, Harvard Medical School The Landmark Center | Treatment and management of musculoskeletal pain-related conditions. | • Acupuncture, herbal therapies, chiropractic, relaxation techniques, and therapeutic massage | | | |
| Duke Center for Integrative Medicine | | Touch therapy; herbs-botanicals | | | |
| Haehth | We draw on our extensive resources to assist you in developing a program that combines the most effective therapies for your particular health needs—from Yoga, massage therapy, one-on-one fitness training, nutritional coaching, acupuncture, Chinese medicine | Yes | No | Both |
### SITE OVERVIEW: CLINICAL

<table>
<thead>
<tr>
<th>Organization</th>
<th>Array of Conditions Treated</th>
<th>Array of Services Provided</th>
<th>Information Resources for Clients</th>
<th>Natural Products Pharmacy/Dispensary</th>
<th>Integrator Role</th>
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<td><strong>Inner Harmony Wellness Center</strong>&lt;br&gt;<strong>Mental health</strong>&lt;br&gt;Pain management&lt;br&gt;Cancer care&lt;br&gt;Women’s health&lt;br&gt;Weight management&lt;br&gt;Smoking cessation&lt;br&gt;Mind-Body skills</td>
<td>Prevention and well-being to management of chronic conditions like cancer, diabetes, heart disease, stress, anxiety and depression, colitis, irritable bowel syndrome and non-specific abdominal pain, low back pain and chronic pain, allergic responses (such as dermatitis and asthma), eating disorders, immune mediated, pediatric problems (such as Attention Deficit Disorder)</td>
<td>and herbal healing, Chi Gung, mindfulness meditation, guided imagery</td>
<td></td>
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<td>Both</td>
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<tr>
<td><strong>Institute for Health and Healing California Pacific Med Center</strong>&lt;br&gt;Cancer, stress, anxiety and depression, immune mediated diseases, pediatric problems (such as Attention Deficit Disorder), colitis, irritable bowel syndrome and non-specific abdominal pain, low back pain and chronic pain, allergic responses (such as dermatitis and asthma), eating disorders</td>
<td></td>
<td></td>
<td></td>
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<td>Both</td>
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<tr>
<td><strong>Integrative care.com</strong>&lt;br&gt;All aspects of health, function, aging, and disease.</td>
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<td></td>
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<tr>
<td><strong>Jefferson Center for Integrative Medicine Thomas Jefferson University Hospital</strong>&lt;br&gt;Wide range of conditions.</td>
<td>Disorders such as chronic fatigue, irritable bowel syndrome, and fibromyalgia&lt;br&gt;Allergies, food and chemical sensitivities&lt;br&gt;Chronic pain&lt;br&gt;Cancer, hepatitis C, and other illnesses requiring additional, supportive therapy&lt;br&gt;Intolerance to standard medicines such as anti-inflammatories and pain relievers&lt;br&gt;Recurrent sinusitis, bronchitis and middle ear infections&lt;br&gt;Stress-related conditions, anxiety, and depression&lt;br&gt;Women’s health issues&lt;br&gt;Some patients simply look to experience greater energy and wellness.</td>
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<td><strong>North Hawaii Community Hospital</strong>&lt;br&gt;All conditions treated within the hospital setting. The Center specializes in chronic pain.</td>
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<tr>
<td><strong>Osher Center for Integrative Medicine at UCSF</strong>&lt;br&gt;All</td>
<td>Integrative Medicine consultations with a physician&lt;br&gt;Therapeutic massage and bodywork&lt;br&gt;Acupuncture</td>
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<td>Organization</td>
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<tr>
<td><strong>Scripps Clinic - Torrey Pines</strong></td>
<td>The Scripps Center for Integrative Medicine offers pain relief programs that integrate several approaches to address the behavioral, emotional, spiritual, and physical dimensions of pain. Robert Bonakdar, MD, the center’s first clinical and research fellow in Integrative Medicine, is the director of Integrative Pain Services and co-chair of the Scripps Green Hospital Pain Management Committee. He works with other staff to design comprehensive integrative pain relief programs for patients.</td>
<td>• Nutritional counseling  • Psychotherapy  • Group programs include: Mindfulness-based stress reduction  Integral nutrition  Tai Chi Chuan  Therapeutic yoga</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>The Center for Integrative Medicine (CIM), University of Maryland School of Medicine</strong></td>
<td>The diagnostic areas of primary interest to CMP are pain and stress-related disorders. As part of our NIH Specialized Center of Research, we focus on arthritis and related disorders. At CMP we are interested in exploring the potential role of complementary medicine and an integrative, multidisciplinary, humanistic approach to relieving the suffering caused by pain. Large numbers of people with painful conditions are already using complementary therapies. In fact, problems such as back pain, headaches, and chronic pain are the reasons most people turn to complementary medicine.</td>
<td>• Acupuncture  • Healing touch  • Biofeedback  • Massage  • Mindful stress management  • Stress mastery</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>True North Health Center</strong></td>
<td>All</td>
<td>• Comprehensive women’s health care including gynecology and gynecologic surgery, fertility/preconception, and family planning, healthy menopause, hormone balancing, annual exams, healthy aging, etc.  Physician consultation regarding holistic treatment alternatives for people with cancer/chronic illness or disease.  Comprehensive holistic health evaluation, personalized preventive medicine, and health mentoring.  Nutritional assessment and counseling including therapeutic nutrition and food supplement information</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### SITE OVERVIEW: CLINICAL

<table>
<thead>
<tr>
<th>Organization</th>
<th>Array of Conditions Treated</th>
<th>Array of Services Provided</th>
<th>Information Resources for Clients</th>
<th>Natural Products Pharmacy/Dispensary</th>
<th>Integrator Role</th>
</tr>
</thead>
</table>
| Tzu Chi Institute for Complementary and Alternative Medicine | People enroll in the Integrated Care Programs for a variety of reasons. Some have illnesses such as cancer, arthritis, depression, HIV/AIDS, or allergies. Many are living with more than one chronic condition. Others have no serious medical concerns, but are seeking ways to maintain optimum health. | • Acupuncture  
• Chiropractic  
• Massage Therapy  
• Program  
• Naturopathic Medicine  
• Nutrition Therapy  
• Yoga | Yes | No | Patient |
| Univ. of Massachusetts Center for Mindfulness in Medicine, Health Care and Society | Stress, chronic pain and illness, anxiety and panic, GI distress, Sleep disturbances and fatigue, High blood pressure, Headaches | • Mindfulness stress reduction as well as how to teach it or incorporate in the practice. | Yes | No | Patient |
| University of Arizona Program in Integrative Medicine | General array of conditions.                                                                                                                                                                                                  | • Many mainstream and complementary therapists include an acupuncturist, nutritionist, osteopathic physician, energy medicine practitioner, a specialist in mind-body approaches, homeopathic physicians. | Yes | No | Both |
Physician Office Visits

Of the mapping interviewees, clinic and center leaders reported that the average length of time for an intake visit at an IM clinic is 60-90 minutes; and the average length of an office visit and treatment is 50-60 minutes. In comparison, the average length of conventional physician visits is approximately 18-19 minutes.

Mean Length of Physician Office Visits (in Minutes), by Payment Type, 1989–1999

Perhaps contrary to popular belief, physician visits have gotten longer, not shorter in the last 10 years. Both prepaid and non-prepaid visits were on average over three minutes longer in 1999 than in 1989. The trend has not been continuous: the length of visits increased from 1989 to 1995, decreased in recent years, then rose in 1999. Across the period, non-prepaid visits were slightly longer than prepaid visits.

NOTES:
Prepaid visits are visits reimbursed by capped payments from HMOs.

SOURCE:
Insurance Facts

Chart A

HIAA offers trend data related to private health insurance coverage and cost drivers within the United States

National health expenditures are projected to reach $2.6 trillion by 2010.

Chart B

Prescription drugs are the fastest rising component of personal health expenditures

Source: U.S. Department of Health and Human Services, Health Care Financing Administration, March 2001
Chart C

Medical care inflation is now only about 20% above the overall inflation rate.

Source: U.S. Department of Labor, Bureau of Labor Statistics
Chart D

Personal consumption expenditure data for 1999 reveal that Americans spend 15 cents out of every dollar for medical care.

Source: Department of Commerce, Survey of Current Business, September 2000
Chart E

Of 274 million people in the United States, 232 million had health insurance in 1999.

Eighty-eight percent of people covered by private health insurance are covered through an employer.

Source: U.S. Census Bureau, 2000
Chart F

An estimated one-third of the national health expenditure was paid by private health insurance in 1999.

Source: U.S. Department of Health and Human Services, Health Care Financing Administration, March 2001
Chart G

The net cost of private third-party health coverage averaged 11.8% of total private expenditures from 1994-1999.

Source: U.S. Department of Health and Human Services, Health Care Financing Administration, March
EXHIBIT 2

Increases in Health Insurance Premiums Compared to Other Indicators, 1988-2002


Note: Data on premium increases reflect the cost of health insurance premiums for a family of four.

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Increases in Health Care Premiums Compared to Other Indicators

Part III: Visual Maps of the Field
### Organizations

**The Mind/Body Medical Institute**
http://www.mbmi.org/Default.asp  
824 Boylston St.  
Chestnut Hill, MA 02467  
Telephone: (617) 991-0102  
Toll free: (866) 509-0732  
Fax: (617) 991-0112

**International Center for the Integration of Health and Spirituality (ICIHS)**
http://www.nihr.org/  
6110 Executive Blvd., Suite 908  
Rockville, MD 20852  
301-984-7162  
Fax: 301-984-8143

**Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM)**
http://www.acaom.org/  
Maryland Trade Center 3  
7501 Greenway Center Dr. Suite 820  
Greenbelt, MD 20770

**Acupuncture and Oriental Medicine Alliance (Acupuncture Alliance)**
www.AcupunctureAlliance.org  
14637 Starr Road S.E. Olalla, WA 98359  
(253) 851-6896,  
fax (253) 851-6883

**Acupuncture and Oriental Medicine Alliance (AOMA)**
http://www.acuall.org/  
Acupuncture and Oriental Medicine Alliance  
14637 Starr Road Southeast  
Olalla, Washington, 98359

**American Academy of Medical Acupuncture (AAMA)**
http://www.medicalacupuncture.org  
4929 Wilshire Boulevard, Suite 428  
Los Angeles, California 90010  
(323) 937-5514 (phone)

**American Association for Teachers of Oriental Medicine**
ACUAOM@aol.com  
P.O. Box 9563  
Austin, TX 78766-9563  
(512) 451-2866 (phone)  
(512) 454-7001 (fax)

**American Association of Naturopathic Physicians (AANP)**
http://www.naturopathic.org/
<table>
<thead>
<tr>
<th>Organization</th>
<th>Address</th>
<th>Phone Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>American Association of Oriental Medicine (AAOM)</strong></td>
<td>433 Front Street, Catasauqua, PA 18032</td>
<td>(610) 266-1433, fax (610) 264-2768</td>
</tr>
<tr>
<td><strong>American Chiropractic Association</strong></td>
<td>1701 Clarendon Blvd, Arlington, VA 22209</td>
<td>Phone 800/986-4636, Fax 703/243-2593</td>
</tr>
<tr>
<td><strong>American Naturopathic Medical Association (ANMA)</strong></td>
<td>P.O. Box 96273, Las Vegas, Nevada 89193</td>
<td>(702) 897-7053 (phone), (702) 897-7140 (fax)</td>
</tr>
<tr>
<td><strong>American Naturopathic Medical Certification and Accreditation Board (ANMCAB)</strong></td>
<td>8170 S. Eastern Avenue, Suite 4-133, Las Vegas, NV 89123</td>
<td>(702) 897-4915</td>
</tr>
<tr>
<td><strong>American Organization for the Bodywork Therapies of Asia (AOBTA)</strong></td>
<td>Laurel Oak Corporate Center Suite 408, 1010 Haddonfield-Berlin Rd Voorhees, NJ 08043</td>
<td>(609) 782-1616, Fax (609) 782-1653</td>
</tr>
<tr>
<td><strong>Congress of Chiropractic State Associations</strong></td>
<td>P.O. Box 2054, Lexington, South Carolina 29071-2054</td>
<td>(803) 356-6809, Fax (803) 356-6826</td>
</tr>
<tr>
<td><strong>Council of Colleges of Acupuncture and Oriental Medicine (CCAOM)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organization</td>
<td>Address</td>
<td>Phone Numbers</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>Council on Licensure, Enforcement and Regulations (CLEAR)</td>
<td>403 Marquis Avenue, Suite 100, Lexington, KY 40502</td>
<td>(859) 269-1289 (phone) (859) 231-1943 (fax)</td>
</tr>
<tr>
<td>Federation of Associations of Regulatory Boards</td>
<td>1603 Orrington Avenue, Suite 2080F, Evanston, IL 60201</td>
<td>(847) 328-7909 (847) 864-0588</td>
</tr>
<tr>
<td>Federation of Chiropractic Licensing Boards</td>
<td>901 54th Avenue Suite 101, Greeley, CO 80634-4400, USA</td>
<td>970.356.3500 970.356.359</td>
</tr>
<tr>
<td>INTERNATIONAL CHIROPRACTORS ASSOCIATION</td>
<td>1110 North Glebe Road, Suite 1000, Arlington, VA 22201</td>
<td>1-800-423-4690 or 1-703-528-5000</td>
</tr>
<tr>
<td>NAFTA Acupuncture and Oriental Medicine Commission</td>
<td>14637 Starr Road SE Olalla, WA 98359</td>
<td>(253) 851-6895 (253) 851-6883</td>
</tr>
<tr>
<td>National Academy of Acupuncture and Oriental Medicine</td>
<td>P.O. Box 62, Tarrytown, NY 10591</td>
<td>(914) 631-2369</td>
</tr>
<tr>
<td>National Acupuncture Detoxification Association (NADA)</td>
<td>P.O. Box 1927, Vancouver, WA 98668-1927</td>
<td>(888) 765-NADA (360) 260-8620</td>
</tr>
<tr>
<td>National Acupuncture Foundation (NAF)</td>
<td>P.O. Box 2271, Gig Harbor, WA 98335-4271</td>
<td></td>
</tr>
<tr>
<td><strong>National Board of Chiropractic Examiners</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong><a href="http://www.nbce2.org/">http://www.nbce2.org/</a></strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 901 54th Avenue  
Greeley, CO 80634  970-356-9100 (Voice)  
970-356-6134 (FAX)  
http://www.nbce2.org/ |

| **National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM)** |
| **http://www.nccaom.org/** |
| 11 Canal Center Plaza. Suite 300  
Alexandria, VA 22314  
(703) 548-9004, (703) 548-9079 |

| **National Sports Acupuncture Association (NSAA)** |
|  
P.O. Box 2271 Gig Harbor, WA 98335-4271  
(415) 704-3123 Phone/fax |

| **Society for Acupuncture Research (SAR)** |
| **www.acupunctureresearch.org** |
| 5415 W. Cedar Lane, Suite 204 B  
Bethesda, MD 20814  
(301) 571-0624 |

| **The American Academy of Veterinary Medical Acupuncture (AAVMA)** |
| **http://www.aavma.com** |
| Department of Clinical Sciences  
Colorado State University Veterinary Teaching Hospital  
300 West Drake Road  
Fort Collins, CO 80523  
(970) 221-4535 (phone)  
(970) 491-1275 (fax) |

| **The American Alternative Medical Association (AAMA)** |
| **http://www.joinaama.com/** |
| 708 Madelaine Drive  
Gilmer, TX 75644-3140  
(903) 843-6401 (phone)  
(888) 764-2237 |

| **The American Association of Drugless Practitioners Certification and Accreditation Board** |
| **http://www.aadp.net/** |
| 708 Madelaine Drive  
Gilmer, TX 75644-3140  
(903) 843-6401 (phone) |
PART IV:

THE REPORT APPENDICES
Appendix A: Performance Factors in Centers and Clinics:
- Key milestones and major successes
- Missteps, failures, and lessons learned
- Valued by clients/patients
- Impact on the partner or parent institution

KEY MILESTONES and MAJOR SUCCESSES

<table>
<thead>
<tr>
<th>FOCUS AREA:</th>
<th>Hospital Based Center</th>
<th>Academic Based Center</th>
<th>Free-Standing Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>Success</td>
<td>Fiscal</td>
<td>Academic Based Center</td>
<td>Fiscal</td>
</tr>
<tr>
<td></td>
<td>Got start up funding; in 2 cases this was at least a $1M start up gift</td>
<td>Winning some big grants, especially federal research money</td>
<td>Willingness of patients to pay directly for services</td>
</tr>
<tr>
<td></td>
<td>In 3 years: services, programs, café, herbal pharmacy in place to generate revenue</td>
<td>Created internal endowment that funds pilot studies, pre-research, and small projects</td>
<td>Return clients; average 2.2 visits per client per month</td>
</tr>
<tr>
<td></td>
<td>Created a retail business to help fund operations (holistic health products)</td>
<td>Having multiple streams of income, including earned revenue</td>
<td>Got control of expenses after generous start up capital phase; stopped financial hemorrhaging</td>
</tr>
<tr>
<td></td>
<td>Gratitude from patients ($3.6M gift from one patient)</td>
<td>On track to break even between 3 and 5 years</td>
<td>Added a pharmacy within 3 months for additional revenue</td>
</tr>
<tr>
<td>Space/Infrastructure</td>
<td>Adequate and identifiable space</td>
<td>Successful transfer of leadership from founder</td>
<td>Space/Infrastructure</td>
</tr>
<tr>
<td></td>
<td>Successful working with parent bureaucracy</td>
<td>Hired a Director of Research</td>
<td>Identifiable space</td>
</tr>
<tr>
<td></td>
<td>Having a great physical facility</td>
<td>Created a model credentialing process that can be used/adapted by others</td>
<td>Set up electronic medical records</td>
</tr>
<tr>
<td></td>
<td>Partner school donated a building</td>
<td>Built positive relationships with the surrounding bureaucracy</td>
<td>Personnel</td>
</tr>
<tr>
<td></td>
<td>Having a building designed for mind-body interaction</td>
<td>Helped pass statewide legislation to include naturopaths and acupuncturists in health insurance coverage</td>
<td>Recruited a “right mix” of practitioners; spent considerable time on designing jobs and search process</td>
</tr>
<tr>
<td></td>
<td>Staff of 35</td>
<td>Created the Consortium of Academic Centers is key to our success</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>Education programs established with University partner</td>
<td>Evolution from Project to Program</td>
<td></td>
</tr>
<tr>
<td>Research</td>
<td>Comprehensive program with ongoing research</td>
<td>Education and curriculum initiative in place</td>
<td>Education</td>
</tr>
<tr>
<td>Identity</td>
<td>Signature program (e.g., Healing Heart)</td>
<td>Education</td>
<td>Keeping a high profile in the community and industry; public education and information is a major part of the budget</td>
</tr>
<tr>
<td></td>
<td>Patient success and satisfaction</td>
<td>curriculum initiative in place</td>
<td>Sponsored a national conference</td>
</tr>
<tr>
<td>Research</td>
<td>Doing evidence-based research on CAM</td>
<td>Research</td>
<td>Research</td>
</tr>
<tr>
<td></td>
<td>Clinical trial research that demonstrated the value of integration of therapies not just the value of one medication or treatment</td>
<td>Evidence: Deep data on outcomes and satisfaction on every patient over the last 4 years</td>
<td></td>
</tr>
<tr>
<td>Identity</td>
<td>Signature program services (e.g., cancer, stress reduction)</td>
<td>Identity</td>
<td>Identity</td>
</tr>
<tr>
<td></td>
<td>Hosted a national conference to advance women’s health care; gain visibility and credibility</td>
<td>Meeting the needs of patients that conventional care can’t help, i.e., chronic pain and illness; aging</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Media see us as a resource...not as the “fringe”</td>
<td>High satisfaction from patients</td>
<td></td>
</tr>
</tbody>
</table>

Page 133
### MISSTEPS, FAILURES and LESSONS LEARNED

<table>
<thead>
<tr>
<th>FOCUS AREA: Failures/Lessons Learned</th>
<th>Hospital-Based Center</th>
<th>Academic-Based Center</th>
<th>Free-Standing Center</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fiscal</strong></td>
<td><strong>Fiscal</strong></td>
<td><strong>Fiscal</strong></td>
<td><strong>Fiscal</strong></td>
</tr>
<tr>
<td>- Diversify funding: philanthropic funding comes faster than government and is essential but NIH funding brings credibility.</td>
<td>- Financial constraints; insufficient start up capital.</td>
<td>- Trying to do too much too fast on too few resources; it was a mistake to try to launch research, education, and clinical services all at once.</td>
<td>- Recruit people with a practice to decrease the lag time to profitability.</td>
</tr>
<tr>
<td>- At some point innovation will have to survive financial crisis; be prepared.</td>
<td>- Not proactive enough on fundraising resulting in capital starvation; we needed at least $200,000 on hand in unrestricted operating fund.</td>
<td></td>
<td>- Lack of business leadership on staff and on the board.</td>
</tr>
<tr>
<td>- Tie all activities to sustainability and revenue planning.</td>
<td>- Trying to do too much too fast on too few resources; it was a mistake to try to launch research, education, and clinical services all at once.</td>
<td></td>
<td>- Board did not understand its role as a &quot;working board.&quot;</td>
</tr>
<tr>
<td><strong>Space/Infrastructure</strong></td>
<td><strong>Personnel</strong></td>
<td><strong>Education</strong></td>
<td><strong>Identity</strong></td>
</tr>
<tr>
<td>- The legal groundwork is key to a successful launch.</td>
<td>- Failed to keep upper administration thoroughly informed; failure to pay proper credit to the Chair.</td>
<td>- Learned to use a community development model that emphasizes listening to stakeholders.</td>
<td>- Fear of scrutiny from academic centers and government held us back; we had to learn to trust our own judgment.</td>
</tr>
<tr>
<td>- The closer the link between the hospital and/or clinic to the medical school, the tougher it is to be innovative (more constraints and barriers).</td>
<td>- Missed opportunities for effective communications—some members of the institution perceived that IM was &quot;in place of&quot; their therapy instead of &quot;alongside.&quot;</td>
<td>- Too closely aligned with conventional medicine to be creative.</td>
<td>- Failure to communicate to the public quickly or well enough.</td>
</tr>
<tr>
<td>- Don’t underestimate the difficulty of establishing an innovative structure inside a conventional health care system. None of the existing systems are an exact fit and the adaptation process is demanding.</td>
<td>- Centers need IM physicians who are well-trained in general medicine and well-rounded CAM practitioners with a high level of credibility/credentials in their own areas.</td>
<td>- Marketing is tricky; establish trust first; spent a lot and it didn't work.</td>
<td>- Fear of scrutiny from academic centers and government held us back; we had to learn to trust our own judgment.</td>
</tr>
<tr>
<td><strong>Identity</strong></td>
<td><strong>Research</strong></td>
<td><strong>Identity</strong></td>
<td></td>
</tr>
<tr>
<td>- Use a consumer-friendly vocabulary instead of &quot;IM, CAM, Alternative Medicine, Mind-Body, etc.&quot;</td>
<td>- We are &quot;short&quot; on randomly controlled trial data; makes it difficult to create public messages.</td>
<td>- Failure to communicate to the public quickly or well enough.</td>
<td>- Fear of scrutiny from academic centers and government held us back; we had to learn to trust our own judgment.</td>
</tr>
<tr>
<td></td>
<td><strong>Identity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- IM physicians need to keep visibility and credibility among conventional peers to prevent perceptions of quackery.</td>
<td></td>
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</tr>
</tbody>
</table>
**VALUED BY CLIENTS/PATIENTS**

<table>
<thead>
<tr>
<th>FOCUS AREA: Most Valued by Clients/Patients</th>
<th>Hospital-Based Center</th>
<th>Academic-Based Center</th>
<th>Free-Standing Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>Space/Infrastructure</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>• Comprehensive services all in one facility—both alternative and primary care.</td>
<td></td>
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</tr>
<tr>
<td>• The space is a healing sanctuary.</td>
<td></td>
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<tr>
<td>Personnel</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Relationship-based care.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Availability of healing touch provider as part of routine services.</td>
<td></td>
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</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Intensive education efforts to engage patients in self-care (one clinic offers as many as 36 education classes each trimester).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Time and attention is more generous than in conventional clinics.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Treat the whole person—their family and lifestyle.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Personnel</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Practitioner-patient partnership.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Feeling well-cared for; a culture of attentiveness to the person. Feeling that practitioners and all staff are truly present; that we all believe and practice principles of mind-body-spirit.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Physicians’ and practitioners’ open-mindedness about both alternative and conventional therapies.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Intensive educational services.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The research and documentation we have done to study alternative therapies in a scientifically rigorous way. We have published 150 articles; this builds credibility and trust.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• They come to us as a last resort and they usually find some relief through nutrition, acupuncture, health counseling, and naturopathic services.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Use of fewer medications and emphasis on self-healing.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Space/Infrastructure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The compounding pharmacy.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Interesting array of services—beyond the minimal access to acupuncture and massage.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Comprehensive health testing and evaluation—using functional as well as conventional testing.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personnel</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Open access to providers on e-mail.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• High quality of practitioners, e.g., acupuncture by a certified and particularly gifted healer.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Learning and transformation about self-care and care options.</td>
<td></td>
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<td>Identity</td>
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<tr>
<td>• Generous amount of time spent at intake and regular visits.</td>
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</table>
### IMPACT ON THE PARTNER OR PARENT INSTITUTION

<table>
<thead>
<tr>
<th>FOCUS AREA: Impact on the Partner or Parent Institution</th>
<th>Hospital-Based Center</th>
<th>Academic-Based Center</th>
<th>Free-Standing Center</th>
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<tbody>
<tr>
<td><strong>Space/Infrastructure</strong></td>
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<tr>
<td>- Everyone in the institution is now talking about “healing environments.”</td>
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<tr>
<td><strong>Personnel</strong></td>
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<tr>
<td>- Our work has made it okay for medical personnel to bring emotion and spirit into their role.</td>
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<tr>
<td>- The IM center staffing model is being singled out as a model for other teams/ departments.</td>
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<tr>
<td>- Not enough crossover with physicians in the rest of the hospital; CAM therapists aren’t used widely enough.</td>
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<tr>
<td><strong>Research</strong></td>
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<tr>
<td>- Some studies supporting efficacy and science behind IM have quieted critics.</td>
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<td><strong>Identity</strong></td>
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<tr>
<td>- IM center is not fully accepted as an &quot;equal&quot; but it is no longer seen as &quot;quackery.&quot;</td>
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<tr>
<td><strong>Fiscal</strong></td>
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<tr>
<td>- University’s financial constraints have closed down time and opportunities for learning across disciplines and departments.</td>
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<tr>
<td><strong>Personnel</strong></td>
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<tr>
<td>- We are turning key skeptics into supporters (e.g., Chair of the Dept. of Medicine) but we haven’t yet changed the culture.</td>
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<tr>
<td><strong>Research</strong></td>
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<tr>
<td>- Research and success in winning research grants has won us credibility and some recognition.</td>
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<td><strong>Identity</strong></td>
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<tr>
<td>- IM center has great PR and visibility; this has made the top University leadership more supportive, yet it has eroded many peer relationships.</td>
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<td><strong>Identity</strong></td>
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<tr>
<td>- Local hospitals and providers are more understanding and less hostile; they are beginning to realize that we and our ideas are here to stay.</td>
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</table>
## Appendix B: Summary of “The Benchmarks” Study of Clinics

### Integrative Clinics Benchmarking Project 1998-2001: Summary of Information

<table>
<thead>
<tr>
<th>GENERAL CHARACTERISTICS</th>
<th></th>
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<tbody>
<tr>
<td>Planning prior to the clinic’s opening:</td>
<td>Varied ranging from 5 month to 7 years, with the majority spending between 6-12 months from initial planning to opening.</td>
</tr>
<tr>
<td>Year opened:</td>
<td>The oldest was opened in 1991, with the majority clustered in 1997 and 1998.</td>
</tr>
<tr>
<td>Part of a larger health care system:</td>
<td>20 were part of a larger system, 9 were not.</td>
</tr>
<tr>
<td>Square footage of initial clinics:</td>
<td>850-26,000 ft$^2$.</td>
</tr>
<tr>
<td>Funded via private capital:</td>
<td>Approximately 28% were funded by private dollars, with 10% funded by philanthropy.</td>
</tr>
<tr>
<td>Funded via a health care system:</td>
<td>Approximately 55% were funded via a health care system.</td>
</tr>
<tr>
<td>Legal status of clinic:</td>
<td>Approximately 55% were 501(c) 3s, with the remainder filing as corporations or partnerships of some form.</td>
</tr>
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</table>

### CLINICAL SERVICES

| CAM Modalities offered: | Wide range from acupuncture to yoga. |
| Conventional medicine offered? | 65% offered conventional medicine. |
| General informational programs? | 97% offered programs. |
| Exercise programs offered? | 52% offered programs. |
| Providers routinely see patients as a team? | 66% saw patients as a team. |
| Regular case review process? | 79% had such a process with 17% developing one. |
| Formal list of community CAM providers to whom you refer? | 48% had a formal list, with 21% using an informal one. |

### NATURAL PRODUCTS DISPENSARY

| Natural products dispensary on site? | 72% have a dispensary on-site. |
| Distinct products carried: | 15-5000, with the average being 200-400. |
| Sell books/self-care materials? | 76% have such materials. |

### LABORATORY SERVICES

| Laboratory services on-site? | 62% had labs in the clinic or in the parent institution. |
| Relationship with labs serving CAM providers: | 59% reported yes. |
| Frequently conduct tests not routinely used in conventional medicine? | 59% reported yes. |

### CLINICAL AND ADMIN STAFF

<p>| Staffing numbers: | 1.5-41.0, with a mix of employees and contractors, full and part-time. |
| Medical Director: | 86% reported yes. |
| Non-clinical FTEs: | 0.7-15 FTEs, with most sites in the 2-3 range. |</p>
<table>
<thead>
<tr>
<th><strong>CLINICAL AND ADMIN STAFF</strong></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Staff from parent organization routinely part of operations?</td>
<td>34% reported yes.</td>
</tr>
<tr>
<td>Computerized records?</td>
<td>41% reported yes.</td>
</tr>
<tr>
<td>Records shared between providers?</td>
<td>83% reported yes.</td>
</tr>
<tr>
<td>Links to area insurers or health systems?</td>
<td>52% reported yes.</td>
</tr>
<tr>
<td>Use a billing service?</td>
<td>72% reported yes.</td>
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<thead>
<tr>
<th><strong>RESEARCH/OUTCOMES</strong></th>
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<tbody>
<tr>
<td>Do you research/outcomes?</td>
<td>83% reported yes.</td>
</tr>
<tr>
<td>Standardized intake that can be used for outcomes?</td>
<td>90% reported yes.</td>
</tr>
<tr>
<td>Research affiliations?</td>
<td>59% reported yes, 21% developing affiliations.</td>
</tr>
<tr>
<td>Survey client satisfaction?</td>
<td>86% reported yes.</td>
</tr>
<tr>
<td>Routinely evaluate health status/quality of life?</td>
<td>93% reported yes.</td>
</tr>
<tr>
<td>Evaluating whether CAM is an add-on or a replacement?</td>
<td>45% reported yes.</td>
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<table>
<thead>
<tr>
<th><strong>MARKETING</strong></th>
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<tbody>
<tr>
<td>% of Referrals: Self/friend/family</td>
<td>Reported ranges from 0-100%, with the majority reporting 70% or more.</td>
</tr>
<tr>
<td>Conventional Medicine MD/DO:</td>
<td>Reported ranges from 2-100%, with the vast majority reporting less than 20%.</td>
</tr>
<tr>
<td>Other CAM providers</td>
<td>5-10% reported by most.</td>
</tr>
<tr>
<td>% of marketing that is paid media?</td>
<td>0-90% was the reported range, with 55% reporting %s of 30 or below.</td>
</tr>
<tr>
<td>Directly contacting with insurers/HMOs/employers?</td>
<td>48% reported yes.</td>
</tr>
<tr>
<td>Most successful marketing focus:</td>
<td>Word of mouth, presentations.</td>
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<thead>
<tr>
<th><strong>REVENUES AND EXPENSES</strong></th>
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<tbody>
<tr>
<td>Expect clinic to be a significant revenue source (SRS) or break even (BE)?</td>
<td>59% reported BE, with 18% of those becoming RS over time—but not necessarily a significant revenue source. 41% reported RS.</td>
</tr>
<tr>
<td>Projected # months from opening to BE?</td>
<td>Reported projected range was 6-60 months, with the majority in the 12-24 month range.</td>
</tr>
<tr>
<td>If BE, how long did it take?</td>
<td>7 sites reported breaking even, with a range of &quot;immediately&quot; to 12 months.</td>
</tr>
<tr>
<td>Approximate $ spent prior to opening:</td>
<td>Reported ranges were $1000 to $1M, with the majority reporting over the $100K mark.</td>
</tr>
<tr>
<td>Average opening expense per month:</td>
<td>Reported ranges were $2K-$100K, with the majority reporting in at the $25K range.</td>
</tr>
<tr>
<td>% revenue from conventional medicine:</td>
<td>Reported ranges from 0-60%, with almost 50% reporting 10% or less.</td>
</tr>
<tr>
<td>% revenue self-pay?</td>
<td>Reported ranges from 15-100%, with the majority reporting more than 50%.</td>
</tr>
<tr>
<td>% revenue traditional indemnity?</td>
<td>Reported ranges from 0-70%, with almost 50% reporting 20% or less.</td>
</tr>
</tbody>
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Appendix C

Supporting Reports

1. The Chantilly Report
   Alternative Medicine: Expanding Medical Horizons
   A Report to the National Institutes of Health on Alternative
   Medical Systems and Practices in the United States

2. White House Commission on Complementary and Alternative
   Medicine Policy

3. National Policy Dialogue to Advance Integrated Health Care:
   Finding Common Ground

4. National Center for Complementary and Alternative Medicine:
   Five Year Strategic Plan 2001-2005
   Expanding Horizons of Healthcare

5. Trends in Alternative Medicine Use in the United States, 1990-
   1997: Results of a Follow-up National Survey
   David M. Eisenberg
Appendix D: The following is taken directly from the White House Commission on Complementary and Alternative Medicine Policy-March 2002, Chapter 10 “Recommendations and Action” in its entirety.

COORDINATION OF RESEARCH

Recommendation 1: Federal agencies should receive increased funding for clinical, basic, and health services research on CAM.

Actions

1.1 Federal agencies should increase their activities with respect to CAM in accordance with their biomedical research, health services research, or other health care-related responsibilities and make these activities, including available technical assistance, known to CAM and conventional researchers and practitioners. Activities might include funding initiatives such as requests for applications and proposals; CAM-focused offices or centers; CAM-focused staff positions; CAM advisory committees or the representation of qualified CAM professionals on such committees.

1.2 Federal agencies should assess the scope of scientific, practice, and public interest and needs regarding CAM that are relative to their missions, examine their portfolios, and develop funding distribution strategies to address these interests and needs.

1.3 The Agency for Health Care Research and Quality together with The National Center for Complementary and Alternative Medicine should develop ways to expand health services research in CAM and explore methodologies for health services research in this area.

1.4 The Federal, private, and nonprofit sectors should support more research on (1) complex compounds frequently found in CAM products, (2) clinical interventions consisting of multiple treatments, (3) how patient practitioner interactions affect treatment outcomes, and (4) individualizing treatments.

1.5 In order to protect public health and maximize benefits, Congress should provide adequate public funding for research on frequently used or promising CAM products that would be unlikely to receive private research support.

1.6 The Federal government should support research on CAM practices that appear to be effective but may not be profitable to private investors, such as biofeedback, meditation, guided imagery, art therapy, and music therapy.

Recommendation 2: Congress and the Administration should consider enacting legislative and administrative incentives to stimulate private sector investment in CAM research on products that may not be patentable.

Actions

2.1 Incentives to stimulate private sector investment in CAM research should focus on (1) research on dietary supplements and other natural products that may not be patentable; (2) research on other CAM products that may not be patentable, including therapeutic devices; and (3) the development of analytical methods for producing better quality CAM products.
2.2 The Federal and private sectors should provide support for workshops to discuss the research needed by regulatory agencies for their review and approval processes for CAM products and devices.

2.3 Federal agencies should develop outreach programs to inform manufacturers of CAM products and devices about the Federal research support available to private industry and how the agency can assist them.

Recommendation 3: Federal, private, and nonprofit sectors should support research on CAM modalities and approaches that are designed to improve self-care and behaviors that promote wellness.

Recommendation 4: Federal, private, and nonprofit sectors should support new and innovative CAM research on core questions posed by frontier areas of scientific study associated with CAM that might expand our understanding of health and disease.

Actions

4.1 The National Center for Complementary and Alternative Medicine, assisted by the Institute of Medicine of the National Academy of Sciences, should develop guidelines for establishing research priorities in CAM.

4.2 The National Science Foundation, in collaboration with The National Center for Complementary and Alternative Medicine, should examine frontier areas of science associated with CAM that are outside the current research paradigm and methodological approaches to study them.

4.3 Multidisciplinary workshops and expert panels should be convened by Federal, private and nonprofit organizations, collaboratively or independently, to explore the challenges in design and methodology presented by research questions in CAM areas that are outside the current research paradigm.

4.4 The National Institute of General Medical Sciences of the NIH, the Department of Energy, and the Department of Defense are among the Federal organizations that should consider contributing collaboratively or independently to the support of research on core questions in areas described in many CAM systems.

4.5 The National Center for Complementary and Alternative Medicine, working with the World Health Organization, should examine investigative approaches for studying the traditional systems of medical practice from a variety of cultures.

Recommendation 5: Investigators engaged in research on CAM should ensure that human subjects participating in clinical studies receive the same protections as are required in conventional medical research and to which they are entitled.

Actions

5.1 Licensed practitioners using CAM systems and modalities who wish to conduct or collaborate in clinical research should follow the same requirements as in conventional medical research. They should develop, or partner with a research institution to develop, a scientifically valid research protocol and obtain Institutional Review Board approval to ensure that they meet accepted standards of ethical conduct and their responsibilities to protect human subjects.
5.2 Accredited CAM institutions and CAM professional organizations should establish Institutional Review Boards where possible, and guide their colleagues and members to utilize the Institutional Review Board process, which is required to conduct clinical research.

5.3 Institutional Review Boards that review CAM research studies should include the expertise of qualified CAM professionals in the review.

5.4 Research institutions, National Institutes of Health Institutes and Centers, and other Federal research and health care agencies should be more proactive in developing programs that (1) provide opportunities for expert review of promising CAM practice-based observational data by experienced researchers, (2) stimulate practitioner response to the opportunities offered by the programs and (3) facilitate communication and stimulate partnerships between CAM practitioners and conventionally-trained researchers in designing and implementing clinical studies.

Recommendation 6: The Commission recommends that state professional regulatory bodies include language in their guidelines stating that licensed, certified, or otherwise authorized practitioners who are engaged in research on CAM will not be sanctioned solely because they are engaged in such research if they:

1.) are engaged in well-designed research that is approved by an appropriately constituted Institutional Review Boards,

2.) are following the requirements for the protection of human subjects, and

3.) are meeting their professional and ethical responsibilities. All CAM and conventional practitioners, whether or not they are engaged in research, must meet whatever State practice requirements or standards govern their authorization to practice.

Recommendation 7: Increased efforts should be made to strengthen the emerging dialogue among CAM and conventional medical practitioners, researchers and accredited research institutions; Federal and state research, health care, and regulatory agencies; the private and nonprofit sectors; and the general public.

Actions

7.1 CAM and conventional medical researchers and practitioners should adhere to the same high standards of quality and ethics in all aspects of research and related activities.

7.2 Federal agencies should develop programs to stimulate cooperation and partnerships between CAM and conventional medical professionals and accredited institutions.

7.3 Committees reviewing or advising on research, journal submissions, regulatory compliance, and health insurance coverage in both the public and private sectors should include as members or consultants trained, experienced, and properly qualified CAM health care professionals.

7.4 Multidisciplinary conferences, workshops, and expert panels on CAM research and related activities, including research methodology, should be supported independently or collaboratively by the public, private, and nonprofit sectors.
7.5 The nonprofit sector and the private sector should create funding partnerships, whether independently or with Federal agencies, to augment support for CAM research, research infrastructure and training, research conferences, and information dissemination.

7.6 The Federal government should support research, including population-based research, to learn more about why people use CAM practices and products, how they determine the safety and effectiveness of the practices and products they use, and what they find satisfying or unsatisfying about them.

7.7 To benefit patients and future research protocol development and to add to our knowledge about the use of CAM, Institutional Review Boards should consider requiring that all research subjects be asked about their use of herbal or other dietary supplements.

7.8 Federal agencies supporting biomedical and health services research should develop orientation and training programs for public representatives to enhance the effectiveness of their participation on advisory committees concerned with CAM.

Recommendation 8: Public and private resources should be increased to strengthen the infrastructure for CAM research and research training at conventional medical and CAM institutions and to expand the cadre of basic, clinical, and health services researchers who are knowledgeable about CAM and have received rigorous research training.

Actions

8.1 Funding should be made available to accredited CAM and conventional medical institutions develop programs that examine CAM research questions and that stimulate cross-institutional collaborations involving faculty and students in research and research training.

8.2 Funding should be made available to accredited CAM and conventional medical institutions support joint research and professional education and training programs to enhance the quality and clinical relevance of CAM research and link the research with evidence-based education and training of practitioners.

8.3 Federal health agencies with research training programs and responsibilities that encompass CAM-related questions should be given adequate support to increase research training in CAM.

8.4 Existing resources, such as The National Center for Complementary and Alternative Medicine-supported centers and the National Center for Research Resources’ General Clinical Research Centers should be utilized to increase opportunities to conduct clinical research and training on CAM and examine the inclusion of CAM into the clinical setting.

8.5 Federal support should be increased for career development awards, including those that enable investigators focusing on CAM to develop into independent investigators and faculty members, and mid-career awards that provide the time required to mentor new CAM investigators.

Recommendation 9: Public and private resources should be used to support, conduct, and update systematic reviews of the peer-reviewed research literature on the safety, efficacy, and cost-benefit of CAM practices and products.
Actions

9.1 The Agency for Health Care Research and Quality should expand its Evidence-based Practice Center systematic reviews on CAM systems and treatments for use by private and public entities in developing tools, such as practice guidelines, performance measures, and review criteria, and for identifying future research needs.

9.2 The National Center for Complementary and Alternative Medicine should issue a comprehensive, understandable, and regularly updated summary of current clinical evidence on the safety and efficacy of CAM systems and treatments for health care practitioners and the public.

EDUCATION AND TRAINING OF HEALTH CARE PRACTITIONERS

Recommendation 10: The education and training of CAM and conventional practitioners should be designed to ensure public safety, improve health, and increase the availability of qualified and knowledgeable CAM and conventional practitioners and enhance the collaboration among them.

Actions

10.1 Conventional health professional schools, postgraduate training programs, and continuing education programs should develop core curricula of knowledge about CAM to prepare conventional health professionals to discuss CAM with their patients and clients and help them make informed choices about the use of CAM.

10.2 CAM education and training programs should develop curricula that reflect the fundamental elements of biomedical science and conventional healthcare relevant to and consistent with the practitioners’ scope of practice. CAM and conventional education and training programs should develop curricula and other methods to facilitate communication and foster collaboration between CAM and conventional students, practitioners, researchers, educators, institutions and organizations.

10.3 CAM and conventional education and training programs should develop curricula and other methods to facilitate communication and foster collaboration between CAM and conventional students, practitioners, researchers, educators, institutions and organizations.

10.4 Increased Federal, state, and private sector support should be made available to expand and evaluate CAM faculty, curricula, and program development at accredited CAM and conventional institutions.

10.5 Expansion of eligibility of CAM students at accredited institutions for existing of loan programs should be explored.

10.6 The Department of Health and Human Services should conduct a feasibility study to determine whether appropriately educated and trained CAM practitioners enhance and/or expand health care provided by primary care teams.* This feasibility study could lead to demonstration projects to identify: 1) the type of practitioners, 2) their necessary education and training, 3) the appropriate practice settings, and 4) the health outcomes attributable to the addition of these practitioners and services to comprehensive care.

10.7 The Department of Health and Human Services and other Federal Departments and Agencies should convene conferences of the leaders of CAM, conventional health, public health, evolving health professions, and the public; of educational institutions; and of appropriate organizations to facilitate establishment of CAM education and training guidelines. Subsequently, the guidelines should be made available to the states and professions for their consideration.
10.8 Feasibility studies of postgraduate training for appropriately educated and trained CAM practitioners should be conducted to determine the type of practitioners, practice setting, and their impact on clinical competency, quality of health care, and collaboration with conventional providers.

10.9 Practitioners who provide CAM services and products should complete appropriate CAM continuing education programs that include critical evaluation of CAM to enhance and protect the public’s health and safety.

CAM Information Development and Dissemination

Recommendation 11: The Federal government should make available accurate, useful, and easily accessible information on CAM practices and products, including information on safety and effectiveness,

Actions

11.1 The Secretary of Health and Human Services should establish a task force to facilitate the development and dissemination of CAM information within the Federal government and to eliminate existing gaps in CAM information. The task force should include consumers, CAM providers, scientists, and conventional health care practitioners. Resources should subsequently be provided to close identified gaps and improve the availability, coordination, and dissemination of information.

11.2 Federal Departments and agencies with missions or activities relevant to CAM should 1) develop informational materials about CAM that are easy to understand and use, and 2) support and collaborate with national and local community leaders and CAM leaders and organizations to identify strategies for enhancing the development, availability, and accessibility of information on the safety and effectiveness of CAM practices and products.

11.3 Increased funding should be provided to the National Library of Medicine and the American Library Association to expand training of librarians to include helping consumers find information on CAM.

11.4 The Secretary of Health and Human Services should direct resources to streamline the process of identifying and making available relevant, high-quality CAM information from other countries and in other languages.

Recommendation 12: The quality and accuracy of CAM information on the Internet should be improved by establishing a voluntary standards board, a public education campaign, and actions to protect consumers’ privacy.

Actions

12.1 The Secretary of Health and Human Services should form a public-private partnership to review new and existing websites and to develop voluntary standards promoting accuracy, fairness, comprehensiveness, and timeliness of information on CAM web sites, as well as the disclosure of sources of support and possible conflicts of interest. Sites reviewed and found in compliance with the standards could publicize the fact and display a logo denoting their merit.
12.2 Funding should be provided to the Department of Health and Human Services and the Department of Education to conduct a joint public education campaign that teaches consumers how to evaluate health care information, including CAM information, on the Internet and elsewhere.

12.3 Congress should protect consumers’ privacy by requiring all health information sites, including CAM sites, to disclose whether they track users and if so, how that information is used and stored, including whether it is sold to third parties.

Recommendation 13: Information on the training and education of providers of CAM services should be made easily available to the public.

Actions

13.1 The Commission recommends that states require all persons providing CAM services to disclose information regarding their level and scope of training and to make it easily available to consumers.

13.2 The Commission recommends that states disclose information on State guidelines, requirements, licensure, certification, and disciplinary actions of health providers, including CAM providers, and make it easily accessible to the public.

Recommendation 14: CAM products that are available to U.S. consumers should be safe and meet appropriate standards of quality and consistency.

Actions

14.1 The efforts of both the public and private sectors to ensure the development, validation, and dissemination of analytical methods and reference materials for dietary supplements should be accelerated.

14.2 The proposed Good Manufacturing Practices for Dietary Supplements should be published expeditiously, followed by a timely review of comments and completion of a final rule. The Food and Drug Administration should be provided with adequate resources to complete this task.

14.3 Adequate funding should be provided to appropriate Federal agencies, including U.S. Customs and Food and Drug Administration inspection authorities, to enforce current laws monitoring the quality of imported raw materials and finished products intended for use as dietary supplements.

14.4 Manufacturers should have on file and make available to the FDA upon request scientific information to substantiate their determinations of safety, and current statutory provisions should be periodically reexamined to determine whether safety requirements for dietary supplements are adequate.

14.5 An objective process for evaluating the safety of dietary supplement products should be developed by an independent expert panel.

Recommendation 15: Provisions of the Federal Food, Drug, and Cosmetic Act, as modified by the Dietary Supplement Health and Education Act of 1994, should be fully implemented, funded, enforced, and evaluated.

Actions
15.1 The Food and Drug Administration and other agencies with regulatory responsibilities should be provided with additional resources to 1) enforce the Dietary Supplement Health and Education Act’s regulations regarding labeling of dietary supplements, 2) enforce current provisions requiring that dietary supplements be labeled in English, even if the same information is also included in another language, and 3) employ additional professionals with expertise in dietary supplements.

15.2 Current provisions requiring disclosure of material facts by manufacturers of CAM products should be enforced, and manufacturers should meet their responsibility to disclose material facts on the label, package, and/or package insert, so that the public will have information about known risks and well-documented significant interactions. Information on potential benefits of dietary supplements should also be made easily available at the time of purchase.

15.3 Congress should periodically evaluate the effectiveness, limitations, and enforcement of the Dietary Supplement Health and Education Act of 1994, including its impact on public health, and take appropriate action to ensure the public’s safety.

Recommendation 16: Activities to ensure that advertising of dietary supplements and other CAM practices and products is truthful and not misleading should be increased.

Actions

16.1 Congress should provide additional support to the Federal Trade Commission to 1) expand efforts to identify false and deceptive advertising of CAM-related health services and products and take appropriate enforcement action when necessary, 2) use appropriate CAM experts in the process of examination of CAM-related advertising, 3) increase activities to help consumers distinguish useful and reliable information from deceptive and unsubstantiated advertising in all forms of marketing and advertising, including at the point of purchase; and 4) seek additional public comment on the benefits and potential problems in the advertising of CAM-related services and products.

Recommendation 17: The collection and dissemination of information about adverse events stemming from the use of dietary supplements should be improved.

Actions

17.1 Congress should require dietary supplement manufacturers and suppliers to register with the Food and Drug Administration, and the agency should encourage voluntary registration until such a requirement is in effect, so that manufacturers, suppliers, and consumers can be promptly notified if a serious adverse event is identified.

17.2 Recent congressional support for improving the Food and Drug Administration’s adverse events reporting system should be enhanced by requiring dietary supplement manufacturers and suppliers to maintain records and report serious adverse events to the agency.

17.3 Additional resources and support should be provided to 1) the Food and Drug Administration to simplify the adverse events reporting system for dietary supplements, and to streamline the database for timely review and follow-up on received reports; and 2) the Food and Drug Administration, the Centers for Disease Control and Prevention, and other appropriate Federal agencies to increase outreach activities to consumers,
health professionals (including poison control centers, emergency room physicians, CAM practitioners, and mid-level marketers) in order to improve both manufacturers’ and the public’s awareness of and participation in voluntary event reporting.

Access and Delivery

Recommendation 18: The Department of Health and Human Services should evaluate current barriers to consumer access to safe and effective CAM practices and to qualified practitioners and should develop strategies for removing those barriers in order to increase access and to ensure accountability.

Actions

18.1 The Department of Health and Human Services should assist the States in evaluating the impact of legislation enacted by various States on access to CAM practices and on public safety.

18.2 The Department of Health and Human Services and other appropriate Federal agencies should use health care workforce data, data from national surveys on use of CAM, regional public health reports on CAM activities and other studies to identify current and future health care needs and the relevance of safe and effective CAM services for helping address these needs.

Recommendation 19: The Federal Government should offer assistance to states and professional organizations in 1) developing and evaluating guidelines for practitioner accountability and competence in CAM delivery, including regulation of practice, and 2) periodic review and assessment of the effects of regulations on consumer protection.

Actions

19.1 The Secretary of Health and Human Services should create a policy advisory committee, including CAM and conventional practitioners and representatives of the public, to address issues related to providing access to qualified CAM practitioners, provide guidance to the states concerning regulation possibilities, and provide a forum for dialogue on other issues related to maximizing access.

19.2 The Secretary of Health and Human Services, in collaboration with states, should assist CAM organizations that wish to develop consensus within their field of practice regarding standards of practice, including education and training. The conclusions reached by CAM professional groups concerning these matters should be considered by states and regulatory bodies in determining the appropriate status of these practitioners for such regulatory options as registration, licensure or exemption.

Recommendation 20: States should evaluate and review their regulation of CAM practitioners and ensure their accountability to the public. States should, as appropriate, implement provisions for licensure, registration, and exemption consistent with the practitioners’ education, training, and scope of practice.

Action

20.1 The Department of Health and Human Services’ policy advisory committee, in partnership with state legislatures, regulatory boards, and CAM practitioners, should develop model guidelines or other guidance for the regulation and oversight of licensed
and registered practitioners who use CAM services and products. This guidance should balance concerns regarding protection of the public from the inappropriate practice of health care, provide opportunities for appropriately trained and qualified health practitioners to offer the full range of services in which they are trained and competent, maintain competition in the provision of CAM and other health services, preserve CAM styles and traditions that have been valued by both practitioners and consumers, and determine the extent of the public’s choice among health care modalities.

Recommendation 21: Nationally recognized accrediting bodies should evaluate how health care organizations under their oversight are using CAM practices and should develop strategies for the safe and appropriate use of qualified CAM practitioners and safe and effective products in these organizations.

Actions

21.1 National accrediting bodies, in partnership with other public and private organizations, should evaluate present uses of CAM practitioners in health care delivery settings and develop strategies for their appropriate use in ways that will benefit the public.

21.2 Nationally recognized accrediting bodies of health care organizations and facilities should consider increasing on-going access to CAM expertise to ensure that processes to develop accreditation standards and interpretations reflect emerging developments in the health care field.

21.3 Nationally recognized accrediting bodies, using CAM experts, should review and evaluate current standards and guidelines to ensure the safe use of CAM practices and products in health care delivery organizations.

Recommendation 22: The Federal government should facilitate and support the evaluation and implementation of safe and effective CAM practices to help meet the health care needs of special and vulnerable populations.

Actions

22.1 The Department of Health and Human Services and other Federal Departments should identify models of health care delivery that include safe and effective CAM practices, evaluate them, and then support those models which are successful for use with special and vulnerable populations, including the chronically and terminally ill.

22.2 The Department of Health and Human Services should sponsor the development and evaluation of demonstration projects that integrate the use of safe and effective CAM services as part of the health care programs in hospices and community health centers.

22.3 The Department of Health and Human Services should identify ways to support the practice of indigenous healing in the United States and to improve communication among indigenous healers, conventional health care professionals, and CAM practitioners.

COVERAGE AND REIMBURSEMENT

Recommendation 23: Evidence should be developed and disseminated regarding the safety, benefits, and cost-effectiveness of CAM interventions, as well as the optimum models for complementary and integrated care.
Actions

23.1 The Secretary of Health and Human Services should convene a joint public and private task force to identify and set priorities for studying health services issues related to CAM and to help purchasers and health plans make prudent decisions regarding coverage of and access to CAM.

23.2 Federal agencies, States, and private organizations should increase funding for health services research, demonstrations, and evaluations related to CAM, including outcomes of CAM interventions, coverage and access, effective sequencing and integration with conventional therapies, effective models for service delivery, and the use of CAM in underserved, vulnerable, and special populations.

23.3 Federal, State, and private entities should fund health services research on the costs, cost-benefits, and cost-effectiveness of CAM interventions and wellness programs.

23.4 The Secretary of Health and Human Services and the National Committee for Vital and Health Statistics should authorize a national coding system that supports standardized data for CAM. This system should make possible the collection of data for clinical and health services research on CAM, and support compliance with the electronic claims requirements of the Health Insurance Portability and Accountability Act.

23.5 The National Center for Complementary and Alternative Medicine, through its clearinghouse, should provide information on health services research, demonstrations, and evaluations of CAM services and products.

23.6 Public agencies and private organizations should support the development of informational programs on CAM targeted to health plan purchasers and sponsors, health insurers, managed care organizations, consumer groups, and others involved in the provision of health care services.

23.7 Congress should request periodic reports from appropriate Federal departments on coverage of and reimbursement for CAM practices and products for Federal beneficiaries, Medicaid beneficiaries, Federal employees, military personnel, veterans, and eligible family members and retirees, as well as any legislative, regulatory, or programmatic impediments to covering safe and effective CAM interventions.

Recommendation 24: Insurers and managed care organizations should offer purchasers the option of health benefit plans that incorporate coverage of safe and effective CAM interventions provided by qualified practitioners.

Actions

24.1 Health insurance and managed care companies should modify their benefit design and coverage processes in order to offer purchasers, for their consideration, health benefit plans that include safe and effective CAM interventions.

24.2 Health insurance and managed care companies should make use of CAM expertise in the development of benefit plans that include safe and effective CAM interventions.

24.3 Health insurers, managed care organizations, CAM professional associations, CAM experts, private organizations that develop medical criteria, and Federal agencies are
encouraged to develop appropriate Clinical criteria and guidelines for the use of CAM services and products.

Recommendation 25: Purchasers, including Federal agencies and employers, should evaluate the possibility of covering benefits or adding health benefit plans that incorporate safe and effective CAM interventions.

Actions
25.1 Employers, Federal agencies, other purchasers and sponsors should enhance the processes they use to develop health benefits and give consideration to safe and effective CAM interventions.

25.2 Public purchasers such as the Centers for Medicare and Medicaid Services and the Department of Defense, employers, other health benefit sponsors, and health industry organizations should include CAM practitioners and experts on advisory bodies and workgroups considering CAM benefits and other health benefit issues.

25.3 The Secretary of Health and Human Services, preferably through the Federal CAM coordinating office when established, should maintain a list of opportunities for CAM experts to participate on advisory committees and other workgroups.

25.4 The Secretary of Health and Human Services should direct agencies under his authority to convene workgroups and conferences to assess the state-of-the-science of CAM services and products and to develop consensus and other guidance on their use.

25.5 State governments should consider, as part of evaluating and reviewing their regulations, how regulation of CAM practitioners could affect third-party coverage of safe and effective CAM interventions.

CAM in Wellness and Health Promotion

Recommendation 26: The Department of Health and Human Services and other Federal agencies and public and private organizations should evaluate CAM practices and products that have been shown to be safe and effective to determine their potential to promote wellness and help achieve the nation’s health promotion and disease prevention goals. Demonstration programs should be funded for those determined to have benefit.

Actions
26.1 The Healthy People Consortium should evaluate the role of safe and effective CAM practices and products in addressing the ten leading health indicators and develop strategies, including demonstration programs, to encourage the use of CAM practices and products found to be beneficial in addressing these indicators.

26.2 Questions on the extent and use of CAM products and practices should be included in national surveys and other assessment tools including the National Health Interview Survey, the National Health and Nutrition Examination Survey, and the Medical Expenditure Panel Survey. Where appropriate, information from these sources should be incorporated into the Healthy People 2020 goals and objectives.

26.3 The Department of Health and Human Services, as part of the Healthy People 2010 initiative, should support the development of a national campaign to teach and encourage behaviors that focus on improving nutrition, promoting exercise, and teaching stress
management for all Americans, especially children. This campaign should include safe and effective CAM practices and products where appropriate.

26.4 The Federal government, in partnership with public and private organizations, should evaluate safe and effective CAM practices and products to determine their applicability to improving nutrition, promoting exercise, and teaching stress management to children. Demonstration programs should be funded for those found to be applicable to children.

26.5 The Health Resources and Services Administration, the Centers for Disease Control and Prevention, the Department of Agriculture, the Department of Education, and other Federal agencies that develop school health guidelines should evaluate the potential applicability of safe and effective CAM practices and products to these school health guidelines. Those found to have benefits should be included in the guidelines.

26.6 Federal agencies, in partnership with the business community, should develop incentives for schools to make lunches and snacks healthful, and to limit the sale—and eliminate the advertising—of high-fat snacks, soft drinks, and other products that do not contribute to healthy lifestyles.

26.7 The Department of Health and Human Services and the Department of Labor should evaluate safe and effective CAM practices and products to determine their potential role in workplace wellness and prevention activities, and include them in Federal workplace wellness and health promotion programs and Federal health coverage plans when appropriate.

26.8 Federal agencies, in conjunction with the business community, should develop incentives for employers to include CAM practices and products found to be beneficial in workplace wellness programs and health coverage.

Recommendation 27: Federal, State public, and private health care delivery systems and programs should evaluate CAM practices and products to determine their applicability to programs and services that help promote wellness and health. Demonstration programs should be funded for those determined to be beneficial.

Actions

27.1 The Secretaries of Health and Human Services, Agriculture, Veterans Affairs, and Defense and the Commissioner of the Administration for Children and Families, should evaluate safe and effective CAM practices and products that contribute to wellness and health and determine their applicability to Federal health systems and programs.

27.2 The Secretary of Health and Human Services should facilitate the bringing together of public and private health care organizations to evaluate safe and effective CAM practices and products that contribute to wellness and health and determine their applicability to health systems and programs, especially in the nation’s hospitals and long-term care facilities and in programs serving the aging, those with chronic illness, and those at the end of life.

27.3 CAM and conventional health professional training programs should consider offering training and educational opportunities for students in self-care and lifestyle
decision-making to improve practitioners’ health and to enable practitioners to impart this knowledge to their patients or clients.

Recommendation 28: Research on the role of CAM in wellness and health promotion, the application of CAM principles and practices, and the role of CAM practitioners in the management of chronic disease should be expanded.

Actions

28.1 The Department of Health and Human Services should fund demonstration projects to evaluate the clinical and economic impact of comprehensive health promotion programs that include CAM. These studies should include underserved and special populations.

28.2 The Federal government and private health organizations should evaluate CAM practices and products that are currently being used for us and health promotion to determine their effectiveness and applicability to the management of chronic disease. Funding should be provided for demonstration projects in the Centers for Medicare and Medicaid Services, the Department of Veterans Affairs, the Department of Defense, the Health Resources and Services Administration, and other Federal agencies for those CAM practices and products found to have benefit in the management of chronic disease, end of life such as hospice.

COORDINATING FEDERAL EFFORTS

Recommendation 29: The President, Secretary of Health and Human Services, or Congress should create an office to coordinate Federal CAM activities and to facilitate the integration into the nation’s health care system of those complementary and alternative health care practices and products determined to be safe and effective.

Actions

29.1 The office should be established at the highest possible and most appropriate level in the Department of Health and Human Services and should be given sufficient staff and budget to meet its responsibilities.

29.2 The office should charter an advisory council. Members should include CAM and conventional practitioners with expertise, diverse backgrounds, and necessary training, as well as representatives of both the private and public sectors, to guide and advise the office about its activities.

29.3 The office’s responsibilities should include, but not be limited to, coordinating Federal CAM activities; serving as a Federal CAM policy liaison with conventional health care and CAM professionals, organizations, institutions, and commercial ventures; planning, facilitating, and convening conferences, workshops, and advisory groups; acting as a centralized Federal point of contact regarding CAM for the public, CAM practitioners, conventional health care providers, and the media; facilitating implementation of the Commission’s recommendations and actions; and exploring additional and emerging topics not considered by the Commission.