

Running Header: AN EXPLORATION OF CAM INTEGRATION

An Exploration of Complementary Alternative Medicine Integration

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Table of Contents

Abstract	3
An Exploration of Complementary Alternative Medicine Integration	4
Why Patient Demand For CAM Is Increasing	4
Defining Complementary Alternative Medicine	5
CAM Must Have Proven Medicinal And/Or Therapeutic Value	7
The Benefits Of Hospitals Implementing A CAM Program	8
Barriers To Adoption Of CAM In Hospitals	11
A Framework for Deciding To Integrate CAM	13
Conclusion	16
References	17

Abstract

Patient demand for alternative medical practices has skyrocketed over the past decade as traditional Western medical practice has become impersonal and indifferent to the body-spirit connection in overall health and well being. Because of this increasing interest and consumer demand, health care institutions must decide whether to offer Complementary Alternative Medicine (CAM) therapies in conjunction with traditional Western methodologies in order to meet demand and maximize profitability. Research consists primarily of peer-reviewed articles and a personal interview with Dr. Lew Huff, D.C., P.C. who teaches at Texas Chiropractic College, serves as director of the Moody Health Center, and serves as a committee member for the “Interactive Medicine Coordination Council for Integrating CAM Modalities” at Memorial Hermann Hospital in Houston, Texas.

An Exploration of Complementary Alternative Medicine Integration

Over the past decade the medical profession has changed dramatically. Most are familiar with the increasing trends in insurance, health maintenance organizations, and new drug therapies. These trends have all been initiated by the healthcare industry itself. However one of the greatest changes in medicine has come from the patients themselves. Over the past decade the number of patients seeking alternative therapies to deal with their healthcare problems has increased significantly. As more people choose to spend their healthcare dollars on these therapies, traditional healthcare providers are increasingly willing to offer these alternative therapies or Complementary Alternative Medicine (CAM) therapies to their patients.

Why Patient Demand For CAM Is Increasing

Healthcare consumers are seeking out CAM therapies for a variety of reasons. First, healthcare consumers are often dissatisfied with the therapeutic limitations of conventional medicine, especially in the treatment of chronic diseases (McKee, 2000). The reasons for this dissatisfaction are obvious. Often, especially for chronic conditions, traditional medications and therapies may not be very effective and patients are understandably searching for alternatives that may be more successful. Often, traditional drug therapies come with debilitating side effects that may be worse than the actual ailment. Patients also may seek CAM therapies for better value – CAM is often far less expensive than traditional healthcare. Finally, patients are frustrated with assembly-line doctors who see far too many patients per day and spend no time building relationships with their patients (Herochik, 2002). CAM practitioners usually spend more time with

patients and build relationships with them which patients find attractive in the increasingly impersonal medical field.

There is also a cultural aspect for patients' new desires to seek out alternative therapies. The search for these alternative healthcare options has come from the baby boom generation that came of age during the sixties and seventies. Though they became yuppies in the eighties, the baby boomers still hold some of the ideology of their hippy days when they were introduced to oriental and other cultures. This allows the baby boom generation to question traditional Western medical practices and adopt more natural or holistic medicinal therapies to deal with their healthcare problems. These consumers are also disenchanted with the concept of drug treatment for all acute diseases and the exclusion of the spirit and psyche as part of a treatment plan (McKee, 2000). The integrative medicine practiced by CAM practitioners seeks to treat the physical as well as the spiritual needs of its patients which is highly attractive to the baby boom generation.

Defining Complementary Alternative Medicine

So what exactly is CAM? Attempting to define CAM through the traditional healthcare institutions is a study in confusion. For example, the National Institute of Health has created the National Center for Complimentary and Alternative Medicine to study and evaluate CAM therapies. The best definition they have offered is "treatments and practices not taught widely in medical schools, not generally used in hospitals, and not usually reimbursed by medical insurance companies" (Arnold, 1999, p. 1104). One would be hard pressed to find a more unhelpful definition. Yet, almost all traditional healthcare institutions adopt this demeaning definition. This indicates a tremendous institutional bias and suspicion against alternative medicines.

The only reason most medical institutions here in the United States are considering adding CAM therapies is financial. Between 1990 and 1997, the number of Americans using some type of alternative medicine increased from 60 million to 83 million with Americans spending approximately \$21.2 billion for CAM therapies in 1997 alone (May, 2002). This is the reason for hospitals' interest in CAM therapies. Regretfully, they often misunderstand what CAM is and actually consider CAM therapies inferior or silly; they only want to tap into the vast amount of money spent on such therapies.

If these CAM therapies were truly inferior or unhelpful, hospitals would be doing a major disservice to their patients by offering these services solely for financial gain. However, these therapies are often superior to conventional medicine. In this case, a hospital's concern with the bottom line should help more consumers gain access to helpful therapies.

So again what is CAM? The Journal of Healthcare Management has offered an acceptable definition:

Complementary medicines...are alternative medicines used in conjunction with allopathic methods and include forms of holistic medicines such as acupuncture, ayurvedic, massotherapy, or homeopathy used with traditional practices. Patients use complementary therapies such as massage, counseling, and acupressure to enhance well being, increase the quality of life, provide strength, reduce side effects, or reduce fear and anxiety. (Santa Ana, 2001, p. 3)

One is also inclined to add the use of vitamins, herbs, and other natural supplements as part of one's drug therapies to the CAM definition. Growing scientific evidence exists that links diseases to nutritional, emotional, and lifestyle factors (Pelletier, Marie, Krasner, Haskell, 1997).

What is important to consider when evaluating CAM therapies is whether they work or not – not necessarily how they work. For instance, it is now commonly acknowledged that acupuncture offers many health benefits, but no one can explain exactly why it works. There are several theories that attempt to explain how acupuncture works (the Augmentation of Immunity theory, the Endorphin theory, the Neurotransmitter theory, and the Gate Control theory), yet no one has a definitive explanation for why this treatment is effective (Moyer, 2001). However, acupuncture is very successful and is being rapidly embraced by traditional medical professionals.

CAM Must Have Proven Medicinal And/Or Therapeutic Value

CAM is not the acceptance of every witchdoctor remedy that exists. CAM embraces therapies with proven medical value that are outside the traditional Western medical tradition. The reason that CAM therapies have not been widely accepted prior to now in the United States is often due to lack of quality control in the past – something which is improving but still lacking today. One such example is the chiropractic field. Previously, chiropractors were trained only in technique, not in diagnostics, which led to chiropractic treatment of ailments that were not appropriate for chiropractic treatment (L. Huff, personal communication, April 18, 2002). Today however, chiropractic schools offer anatomy, physiology, pathology, internal diagnostic, and a plethora of other traditional medical courses in order to meld the traditional and alternative medical

practices into a comprehensive, more effective patient treatment (*Texas Chiropractic College: 1998-2000 Catalog*, 2000).

Similarly, there is growing acceptance of vitamins and natural supplements as important tools in the prevention and cure of many diseases. However, not all supplements have been studied for effectiveness and their known dangers not effectively communicated to the public at large. For example, valerian root is an herbal supplement that thins the blood and is contraindicated for use with prescription blood thinners such as Cumadin (L. Huff, personal communication, April 18, 2002). If traditional doctors are ignorant about the effect of valerian root they are endangering their patients lives by not being able to inform patients about these contraindications that are not included on the label of most supplements. Also, the quality of supplements can vary drastically between brands. Adulteration can even occur in supplements where the wrong part of the plant is used in creating the supplement and pose significant health risks, including death (L. Huff, personal communication, April 18, 2002). An educated herbalist doctor or a typical medical doctor with knowledge of supplements can recommend safe brands and monitor dangerous supplement-drug interactions.

The Benefits Of Hospitals Implementing A CAM Program

There are many benefits to a hospital if it offers a quality, professional CAM therapy program. Obviously, a CAM program will increase hospital revenue because the traditional medical practitioners will be tapping into this \$22 billion market. While being a financial boon to a hospital, the adoption of a CAM program still helps patients control costs because CAM therapies are often far less expensive than traditional healthcare

therapies. Also, implementing CAM therapies as part of a preventive healthcare plan ultimately lead to great reductions in healthcare spending (Santa Ana, 2001).

Currently, the majority of hospitals do not have comprehensive CAM programs. Thus, a hospital that implements such a CAM program is able to differentiate itself from its competition and attract many of the patients who have moved away from traditional medicinal treatments (Freshley & Carlson, 2000). Also, this will attract many patients who remain in traditional healthcare treatment programs but who are interested in alternative approaches to medicine (Gonzales, 2002). All types of people seem to be using CAM and the highly educated consumer tends to explore options and seek out alternative forms of therapy (Santa Ana, 2001).

CAM benefits the patients in many ways aside from the financial benefits. CAM therapies can be used in conjunction with traditional medicinal treatment (Pelletier et al., 1997). CAM treatments tend to have far fewer side effects on patients than pharmaceuticals or surgeries (Schuster, 1996). Some CAM therapies, such as acupuncture, are able to aid in recovery, shorten lengths of hospital stays, and help avoid unnecessary surgery (Schuster, 1996).

By adopting CAM therapies, hospitals continue to assist their patients by pressuring the insurance companies to cover CAM therapies. Already, though CAM programs are still relatively scarce, the few programs that have been implemented have caused some insurers to provide CAM coverage (Sullivan, 2000). For instance, Oxford Health Plans that serves over 1.6 million people in the Northeast has implemented a CAM coverage program that includes chiropractic, acupuncture, nutrition, massage, naturotherapy, and yoga (Sullivan, 2000). American LIFECARE and Seattle-based

Group Health Cooperative have also followed suit, and more insurers are following their leads.

CAM also directly benefits the physicians who offer CAM therapies. One aspect of CAM therapies that make them so attractive to consumers is that these therapies often require intimate knowledge of a patient and the medical practitioners must dedicate time to establishing a relationship with their patients. By giving care in this manner, practitioners are able to meet some of their own psychosocial and spiritual needs (Freshley & Carlson, 2000). As Freshley & Carlson pointed out, “The level of burnout among physicians, even executives, is becoming one of the larger crises in medicine, and the return to medical practice with meaning and holistic service will assist individuals and organizations combat burnout and cynicism” (2000, p. 10). CAM therapies allow the practitioner to feel like a real doctor again instead of as an assembly-line prescription filler. This can significantly increase a doctor’s satisfaction with his or her profession.

Finally, integration of CAM therapies into the traditional medical model could enhance community wellness initiatives, enrich medical education, and lower the cost of charitable medical care (Freshley & Carlson, 2000). The lower cost of CAM therapies allows for more funds to be distributed to programs and services that help the entire community and individually needy patients. The quality of medical education is enhanced as doctors increase their knowledge of new treatments and the potential benefits and pitfalls of integrating different therapies. Integration also opens the door for the health system to receive new philanthropic funds targeted to healthcare redesign and innovative program development, particularly in the area of community health (Freshley & Carlson, 2000).

Barriers To Adoption Of CAM In Hospitals

With all of these potential benefits, why have hospitals not rushed to implement CAM programs? As potentially helpful as CAM is, there are still many barriers to CAM implementation and acceptance in the greater healthcare system.

The greatest barrier to acceptance of CAM programs is the attitude of traditional medicine practitioners. It is almost universally agreed that these attitudes, which have been described as “downright hostile” (Crigger, 2000, p. 48) are the greatest obstacle to acceptance of CAM (Crigger, 2000; L. Huff, personal communication, April 18, 2002; Santa Ana, 2001; Ziel, 1999). As with all people, doctors can be quite provincial and stubborn in their acceptance of new or unfamiliar theories and procedures in their areas of expertise. This hostility towards CAM pervades the medical profession and is well known to patients who often hide their use of CAM therapies from their traditional doctors (Torpy, 2002). While studies have found that most patients who use CAM also use traditional Western medicine, 70 % of these patients refuse to reveal this to their doctors for fear of ridicule or embarrassment (Hodge & Ullrich, 1999). Education is a key to breaking down this established bias but it will never be fully erased as many will stubbornly refuse to accept any ideas outside their comfort zone.

Along this same line is the problem of medical language barriers. These language barriers exist between allopathic and CAM providers and cause much misunderstanding. Some suggest that successful medical delivery by different healthcare providers will occur only when allopathic and CAM professionals are able to communicate and acquire a consistent language (Santa Ana, 2001). Luckily, many healthcare professionals believe that the United States is evolving toward a more extensive model of healthcare that will

incorporate different treatments that are efficacious and cost effective (Kligman, 1997). However this process takes time and the ones who begin to start implementing CAM therapies now will be far ahead in providing patients quality care and medical choice.

Another far more valid barrier to acceptance of CAM is Western medical professionals' demands that any new or unorthodox treatment be supported by research and data. Likewise, health administrators and consumers question investment in new ventures (Santa Ana, 2001). They all want assurance that expenditures and treatments have been researched and evaluated appropriately and that CAM demonstrates efficacy in comparison to traditional medical intervention (Santa Ana, 2001). Since CAM integration is a relatively new concept for American medicine, these studies are often unavailable or show only effectiveness without understanding why the treatments are effective. Much more research needs to be conducted on individual CAM therapies and implementation of CAM integration programs in order to allay these fears.

The final barrier is reimbursement complexity. Understandably, hospitals want assurances that CAM services will be reimbursed (Santa Ana, 2001). This is a problem related to what insurers are willing to cover and the difficulties prohibiting them from doing so. As Pelletier et al. note:

A crucial problem in reimbursement is the inconsistency in CAM terminology usage among practitioners, sponsors, and consumers.

Insurers or managed care providers that want to provide CAM coverage often do not because no Current Procedure Terminology codes represent alternative therapies on billing claims. Without uniform coding, insurers

face the problem of providers misusing Current Procedure Terminology codes to get reimbursed for alternative services. (1997, p. 6)

This relates to the previously discussed medical language barrier. Until a uniform medical language is adopted for CAM therapies, insurers will shun coverage for CAM therapies and continue to cause reimbursement complexity issues. Of course, as more hospitals implement CAM integration programs insurers will be pressed into coverage and will likely standardize the language for the healthcare industry as a whole.

A Framework for Deciding To Integrate CAM

As with most of their decisions, healthcare administrators must carefully consider the benefits and barriers before deciding to proceed with a CAM integration program. In order to decide whether such a program is necessary or desirable in a particular hospital, it is helpful to have a framework for solid analysis. A proper framework for decision-making would include consideration of consumer needs, mission statement, scope of service, reimbursement, and staffing.

The first consideration is consumer need. Basically this requires an analysis of the patient market that a hospital serves to determine if the consumers in that market would be willing to use such services. Often, a hospital will find that its market will support CAM integration. CAM integration has been driven by consumer demand and it is expected that consumers will continue to do so (Horrigan, 2001). Also, lack of insurance coverage is often not a barrier. Even without insurance coverage, the public is often willing to pay out-of-pocket because of the overwhelming interest in CAM therapies (Santa Ana, 2001).

The second consideration is mission statement. A hospital should examine its mission statement to determine whether CAM therapies would reasonably fall within the statement's bounds. Reevaluating the institution's mission statement is key to ensure compatibility of CAM with an institution's existing system and doing so will increase acceptance of CAM by the hospital's staff (Santa Ana, 2001). For example, Northwestern Memorial Hospital in Chicago promises to "improve the health of the communities we serve by delivering a broad range of services with sensitivity to the needs of our patients and their families" (Northwestern Memorial Hospital, 2000). Northwestern Memorial found integrating CAM therapies was fully consistent with their own mission statement. Likewise, most other institutions should be able to find room in their mission statements for adopting CAM integration.

The third consideration is scope of service. Few hospitals will implement programs covering every single CAM therapy that exists, as this would be cost-prohibitive and offer unnecessary therapies for ailments that a hospital does not treat on a frequent basis. An organization would not merely employ CAM therapies, but would instead strategically implement those therapies for particular commonly treated ailments to ensure revenue generation (Santa Ana, 2001). For example, a study by the RAND Corporation found that chiropractors were more successful than medical doctors at treating patients with chronic low-back pain and that chiropractic care was about one-tenth the cost of conventional care (Pelletier et al., 1997). If a particular hospital treated a significant number of low-back pain ailments, implementation of a chiropractic program would offer patients a lower-cost, more successful therapy while increasing the hospital's revenue.

The fourth consideration is reimbursement. A hospital must be confident that new programs will be either revenue generation vehicles or offer significant revenue and resource savings. CAM is still primarily paid out-of-pocket, but many managed care organizations are beginning to provide coverage (Santa Ana, 2001). Interestingly, managed care providers that do offer CAM coverage do so because offering this coverage actually increases revenue and provides health systems a competitive edge (Bellandi, 1999). Because of this fact, it can be expected that an increasing number of insurers will continue to add CAM coverage. Currently CAM coverage is relatively scarce and a hospital must make certain that it fits into one of two categories. Either the hospital's market must be wealthy enough to afford to pay for CAM therapies out-of-pocket or the hospital must provide enough charity care that the savings in the CAM program would maximize the effectiveness of a hospital's charity care expenditures.

Finally, the last consideration is staffing. Without qualified CAM practitioners and general staff knowledge of CAM a hospital runs the risk of providing inferior service and potentially having malpractice claims against it which could have significant negative impacts on the hospital. Only recently has this problem been dealt with in the medical profession. Previously, few CAM practitioners were taught traditional Western methodologies of diagnoses and treatment. CAM education now often includes instruction in these areas and traditional medical schools have begun instructing their students in the basics of CAM therapy (L. Huff, personal communication, April 18, 2002; *Texas Chiropractic College: 1998-2000 Catalog*, 2000). This allows for more understanding between the traditional practitioners and the CAM practitioners.

With this increasing understanding between the two types of medical care, the practitioners will be more willing and more qualified to cross-refer their patients for particular ailments. Existing staff should be educated about CAM so that they have a foundation that includes an overview of therapies such as acupuncture, botanical preparations, relaxation techniques, and healing systems such as homeopathy, osteopathy, traditional Chinese medicine, and ayurveda (Milton, 2001). Traditional practitioners with this background will feel more comfortable asking their patients about CAM therapies or products that patients may be using (Milton, 2001). In educating their staffs and being able to hire CAM practitioners whose educations include traditional Western diagnoses and treatment information, CAM staffing is far less of a problem than it has been in the past for hospitals.

Conclusion

Demand for CAM therapies has increased markedly over the past decade and there seems to be no end in sight to this trend in medicine as more patients seek more holistic, natural therapies to deal with ailments. As more hospitals and insurers add CAM therapies to their programs, others will be forced to follow along or lose any competitive edge in the medical services market. The only real question is to integrate CAM now or later. For those who choose to implement CAM in practical, profitable ways now, they will have the competitive advantage, as the rest of the market will inevitably be forced to follow along sooner or later. If a hospital can justify integrating CAM using the framework provided, it can provide itself and its patients an inestimable benefit by offering proven, safe CAM therapies.

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