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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. list	Participants and Contacts Query (partial) (6 pages)	09/15/2000	b(6)
002. resume	Victoria Taylor (partial) (1 page)	nd	b(6)

COLLECTION:
Federal Records
White House Commission on Complementary and Alternative Medicine Policy [WHCCAMP]

OA/Box Number: 43234

FOLDER TITLE:
Seattle Testimony and Talking Points [October 30-31, 2000] [3]

2011-0568-S
kc847

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

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Mary Dennedy

#72

White House Commission on Complemer
Policy
Town Hall Meeting Octc
Town Hall Seattl

Mary Dennedy
#72

Testimony by: Sheila K. Rhodes MA, Direct
Care Center, 2905 Connelly Ave. Bellingham

Summary: Herbal remedies offer safe alternat
practices in long term care facilities and an inp
One herbal tea eliminates urine odor; another prevents urinary tract infections. A third herbal tea has been used successfully for ten years in an inpatient drug and alcohol detoxification center in lieu of drugs to ameliorate symptoms of withdrawal. Herbal remedies are less expensive. Yet physicians are unwilling to authorize their use. They rightfully want to know what impact the teas have on other medications they prescribe for their patients. There is no readily accessible document, such as the **Physician's Desk Reference** to which they can refer for information nor were they taught about CAM in medical school.

Specifics: In particular, one herbal tea comprised of equal parts of chickweed, alfalfa and peppermint successfully eliminates urine odor among elderly patients without harmful side effects. The tea improves digestion and cools the urine. A second herbal tea called Waterfall Tea reduces the instance of kidney infections. Comprised of uva ursi, cornsilk, pipsissewa, catnip, lemongrass, nettles and marshmallow root, this tea has low level antibacterial qualities which flush the urinary tract system and reduces the likelihood of recurring UTIs. Our doctors presently prescribe low level antibiotics continuously for elderly patients with chronic UTIs. Continuous use of antibiotics adversely affects the productive flora in the intestines and leads to yeast infections. A third herbal tea made up of peppermint, scullcap, lemon balm, valerian root, passion flower, and cramp bark has been used successfully for ten years at St. Joseph Hospital Detox Center to reduce spasms, nausea and insomnia related to withdrawal. Patients released from the center continue to use the tea on their own because they have found it also helps reduce their craving.

My UTI

1.Coordinated Research and Development to Increase Knowledge of Complementary and Alternative Medicine Practices and Interventions.
Question: How can we more effectively integrate the CAM and conventional research communities to stimulate and coordinate research? Answer: Recognize the validity of CAM. Use European research as a basis for US research to confirm long held assertions. Call upon recognized seats of CAM learning such as our local Bastyr College to link reputable sources of information. Encourage conventional research communities to work with CAM researchers by offering research grants in this area of inquiry. Lean on the national sources of research funding to designate funds for this purpose.

White House Commission on Complementary and Alternative Medicine Policy
Town Hall Meeting October 30,2000
Town Hall Seattle, WA

Testimony by: Sheila K. Rhodes MA, Director of Social Services, Mt. Baker Care Center, 2905 Connelly Ave. Bellingham, WA 98225. (360-734-4181).

Summary: Herbal remedies offer safe alternatives to standard prescriptive practices in long term care facilities and an inpatient drug treatment program. One herbal tea eliminates urine odor; another prevents urinary tract infections. A third herbal tea has been used successfully for ten years in an inpatient drug and alcohol detoxification center in lieu of drugs to ameliorate symptoms of withdrawal. Herbal remedies are less expensive. Yet physicians are unwilling to authorize their use. They rightfully want to know what impact the teas have on other medications they prescribe for their patients. There is no readily accessible document, such as the **Physician's Desk Reference** to which they can refer for information nor were they taught about CAM in medical school.

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2. Guidance for Access to, Delivery of, and Reimbursement for Complementary and Alternative Medicine Practices and Interventions.
Question: Do you have ready access to CAM practices and interventions? Answer: Yes, in my community of Bellingham, Washington, there is a plethora of CAM practices and interventions. The challenge is in knowing how to use them wisely.
Question:How can access to safe and effective CAM practices and interventions be improved? Answer: If our health care coverage systems are ever going to support CAM, we need a review system by which we as consumers and health providers can determine who/what is reputable and who/what is not. The community grapevine in this instance is less reliable than it might be because of the element of historical folklore that impacts CAM.
Question: What types of CAM practices and interventions should be reimbursable through federal programs or other health care coverage systems? Answer: All CAM practices and interventions which have been validated by solid research and proven effective should be reimbursable. Eventually, reimbursers will discover that health care provision is less expensive if CAM practices and interventions are incorporated. Case in point: chiropractors and naturopaths were not covered by insurance in this state a few years ago. Today, their use is encouraged by my HMO. In fact, I am able to schedule up to 10 visits to a chiropractor per year without seeing my primary care physician (PCP) for a referral. To see any allopathic specialist I still must first obtain a referral from my PCP.

3. Training, Education, Certification, Licensure, and Accountability of Health Care Practitioners in Complementary and Alternative Medicine.
Question: What training and education should be required of all health care providers to assure access to safe and effective CAM practices and interventions? Answer: Naturopaths receive the same basic medical training as allopathic physicians but the latter do not receive naturopathic training. Expand the syllabus in medical schools in the nation to incorporate teaching in CAM and the training in how to access and incorporate CAM in their practice of medicine. No one can be expected to know it all, but all can be expected to know how to find out what is useful.
Question: Are performance standards or practice guidelines needed to ensure the public will have access to the full range of safe and effective CAM practices and interventions? Answer: Absolutely. The challenge will be to find ways to accept the existing performance standards established for each form of CAM. Each is unique and based on, in some cases, centuries of practice.

4. Delivery of Reliable and Useful Information on Complementary and Alternative Medicine to Health Care Professionals and the Public.
Question: How can useful, reliable, and updated information about CAM practices and interventions be made more accessible? How would you like to receive such information? Answer: The way to make them more accessible is to

use existing resources and expand them. For example: for herbal and homeopathic remedies, include them in the **Nurse's Desk Reference (NDR)** and the **Physician's Desk Reference (PDR).** These are "bibles" in daily use in every nursing facility and doctor's office. Future medical texts can include an array of treatment modalities.

Question: As a consumer, what kinds of information about CAM practices and interventions are most needed and important to you? Answer: I want to know how the herbal remedies I use interact with any medications I take. I want to know in what order I should be taking them. Presently, I am learning by experience. I have severe varicose veins in one leg. For recurring bouts of phlebitis, my physician prescribed warfarin and aspirin along with heat and elevation. The medications caused gastric distress. An herbal specialist recommended tincture of horse chestnut, which I now use in lieu of warfarin/aspirin. I also drink green tea. Now the only time I risk an attack of phlebitis is after a contusion to the area. However, I discovered that I needed more information about my self healing program when I bled unusually from a minor surgery conducted in my doctor's office.

Question: As a health care provider, what kinds of information about CAM practices and interventions are most needed an important to you? Answer: The roadblocks to introducing CAM into nursing home protocol are physician ignorance/resistance and consumer unwillingness to try any CAM which is not endorsed by the PCP. Another roadblock is lack of coverage by insurance providers. What is most needed is a thorough understanding by the medical community of how CAM can be incorporated into conventional medical practice. The most immediate help would be to expand the **NDR and PDR** to cover herbal and homeopathic remedies. Britain publishes a reference manual that has done this. Next, place emphasis on CAM in future medical refresher courses. All physicians must accrue a certain number of continuing education hours. You validate CAM by making it required learning.

#79

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BASTYR UNIVERSITY

SPIRITUALITY HEALTH AND MEDICINE

Professional Certificate Program 2000

Metropolitan King County Council
Room 1200, King County Courthouse
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September 18, 2000

Michele Chang
White House Commission on
Complementary and Alternative Medicine
6701 Rockledge Dr., Ste. 1010, Rockledge-II
Bethesda, MD 20817-7707

Dear Ms. Chang,

First let me introduce myself. My name is Karlene Zimmerman. I am a legislative aide for King County Councilmember Kent Pullen and am on the administrative team for King County Integrated Health Care 2010 (KCIHC 2010).

Sheila Quinn asked me to send you some information about KCIHC 2010. Enclosed you will find the following documents:

- KCIHC 2010 Draft Concept Paper (3 pages)
- A draft schematic of the project process (1 page)
- Initiatives, Proposed Projects, and Working Groups in the King County/Puget Sound Region (1 page)
- Database Participants and Contacts Query (6 single and 4 double pages); please note this is in two forms. The report form has many of the entries truncated. Therefore, I have included the table form as well.

If I can be of further help, please feel free to contact me.

Sincerely,

Karlene Zimmerman

Karlene Zimmerman, aide for
Councilman Kent Pullen
(206) 205-5250
Fax: (206) 296-0198
e-mail: karlene.zimmerman@metrokc.gov

KING COUNTY INTEGRATED HEALTH CARE 2010: INTEGRATION OF COMPLEMENTARY AND ALTERNATIVE MEDICINE INTO THE DELIVERY OF HEALTH CARE IN KING COUNTY

CONCEPT

To establish a coordinated vision and innovative strategic plan for the integration of complementary and alternative health care delivery in King County. The process and plan will provide a place, time and agreed upon outline for leveraging energy and resources to accomplish a set of goals by 2010.

King County Integrated Health Care 2010 will be a two-phased, community based process that will bring together major stakeholders in a collaborative environment to craft and implement a ten-year strategic plan. Phase I will be an inclusive and progressively larger series of approximately three meetings during 2000 to engage a planning process, culminating in a Fall meeting of potentially 100-200 people.

Many forces make 2000 an ideal time to reinvigorate this task: escalating demand for complementary and alternative medicine; growing data supporting its effectiveness; expanding networks of groups and agencies addressing the integration of complementary and alternative medicine (CAM) and conventional medicine (CM); and strong history of health care innovation and leadership by the County.

Among the potential issues to be addressed in a coordinated way are:

- Research
- Clinical practice, quality of care and delivery systems
- Underserved and special needs populations
- Professional and public education
- Public Health and environmental health
- Regulation and access to products
- Federal, state, and local benefit programs and regulations
- Reimbursement and insurance

BACKGROUND

In February 1999, a meeting, hosted by King County Council Districts One and Nine, began the groundwork for a public forum to address where King County would like to take natural medicine by the year 2010. Participants, representing CM and CAM providers, payers, regulators, hospitals, educators, experts and others, shared their knowledge, views, and vision for the future and developed action steps to be considered in future meetings. Those attending this meeting supported a continued in-depth and broadly inclusive planning process that will

- celebrate and report on accomplishments of the past;
- identify where we would like integrated medicine to be by 2010;
- identify realistic goals and steps to get there; and
- divide the work, identify accountable agencies or institutions and establish assessment mechanisms.

We want to renew that effort and build on the work and collective vision achieved during the initial meeting.

RATIONALE

Metropolitan King County is in a position to initiate and facilitate an effective process. Many factors contribute to this moment of opportunity.

- *The Puget Sound region* has a national reputation for leadership in health care reform, including the Washington State "every category of provider" law, which became effective in 1996.
- *The Northwest region* enjoys national visibility for education, leadership, clinical services, and research in both CM and CAM medicine. University of Washington, Bastyr University, Northwest Institute of Oriental Medicine, Seattle Midwifery School, Western States Chiropractic College, several massage schools and others are located in the region.
- *Consumer usage* of complementary and alternative medicine is rising nationally and in King County. Studies indicate that the rate of consumer usage of CAM ranges from 34% in 1993 to 40%-69% in 1998.[1] The CAM credentialled workforce will grow by 88% between 1994 and 2010.[2] The CM workforce using or referring for CAM therapies is also growing steadily; reports on referral and usage vary, but studies suggest referral and usage rates range from 7.9% to 73%.[3]
- *The King County Council* has a demonstrated commitment to innovating and advocating for the integration of natural medicine, establishing the King County Natural Medicine Clinic in 1995, the first publicly funded integrated natural medicine clinic in the country. The recent appointment of a naturopathic physician to Harborview Hospital's Board of Trustees is another example.
- *The King County Board of Health* has demonstrated its recognition of the importance of natural medicine by being the only board in the country with a naturopathic physician as a member and creating a task force investigating natural medicine integration into public health programming.

- *Related public and private efforts* examining various aspects of the integration of natural medicine into public policy and private systems are underway in the region, including:
  - The Building Bridges Between Provider Communities Group (DHHS; PHS Region X)[4]
  - The Clinician Work Group on the Integration of Complementary and Alternative Medicine (Office of the Insurance Commissioner, Washington State);
  - Hospital task forces; and
  - The International Conference on Integrative Medicine Conference, among others.
- *The National Institutes of Health National Center for Complementary and Alternative Medicine* (NIHNCCAM) is mandated to "study the integration of alternative treatment, diagnostic and prevention systems, modalities, and disciplines with the practice of conventional medicine as a complement to such medicine and into health care delivery systems in the United States."[5]
- *The White House Commission on the Integration of Complementary and Alternative Medicine Policy* is about to be seated. The Commission has been charged to "study and make recommendations to the Congress on appropriate policies regarding research, training, insurance coverage, licensing and other pressing issues in this area."[6]

The King County Integrated Health Care 2010 strategic planning project will include areas of focus which have been identified for the White House Commission on the Integration of CAM Policy, in preparation for federal research and recommendations concerning health care services in these areas.

A Two-Phased Project

Phase I: Development of a strategic plan for integration of health care delivery in King County.
The first phase (December 1999 - Fall 2000) will be an inclusive process harnessing the intellectual and implementation resources, experience, and the energy of current interests and opportunities. It will consist of a series of three progressively more inclusive meetings of stakeholder participants held in the spring and fall of 2000.

- Identification of accomplishments to date
- Identification and prioritization of future goals better accomplished in coordinated effort
  - Critical data about current and past initiatives will be collected.
  - Identify and recommend specific actions, timelines and lead organizations.
  - A final draft of a strategic plan will be developed by stakeholder participants and reviewed by participating agencies, boards and institutions.
  - Stakeholders will consider the establishment of an oversight or coordinating function or process for implementing the Plan.
- A public outreach process for review and recommendations to the Draft Strategic Plan will be developed.

Phase II: Implementation.
The second phase of the project (2001 - 2010) will be developed, based upon the needs and desires expressed in Phase I. Phase II starts with the adoption of the draft plan, indicators, performance measures and timeline by the participating agencies and organizations, and establishment of an oversight function. Broader public involvement and information distribution will occur. Stakeholders will continue to seek identified grant fund and begin implementing the areas identified for coordinated effort and accomplishment.

Project Management

This project is sponsored by a coalition that will include certain members of the King County Council, Bastyr University, and other stakeholders. A fiscal agent will be recruited and funds designated for that purpose. A steering committee will be formed for the project early in Phase I, composed of sponsors of the project (those participant stakeholders providing financial and inkind support), and will meet quarterly. An executive project team, a small working team composed of project initiators, major sponsors, fiscal agent, will have oversight responsibility for the project and will meet monthly with project staff.

Funding

Funding for Phase I of the project will be provided by stakeholder participants and sponsors; all stakeholders will be asked to be sponsors and to give support, contributing what financial support and in-kind contributions they can. Additional financial support for the project will be sought, as appropriate, from corporations, foundations and federal agencies; grants will be specifically sought for Meeting 3 and Phase II. Initial support for the project has been provided by project initiators, including members of King County Council, Districts One and Nine, and Bastyr University; this funding includes: support of a part-time grant writer and a part-time project coordinator, in-kind contributions and contributed time.

REFERENCES

[1] Eisenberg et al, "Unconventional Medicine in the United States, Prevalence, Costs, and Patterns of Use," NEJM, January 1993: 328: 4; Astin J., "Why Patients Use Alternative Medicine," JAMA, May 20, 1998: 279: 1584-1553; and Stanford University, National Consumer Survey, American Special Health Plan, September 18, 1998.

[2] Cooper, Staflet, "Trends in the Education and Practice of Alternative Medicine Clinicians," Health Affairs: Data Watch, Vol. 15., No. 3, Fall 1996

[3] 1) Berman BM, Slagh BB et al, Primary Care Physicians and Complementary Alternatives vs. Traditional Training, Attitudes, and Practice Patterns, J AM Board Fam Pract, 1998: 11: 272-81. 2) Gordon NP, Sobel DS, Tarazoria EZ. Use of and interest in alternative therapies among adult primary care clinicians and adult members in a large health maintenance organization. West J Med 1998: 169, 153, 161. 3) Weeks J, Layton, R. Integration as Community Organizing: Toward a Model for Optimizing Relationships Between Networks of Conventional and Alternative Providers, Int Med 1998: 1:15-25.

[4] The Building Bridges Between Provider Communities Group, a informal coalition of agencies and organizations with mutual interests in integrating alternative and conventional health care, includes representatives of: US Public Health Service, Region X; Bastyr University, American Association of Naturopathic Physicians; Community Health Centers of King County; Integration Strategies for Natural Health Care; King County Council; Northwest Regional Primary Care Association; Office of the Insurance Commission, Washington State; Seattle King County Department of Public Health; Washington Association of Naturopathic Physicians.

[5] Departments of Labor, Health and Human Services, and Education and Relation Agencies Appropriation Act,, 1999, Conference Report (H. Report 825) on HR328, Making Omnibus Consolidated and Emergency Supplemental Appropriations for Fiscal Year 1999, Title VI, Sec. 601, Subpart 5, Sec. 485D, subsections (a) and (c), Congressional Record, October 19, 1998.

[5] Departments of Labor, Health, and Human Services and Related Agencies Appropriation Bill, 1999, Conference Report 105-300, 105th Congress, 2nd Session.

DRAFT, May 19, 2000

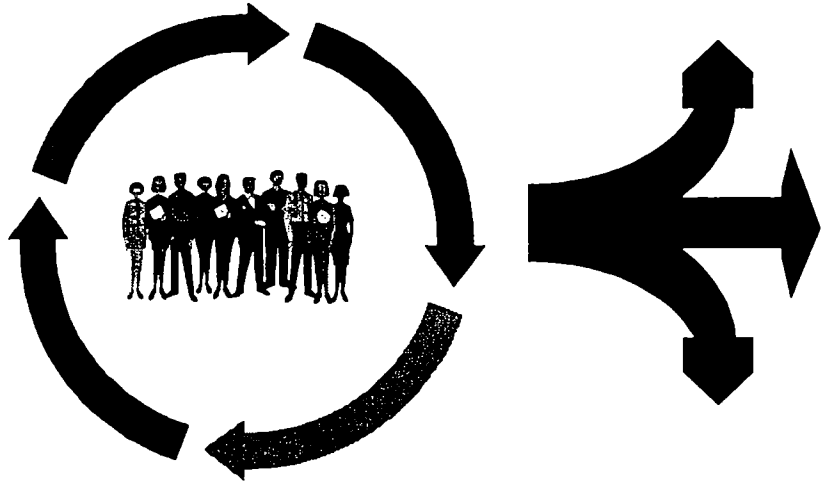
King County Integrated Health Care 2010

Schematic of Project Process

Initiative: King County Integrated Health Care 2010

Stakeholders

- Health Providers
- Payers
- Teaching Institutions
- Consortia
- Initiatives
- Government
- Community Groups
- Research
- Collaborative projects/networking groups



VISION

Coordination

Coordinating Body, Commission or Council for Implementation of Strategic Plan

"King County Commission"

Health People, Healthy Communities 2010

The White House Commission on Complementary and Alternative Medicine Policy

US Department of Health & Human Services

National Center for Complementary and Alternative Medicine

National Institutes of Health

INITIATIVES, PROPOSED PROJECTS, AND WORKING GROUPS IN THE KING COUNTY / PUGET SOUND REGION

INITIATIVES

King County Integrated Health Care 2010 Project

- Goals: to improve individual and community health in King County.
- Activities: to establish a coordinated vision and innovate strategic plan for integration of complementary and alternative health care delivery in King County.
- Status: an ad hoc, collaborative project, developed and sponsored by a collaboration of stakeholders, including health care providers, (CAM/CM), Public Health agencies and organizations, legislators, businesses/corporations, environmental health, citizens groups, cultural and underserved populations.
- Funding: sponsorship funding provided by stakeholders; direct grant and funding support to be sought from corporations, foundations, and federal granting agencies, including NIHCCAM.

King County Integrative Research Institute

- Goals: investigate and promote prevention through collaboration of natural medicine and public health.
- Activities: develop and evaluate innovative demonstration projects, support other applied research, investigate collaborative CAM prevention research opportunities and recommend policy to advance prevention and population health.
- Status: a proposal under the auspices of the King County Board of Health to create a research institute affiliated with Public Health – Seattle and King County, operating as a separate 501 (c) organization and governed by a board that interlocks with the King County Board of Health.
- Funding: direct federal grants, public research institutions, private foundations, and private individuals.

Northwest Center for Community Health, Traditional Medicine and Public Health

- Goals: to create synergistic, coordinated approach to improve health of population of Northwest by integrating CAM and public health, with a special emphasis on underserved populations.
- Activities: research, teaching, clinical services and human resource development, encompassing related areas of public health, rural and community health, poverty and under-served population health, and international health, integrating CAM approaches.
- Status: an initiative, under the joint leadership of Bastyr University, the Northwest Indian College, US Department of Health and Human Services, Region X, and other partners in the Northwest Region.
- Funding: initial seed funding provided for initiative by participating teaching institutions; direct grants from private foundations and federal granting agencies. (DHHS, Region X is only contributing staff time to this project and would not receive any financial support.)

Other initiatives in development, including:

- Proposed CAM Peer Review Advisory Group(OIC CWIC* recommendation)
- Proposed Collaborative Utilization Data Analysis (OIC CWIC recommendation)
- Integrated Care Options for Communities in Need Project (Bastyr University/HPLRS)

WORKING GROUPS CONCERNED WITH INTEGRATION OF CAM/CM, including

- ***The Building Bridges Group***
- ***Children's Hospital/Medical Center, Complementary and Alternative Medicine Committee***
- ***Office of the Insurance Commissioner, Clinician Working Group on the Integration of Complementary***
- ***Alternative Medicine, 1997 – 1999***
- ***Proposed Practice Guidelines Development (OIC CWIC recommendation)***

NOTE

- ***Community Health Centers of King County***, in partnership with Bastyr University and under the oversight of Public Health -- Seattle & King County developed the first public integrated CAM Conventional Medicine community health center, have incorporated CAM services into a second of their health centers and visualize a fully integrated primary care system throughout their health centers.

*Office of Insurance Commissioner, Washington State

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Participants and Contacts Query

First Name	*Last Name*	*Suffix*	*Title*	*Organization*	*Address 1*	*Address 2*	*City*	*State*	*Zip Code*
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Kathleen	Appleyard			American Massa			Normandy Park	WA	98148
Craig	Baldwin	ND	Representative	Washington Ass			Seattle	WA	98112
Scott	Barnhart	MD	Medical Director	Harborview Hos			Seattle	WA	98104
Kris	Beatty		Assistant Staff,	Public Health - S			Seattle	WA	98104
Jim	Bender	MD		Virginia Mason			Seattle	WA	98111
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Fred	Connell		Associate Dean	University of Wa			Seattle	WA	
John	Daley		Executive Vice P	Bastyr University			Kenmore	WA	98028

[001]

First Name	Last Name	Suffix	Title	Organization	Address 1	Address 2	City	State	Zip Code
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Heike	Doyle	LM		Midwives Associ			Woodinville	WA	98072
Andy	Fallat		CEO	Evergreen Com			Kirkland	WA	98034
Maggi	Fimia		Councilmember,	King County Co			Seattle	WA	98104-3272
Ralph	Forquera		CEO	Seattle Indian H			Seattle	WA	98114
Bruce	Frickleton		Executive Direct	Washington Stat					
Peggy	Gerlock	RD		Washington Stat			Tacoma	WA	98498
Charle	Glock Jackson								
Gary	Goldbaum		Acting Director,	Public Health - S			Seattle	WA	98104
Josie	Gordon						Olympia	WA	98502-2607
Barbara	Grigsby	LMP	Representative	American Massa	(b)(6)		Lacey	WA	98503
Jane	Guiltinan	ND	Dean, Clinical Af	Bastyr Natural H			Seattle	WA	98102
Hanns	Haesslein	MD		Providence Seat			Seattle	WA	98124-1008
Maxine	Hayes	MD, MPH	State Health Offi	Washington Stat			Olympia	WA	98504-7890
Ron	Heifitz			Center for Public					
Judy	Huntington		Executive Direct	Washington Stat			Seattle	WA	98121
Christopher	Huson	LA.c.	President	Acupuncture As			Seattle	WA	98102
Carey	Jackson	MD	Medical Director,	Harborview Medi			Seattle	WA	
Larry	Jacobson		Consultant				Mercer Island	WA	98040
Larry	Jacobson								
Laura	James						Redmond	WA	98052

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First Name	Last Name	Suffix	Title	Organization	Address 1	Address 2	City	State	Zip Code
Bev	Jensen		Asst. to John Ca						
Elaine	Jong	MD	Director, Hall He	University of Wa			Seattle	WA	98195-4410
Susan	Kaetz		External Clinics	Northwest Institu			Seattle	WA	98103-8800
Gary	Kaplan	MD	Vice Chairman &	Virginia Mason			Seattle	WA	98111
Aaron	Katz		Director, Health	University of Wa			Seattle	WA	98195-4809
Richard C.	Kelley	PhD	Regional Directo	Department of H			Seattle	WA	98121
Leah	Kliger		Director, Integrat	Evergreen Com			Kirkland	WA	98034
Jan	Knutson		Director	Senior Services			Seattle	WA	98104
Richard	Layton	MD					Seattle	WA	98105
E. Houston	LeBrun		President	American Massa			Seattle	WA	98102
Rayburn	Lewis	MD	Medical Director	Providence Seat	(b)(6)		Seattle	WA	98124-1008
Ginger	Lewis	LMP		Renton Technic			Renton	WA	98056-4195
David	Lilley	MD		Regence Blue S			Seattle	WA	
Jeff	Livovich	MD		Aetna US Health			Seattle	WA	98101-1127
Mary	Looker			Washington Stat					
Richard	Lyons	MD	Regional Health	US Public Healt			Seattle	WA	98121
Geoffrey	MacPherson	MD		Pacificare of Wa			Mercer Island	WA	98040-9005
Lucia	Major			King County Dru					
Merrily	Manthey		Board Member,				Kent	WA	98035
Morgan	Martin	ND, LM	Chair, Midwifery	Bastyr University			Kenmore	WA	98028-4966
Robert	Martinez	ND		American Compl			Kirkland	WA	98033

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Karen	Matsuda	MN, RN	Deputy Regional	US Public Healt			Seattle	WA	98121
David	Matteson		Interim Director,	Bastyr University			Edmonds	WA	98020
Bob	May	ND		Alternare Health			Seattle	WA	98104-1614
Peter	McGough	MD		Washington Stat			Seattle	WA	98109-2549
Austin	McMillin	DC		Washington Stat			Tacoma	WA	98466
Kathy	McVay		Program Admini	Higher Educatio			Olympia	WA	98504-3430
Jim	Metz		Aide for Council	King County Co			Seattle	WA	98104-3272
Bruce	Milliman	ND	Representative	Washington Ass			Seattle	WA	98115-6464
Barbara	Mitchell	JD, LA.c	Executive Direct	National Acupun			Olalla	WA	98359
Chelle	Moat	MD					Sedro Woolley	WA	98284
Donald G.	Moe	MD, ABFP				(b)(6)	Edmonds	WA	98026-7610
Richard	Molteni	MD	Medical Director	Children's Hospit			Seattle	WA	98105-0371
Bob	Mootz	DC		Labor & Industri			Olympia	WA	98504-4321
JoAnne	Myers-Ciecko	MPH		Seattle Midwifer			Seattle	WA	98144-5104
Suzzanne	Nelson-Myer	MS, RD	Nuitrition Progra	Bastyr University			Kenmore	WA	98028-4966
Greg	Nickels		Councilmember,	King County Co			Seattle	WA	98104-3272
Robert	Nicoloff		Executive Direct	Department of H			Olympia	WA	98504-7870
Mark	Oberle	MD, MPH	Associate Dean	University of Wa			Seattle	WA	98195-7230
Beth	Oppliger			Utting School of			Seattle	WA	98103
Margaret	Pageler		Councilmember	Seattle City Cou			Seattle	WA	98104-1876
Laura	Patton	MD	Clinical Director,	Group Health Co			Seattle	WA	98124-1589

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First Name	Last Name	Suffix	Title	Organization	Address 1	Address 2	City	State	Zip Code
Maureen	Pence			Community Heal			Seattle	WA	98104-2891
Tom	Pendergrass	MD, MPH	Associate Profe	University of Wa			Seattle	WA	98195
Joseph	Pizzorno	ND	President	Bastyr University			Kenmore	WA	98028-4966
Alonzo	Plough	MD	Director of Healt	Public Health - S			Seattle	WA	98104-4039
Kent	Pullen		Councilmember,	King County Co			Seattle	WA	98104-3272
Sheila	Quinn						Mountlake Terra	WA	98043
Randy	Ravelle			Washington Hea					
Loren H.	Rex	DO					Edmonds	WA	98020
Susan	Rosen	LMP	Representative	American Massa			Olympia	WA	98506
Linda	Ruiz		Regional Admini	Health Care Fin			Seattle	WA	98121
Dawn	Schmidt		Director of Educ	Brenneke Schoo		(b)(6)	Seattle	WA	98109
Ron	Schneeweiss	MD	Professor, Depa	University of Wa			Seattle	WA	98105
Mary C.	Selecky		Secretary	Washington Stat			Olympia	WA	98504-7890
Deborah	Senn		Washington Stat	Washington Stat			Olympia	WA	98504-0255
Robert	Shook		President	Northwest Institu			Seattle	WA	98103-8800
Andrea	Skelly			Washington Stat			Seattle	WA	98101-1626
Don	Sloma	MPH	Executive Direct	Washington Stat			Olympia	WA	98504-7990
Debbie	Smith-Fedon	RN, BSN		United Health C			Seattle	WA	98101-1127
Pamela	Snider	ND	Associate Dean,	Bastyr University			Kenmore	WA	98028
Mark	Sollek	MD		Premera Blue Cr			Montlake Terrac	WA	98043-2124
Art	Sprenkle	MD		Qual Med Health			Bellevue	WA	98009-3387

[001]

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Eileen	Stretch	ND		American Whole			Seattle	WA	98109
Eugene	Sun	MD		Pacificare of Wa			Mercer Island	WA	98040-9005
Allen	Sussman	MD		Valley Medical C			Renton	WA	98055
Pat	Temple	MD		University of Wa			Seattle	WA	98102
Tom	Trompeter		Executive Direct	Community Heal			Kent	WA	98031
Fernando	Vega	MD		Seattle Healing			Seattle	WA	98115
Sue	Vermeulen		Executive Direct	King County Nur			Seattle	WA	98103
Patricia W.	Wahl	PhD	Dean	University of Wa			Seattle	WA	98195-7230
Ron	Weaver		Asst. Secretary f	Washington Stat			Olympia	WA	98504-7850
John	Weeks		Principal	Integration Strat			Seattle	WA	98116
Peter	West	MD		Blue Cross of W	(b)(6)		Mountlake Terra	WA	98043-2124
Melicent	Whinston	MD	Medical Director	Community Heal			Seattle	WA	98104-2891
Jim	White		Mayor	City of Kent			Kent	WA	98032
Richard	Whitten	MD	Medical Director	Health Care Aut			Olympia	WA	98504
Daryl	Williams	PhD		Bastyr University			Kenmore	WA	98028
Nancy Fugate	Woods	PhD, RN, FAAN	Dean, School of	University of Wa			Seattle	WA	98195-7260
Janet	Woods	PhD	Vice President, I	Bastyr University			Kenmore	WA	98011
Jonathon	Wright	MD							
Ze'ev	Young	MD	Northwest Medic	United Health C			Seattle	WA	98101-1127
Henry	Ziegler	MD, MPH					Bellevue	WA	98008
Karlene	Zimmerman		Aide for Council	King County Co			Seattle	WA	98104-3272

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ACUPUNCTURE & HERBS

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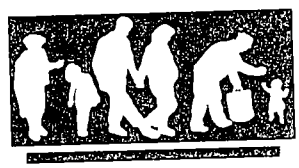
(206) 547-4583



COUNTRY
DOCTOR
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CLINIC

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Seattle, WA 98112
(206) 461-4503
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Brad Roter, MD
Family Physician

COUNTRY DOCTOR
community health centers

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Specialty Clinics. The specialty clinics provide a unique area of focus within the field of Chinese Medicine (e,g., Ion Pumping Cord, Internal Medicine, Neuro-Musculoskeletal and Acute Injury). We draw upon the unique techniques and skills of our clinical faculty to widen the perspective of acupuncture practice.

Observation Clinic. This clinic (previously called 'Grand Rounds Observation') offers students the opportunity to watch a Clinical Faculty member treating a patient, demonstrating appropriate patient-clinician interaction, inquiry, palpatory skills, diagnosis, treatment principles, treatment planning, and clean needle technique as well as appropriate point selection, herbs and other modalities.

COMMUNITY-BASED CLINICS

As a way of adding greater diversity to the student's leaming experience and to fulfill our commitment as an institution to community service and community partnerships, NIAOM has established an extensive network of external (off-campus) clinics. Students have the opportunity to provide acupuncture services within western-oriented medical hospitals, community health clinics, Seattle-area nursing homes, and the criminal-justice system, while learning to be integral members of the larger traditional health care system. These community-based external clinics provide over 12,000 treatments annually.

The **Asian Counseling and Referral Service** is a multicultural, multilingual clinic, located in the international district of Seattle. The ACRS provides a wide array of sliding-scale social and behavioral health services, including vocational and employment services. The ACRS serves Asians and Pacific Islanders who reside in Seattle and King County.

The **Bailey-Boushay House** is an adult therapeutic health care clinic oriented towards persons living with HIV/AIDS, while also treating other life-threatening illnesses. This clinic is one of the five Ryan-White funded clinics that provide an opportunity for Residents to provide free acupuncture for people living with HIV/AIDS.

Carolyn Downs Family Medical Center is a community-based clinic where families are able to receive coordinated medical, social, maternity and childcare services. The goal of the Carolyn Downs Family Medical Center is to provide families with low-cost primary health care options that include alternative medicine modalities, including acupuncture.

Cedar Hills Treatment Center is King County's only residential rehabilitation center. 5-Needle Protocol (ear acupuncture) forms the basis of treatment. Body needles are selected to treat a wide variety of symptoms ranging from insomnia, night sweating, cravings, PMS, low back and neck pain, to more chronic disorders. The atmosphere is pleasant with meditative music added to enhance relaxation during treatments.

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The **Homeless Youth Program** at the 45th Street Clinic is a multidisciplinary health care community clinic with a special programmatic focus on homeless or street-involved youth. NIAOM acupuncturists and students collaborate with primary care physicians, nurses, counselors, and naturopaths, to provide comprehensive and integrated care to this challenging group. Commonly addressed conditions include chemical dependency, chronic pain, anxiety and depression.

Harborview Medical Center is a major regional health care facility serving the Pacific Northwest and Alaska. The medical center's mission is to provide exemplary care, teaching, research and community service. The Harborview clinics, each with their own specialty, offer a unique opportunity to work within a western medical setting and provide participation in an integrative model.

- The **Harborview Chronic Fatigue** clinic specializes in cases of Chronic Fatigue Syndrome and Fibromyalgia

- The **Harborview Madison AIDS** clinic is a grant-funded clinic oriented towards persons living with HIV/AIDS.
- The **Harborview International Clinic** specializes in providing primary health care for people from many nations. Interpreter services are available, when necessary.

Mt. St. Vincent Nursing Center is a progressive nursing center founded by the Sisters of Providence, and is affiliated with Providence Hospital. Our partnership with Mt. St. Vincent provides students with the expe rience of working with elderly populations, providing a range of treatment modalities addressing both acute and chronic disorders.

North Rehab Facility is a minimum-security King County jail, with a Men's Wing and a Women's Wing. 5-Needle Protocol (ear acupuncture) forms the basis of treatment. Acupuncture is offered daily on weekdays. In 1999 we expanded our service at NRF to include whole body acupuncture. Each week there is a 4-hour clinic for men-only and a 4-hour clinic for women-only.

The **Seattle Gay Clinic** is a progressive, community-based health care clinic serving the gay community. Operating from the same location as the Country Doctor Clinic, the Seattle Gay Clinic offers patients HIV counseling and health-screening options, access to various social service programs, and the on-site alternative and general medicine health care treatments. Although students are not able at this time to intern at this clinic, Ryan White funding provides NIAOM post-graduate Residents with the opportunity to provide free acupuncture to people living with HIV/AIDS.

The **Kang Wen Clinic** is a community-based clinic that operates in a location provided by a local church. *Kang Wen* means, "Fight the Pestilence" and serves people living with HIV/AIDS. Kang Wen is funded primarily by outside sources, such as Ryan White funds, or donations. Practitioners are licensed acupuncturists and herbalists who provide service at low or no cost

Standards of Confidentiality

Many of the specific sections which follow address the concern of confidentiality; a general statement is appropriate here as well. Confidentiality is a key issues for all aspects of record-keeping, both medical and academic. It is expected that all associated with these clinics will honor the confidentiality of the relationships created between practitioner and patient, practitioner and practitioner, teacher and student, as well as student and student. In all these areas there is potential for breach of confidence and trust, as well as significant legal ramifications for disregarding this precept.

Clinic Requirements (Master of Acupuncture)

The following is a summary of the requirements students will need to meet in order to graduate and be eligible for NCCA diplomat status and Washington State acupuncture licensure (L.Ac.). (Note that 22 clinical hours equals 1 Quarter Credit)

A total of 40 credits (880 clinic hours) are required for graduation. This includes 8 credits (176 hours) of Observation and 32 credits (704 hours) of Internship.

Clinic Observation

Clinic Observation offers students the opportunity to participate in all facets of patient treatment other than needling. The intention is to provide students with a breadth of exposure to common treatment modalities in the course of varying types of clinical environments.

Prerequisites for beginning in clinic as an observer include the successful completion of the Clinic Observation Orientation, offered once each Fall Quarter. In addition each student must be enrolled in the Master of Acupuncture program, and in good academic standing with passage of Meridians & Points I and Fundamental Principles of TCM. (Approved transfer credit, granted on admission to program, may be substituted.)

Mgt Guidelines - Ultimate Responsibility of Pt -
- Primary Care Provider
- Guidance for Pt. Mgt.
How extensive is Western Training
medicine
middle real world vagaries of budget
- Deficits
- Financing
Immigrant, Indigent
- Reimbursement - for Underserved, Poor Population
- Accreditation & JCAH
- Inclusion of CAM Practitioners -
- Malpractice / Safety
Ac, MT,
~~Access~~ to Integrate
- Focus Diagnosis
- Covering Practitioner & Modalities
- Detox / NCI
- Mental Health - Depression / Suicidal
- 30 years
11,000 patients treated
2,000 new patients
4 - Family Drs
7 - PA, Nurse Practitioners

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COUNTRY DOCTOR

community health centers

Carolyn Downs
Family Medical Center

Country Doctor
Community Clinic

1999
ANNUAL REPORT

JCAHO
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Healthcare for the heart of Seattle

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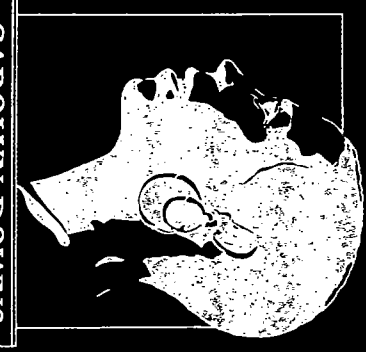
Carolyn Downs Family Medical Center
2101 E. Yesler Way
Seattle, WA 98122

If you have a friend or family member who may need health care, please pass this information along.



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A clinic of Country Doctor Community Health Centers

Working Together for the Health of Our Communities for Over 25 Years

Trabajando Juntos para la Salud de nuestras Comunidades por más de 25 Años

Joint Commission
on Accreditation of Healthcare Organizations

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Seattle, WA 98112

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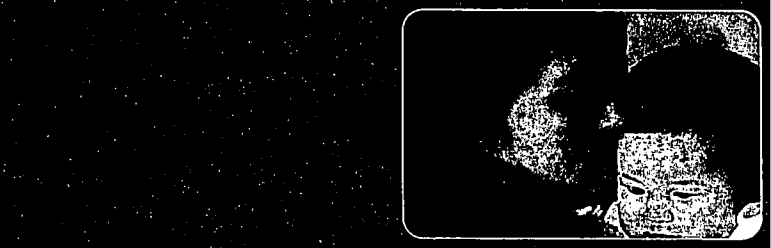

COUNTRY DOCTOR COMMUNITY CLINIC

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ធ្វើការជាមួយគ្នារើម្បីសុខមាលភាពរបស់
សហគមន៍យើងអស់
រយៈពេលជាង២៥ឆ្នាំ

Joint Commission
on Accreditation of Healthcare Organizations

#98

Thank you to the committee for holding these hearings.

My name is Paul Reilly. I am a naturopathic physician in practice for 15 years.

I currently work in an integrated cancer clinic where oncologists work shoulder to shoulder with naturopathic physicians and acupuncturists. I will limit my discussion to day to cancer.

Cancer will affect one American in three and cause the death of one in five. Despite 25 years of the war on cancer we have not significantly improved survival for the vast majority of cancers. 50% of those diagnosed with cancer will eventually die of their disease. Along the way they will suffer from multiple treatment-caused side effects and even worse, 1% will develop a treatment-induced secondary cancer.

CAM therapies can improve this dismal situation. They can increase response to treatment, reduce side effects, and prevent recurrences. For example the simple addition of melatonin to treatment for advanced cancers doubled response rates and 1 year survival over treatment without melatonin. Adding mushroom extracts to radiation quadrupled survival in advanced lung cancer patients.

Our experience at CTCA has confirmed these research results. Our patients have better quality of life and we see enough so-called "hopeless cases" turn around to convince us that CAM therapies are essential ingredients in cancer care.

The Journal of Clinical Oncology recently reported that 2/3 of cancer patients are using some form of CAM. They need help making good choices. NDs with their rigorous science-based training in natural therapies are uniquely qualified to provide the link between conventional oncology and CAM.

The federal government can help cancer patients in four ways:

1. RESEARCH DOLLARS: Provide increased funding to research CAM therapies in the field of oncology.

2. PATIENT CARE DOLLARS: Medicare, Medicaid, and all federal insurance programs should mandate coverage for CAM services during oncology care.

3. EDUCATIONAL DOLLARS: Support accredited CAM school to the same degree as all other medical training institutions, especially through supporting fledgling research departments.

4. EDUCATIONAL OPPORTUNITIES: Mandate that any hospital or medical institution which receives federal support permit students from all accredited health care schools, including CAM schools, to have access to training at those institutions. The cross-pollination of ideas will improve care for everyone.

Making changes such as this can speed the integration of cancer care and thus improve the lives of millions of Americans suffering from cancer.

Thank you.

Testimony of Dr. Jennifer Booker, Naturopathic Physician
White House Commission on Complementary and Alternative Medicine Policy
Oct. 31, 2000

My name is Jennifer Booker. I am a Naturopathic Physician and Chair of Practice Guidelines for the American Association of Naturopathic Physicians. Thankyou for this opportunity to speak. I will define Practice Guidelines, describe how they help fulfill the needs of this White House Commission and President Clinton's Executive order, and will urge this commission to support funding for this project.

Evidence based practice guidelines are statements used by health care providers and patients to make health care treatment decisions. These health care or practice guidelines will provide useful and reliable information to health care provides and patients about naturopathic medicine. These guidelines can also be used to define appropriate access and delivery of naturopathic medicine for health care systems.

We know practice guidelines are a good idea and will help everybody involved in delivery and in receiving health care. We also know they cost money to generate. Since the "every category of provider" mandate law, third party payers, health care policy makers and regulators in the state of WA have made it clear, after many meetings, that they want these guidelines for Naturopathic medicine, **but no one wants to pay for them.**

In the community of Conventional medicine, Cardiologists have developed Cardiac Rehabilitation Guidelines, which provide a good example of how guidelines are generated. The project was funded at $2.3 million from several sources, including government. They were peer driven and reviewed almost 900 articles. Overall it was concluded that diet, exercise and lifestyle change were the most effective interventions.

Naturopathic physicians can similarly produce high quality guidelines for diabetes, hypertension, high cholesterol and airway diseases, to name a few conditions of high concern to federal and state health agencies, **given the funding**. As primary care physicians we integrate, or utilize the tools of what is called alternative medicine, including diet, exercise, and lifestyle modification treatments in our practices on a daily basis .

I would recommend the federal government help us now with funding to create these guidelines. Help us to produce what everyone, including my profession, wants. High quality evidence based practice guidelines that are understandable and therefore useful for health care plans and delivery systems, for patients and for government decisions makers.

Peer driven and led Naturopathic medicine guidelines can extract, grade and organize the scientific literature which studies the modalities used by my profession. Easy to understand guidelines that describe our systematic use of evidenced based Naturopathic medicine serves the consumer, payer and health care educators, **and the needs of this White House Commission.**

My profession has worked hard over the last four years on a volunteer basis from a pool of already overly busy practitioners, and we cannot complete such a long and arduous task without funding. Please help us to help you, by supporting our efforts to achieve funding and complete practice guidelines for the nations most prevalent and expensive diseases.

Jennifer Booker N.D.
6326 Martin Way E., Ste. 205
Olympia WA 98516

Email: jenniferbooker@earthlink.net
Tel.: 360-491-2111

Chair: Practice Guidelines, American Association of Naturopathic Physicians


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5700 SW Spokane Street
Seattle, WA 98116

White House Commission on Complimentary and Alternative Medicine
Town Hall Meeting, Seattle, October 31, 2000

I'm Victoria Taylor, President of Quality Midwifery Associates, and provider of the only statewide quality assurance/risk management program in the country for midwives practicing in birth centers and the client's home. (Attachments 1 and 2)

Thank you for the opportunity to speak about quality assurance at this hearing.

While I am here to talk about quality assurance for midwives, most of these elements are applicable to any health care provider. When I use the term 'midwife' I am specifically referring to Licensed Midwives and Certified Professional Midwives, however, in Washington State, this term includes Certified Nurse-Midwives as well.

There are six legs of quality assurance that must be present in any profession for quality assurance and quality improvement to occur on a regular, profession-wide basis:

1. National certification and reciprocity for practitioners
2. Nationally accredited educational institutions
3. Outcome data collection and research
4. State protected confidentiality assurance for peer, incident and practice reviews
5. Guidelines and standards of care authored by the profession itself
6. Active professional association(s)

Of course, the starting point for any quality conversation has to be the legal practice of a profession nationally. Therefore, it is in the public interest to have it be legal for Certified Professional Midwives to practice midwifery in non-institutional settings in every state in the country and we want the commission to work towards that end. This is the first step in assuring quality care and safely fulfilling consumer demand for alternatives to basic hospital delivery for healthy pregnant women.

The presence of quality care in the midwifery profession is important to all CAM providers because Midwifery care itself is frequently a gateway to alternative care modalities and often the consumer's first encounter with viable alternatives to allopathic medical care.

When quality is present the consumer and the profession benefit in many ways. Some of the more obvious ones: safer care, increased consumer satisfaction and decreased risk of lawsuits due to avoidable poor outcomes.

Not so readily obvious, quality assurance is the hallmark of and further encourages a learning profession.

What midwives need from this commission:

1. Adopt the CPM credential and NARM standardized testing as national certification with resulting reciprocity of midwifery practice nationally.

2. Recommend that it be legal for Certified Professional Midwives to practice midwifery in birth centers and at the client's home in every state.

3. State or federal legislative protection for confidentiality of peer, practice and incident reviews for providers who practice in non-institutional settings.

4. Recommend that risk guidelines for consultation and referral, practice guidelines and content of care documents be developed by midwives and that this be done within their state or national professional associations and not by legislators or other health care practitioners unfamiliar with the midwifery process of care.

5. Support the collection and reporting of midwifery outcome data at the state and national level through funding of the already existing MANA statistical collection database.

Fostering many quality assurance pathways does more than protect the public – it increases consumer satisfaction with health care, minimizes risk of lawsuit for the provider and continues the development of professional standards of midwifery care.

Thank you for hearing my testimony.

BACKGROUND

QA/QI practices of Washington State midwives:

- Engage in midwifery practice site reviews and peer reviews
- Collect practice outcome data and report results annually (Attachment 2, pg3)
- Obtain CEU's for attending annual midwifery association conferences and other educational offerings
- Use Federal and Washington State rules and regulations (Attachment 3), the Midwives' Association of Washington State (MAWS) Standards for the Practice of Midwifery (Attachment 4), and midwifery journals as a guide to scope of practice
- Use MAWS Practice Guidelines for Risk Screening and Indications for Consultation and Referral for Out-of-Hospital Birth (Attachment 5)
- Submit a Current Plan for Consultation, Emergency Transfer and Transport to the Department of Health annually
- Develop and refer to their policy and procedure manual and protocol manual to guide clinical actions, communicate with other health care providers and further define scope of practice.
- Use written informed consents and client handouts to educate their clients and as an adjunct to discussion of possible tests or treatments.

Washington State rules and regulations (Attachment 3) **in support of midwifery care:**
(The first three rules and regulations apply to every licensed CAM provider).

- ✓ Confidentiality protection for participants in peer reviews in a non-institutional setting:
  Coordinated Quality Improvement Program RCW 43.70.510, RCW 70.41.200, Title 42, 34.05.482 and WAC 246-50

- ✓ Inclusion of every category of health care provider in basic health plan services:
  Every Category of Provider RCW 48.43.045

- ✓ Clear, strongly worded outline of elements of informed consent, written or oral:
  Informed Consent RCW 7.70.060

- ✓ Health care plans prohibited from restricting women's access to type of women's health care provider of their choice by asking for prior physician referral:
  Women's Health Care Services RCW 48.42.100

- ✓ Midwifery education and scope of practice for non-nurse midwives:
  Midwifery RCW 18.50 and WAC 246-834
  Legend Drugs and Devices WAC 308-115-250
  Use of Epinephrine and Magnesium Sulfate in Midwifery care

- ✓ Availability of medical malpractice insurance at physician level coverage ($1million/$3million):
  JUA for Midwifery and Birthing Centers Malpractice Insurance RCW 48.87 and WAC 284-87

What fostered collaboration among CAM providers, across public and private agencies and organizations.

- Collaboration was not engendered by any single activity or circumstance.
- The long-term presence of Seattle Midwifery School and its teaching relationship with Bastyr University faculty and students certainly laid the groundwork for cooperation among midwives and naturopathic physicians.
- Midwifery care itself is a gateway to alternative care.
- Midwives are committed to accountability for quality assurance within the midwifery profession and that strengthens our credibility with other providers. This is manifested in several ways:
  - A strong midwifery professional association
  - Midwives active in improving their individual practices and the midwifery profession
  - Midwifery association documents supporting quality care and defining scope of practice
  - Active participation by individual midwives in the legislative process.
- Active Office of the Insurance Commissioner - brought together CAM providers for a series of meetings to assist in the development of guidelines within each profession.

National professional associations that support quality and accountability in direct entry midwifery care.

1. The Midwives Alliance of North America (MANA), a national professional association with strong support for a variety of educational approaches to midwifery training.

2. The North American Registry of Midwives (NARM) developed and administers a national midwifery exam and issues the Certified Professional Midwife national certification, which is accepted in many states, including Washington, as the state-licensing exam.

3. The Midwifery Education and Accreditation Council (MEAC), accredits direct entry non-nurse midwifery educational institutions.

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002. resume	Victoria Taylor (partial) (1 page)	nd	b(6)

COLLECTION:
Federal Records
White House Commission on Complementary and Alternative Medicine Policy [WHCCAMP]

OA/Box Number: 43234

FOLDER TITLE:
Seattle Testimony and Talking Points [October 30-31, 2000] [3]

2011-0568-S
kc847

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

ATTACHMENT 1 - 2F

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Victoria M. Taylor, LM, CPM

5700 SW Spokane Street
Seattle, WA 98116
(206) 923-0866 (W) (b)(6)
(206) 923-1698 (Fax)
homemidwif@aol.com

Objective: To consult with and educate midwives in using risk management and quality improvement principles in the design and delivery of midwifery services regardless of setting, route of education or scope of practice. I am committed to the following for midwives: Quality improvement is not just what we do, it is who we are.

Professional Experience

Quality Midwifery Associates (QMA)
Seattle, WA
1995 to present

Owner and principal in a company specializing in the design and implementation of quality assurance and risk management programs for midwives in independent practice. Design and administer Professional Liability Reviews and site visits for all midwives who purchase malpractice insurance through the Joint Underwriting Association of Washington State. Assist in development of content of midwifery care documents, grievance process and quality assurance program at the request of the Midwives' Association of Washington State. Design and deliver courses on writing policy and procedure manuals and protocol manuals. Consult with other state midwifery organizations on the formation of their quality improvement programs. Worked with Providence Hospital in the initial development of hospital-privileging guidelines for Licensed Midwives in Washington State. Co-developed and delivered Non-Pharmacological Pain Relief Guideline for the Office of the Insurance Commissioner Complimentary and Alternative Provider/Managed Care meetings in 1998 and 1999. Guest lecturer addressing the business aspects of midwifery and quality assurance/risk management mechanisms for Seattle Midwifery School, Bastyr University, Portland Naturopathic College and Oregon School of Midwifery. Professional liability review workshop leader at Midwives' Association of Washington State and Midwives Alliance of North America annual conferences.

Home Midwifery Service
Vancouver, Washington
1993 to 1996

Owned and operated metropolitan midwifery practice delivering full scope maternity care for healthy pregnant women requesting home birth as an option. Actively promoted the availability and use of doulas for labor support and assisted in the formation of Doulas of Vancouver. Clinical Manager of Arlington Birth Center, Washington, while the owner was completing course work toward her CNM.

Bickson, Pitcher, Seeton & Co.
Toronto, Canada
1989 to 1991

Worked as a management consultant and coach to executives and managers of Fortune 500 Companies in Canada and the United States. Helped design and lead courses as well as provided coaching that enabled people to produce breakthroughs in their personal effectiveness and in achieving quantifiable bottom line financial results.

W.E. Foundation
Sausalito, CA
1987 to 1989

Keeler Motor Car Company
Latham, NY
1984 to 1987

Southeastern Otsego Health Center
Worcester, NY
1981 to 1982

Washington Hospital Center
Washington, DC
1978 to 1981

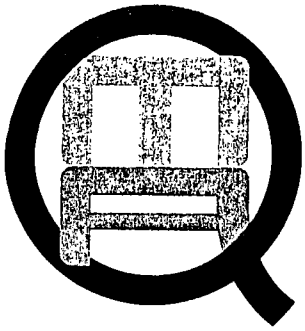
Maternity Center Associates
Bethesda, MD
1975 to 1981

Professional Associations

- *Board of Directors, Seattle Midwifery School*
- *Member: American Society for Quality*
- *Member: Midwives Alliance of North America, Midwives' Association of Washington State, National Association of Childbearing Centers, and Citizens for Midwifery*
- *Participant in numerous medical, midwifery, communication, business, and quality and risk management courses*
- *Produced educational events and courses for 50 to 100 people*

Education

- *Seattle Midwifery School, Seattle, WA; Licensed Midwife 1993, Certified Professional Midwife 1998*
- *Montgomery College, Takoma Park, MD; RN Degree, Phi Theta Kappa, 1978*
- *Howard University, Washington, DC; 1975-76 Toward BSN*



QUALITY
MIDWIFERY
ASSOCIATES

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(206) 923-0866
(206) 923-1698 Fax

PROFESSIONAL LIABILITY REVIEW SUMMARY

The Professional Liability Review (PLR) is a type of midwifery practice review that focuses on risk management and quality of care. This review was developed by Quality Midwifery Associates (QMA) in conjunction with the Midwives' Association of Washington State in order to meet the need of midwives in Washington for a comprehensive on-site practice review. The on-site PLR, using the National Committee on Quality Assurance accreditation standards as a guide, is designed to be conducted every third year. A Professional Liability Review is required of all midwives who purchase professional liability insurance through the Joint Underwriting Association (JUA) of Washington State. Washington Casualty Company and the Board of the JUA use the results of the review in determining eligibility for continued professional liability insurance coverage. The cost of the PLR in Washington for midwives in the JUA is covered by the midwife's annual premium.

The PLR is conducted when the following criteria are met:

- The Joint Underwriting Association (JUA) of Washington State and/or a professional liability insurance carrier contracting with QMA requests a formal review of the midwife's practice to meet the conditions for obtaining or continuing professional liability insurance; and/or,

- The individual midwife, electing to pay directly for the review, requests a formal risk management audit; and,

- The midwife agrees to release to Quality Midwifery Associates (QMA) information that QMA deems pertinent; and,

- The midwife agrees to hold QMA, its employees, directors, officers, contractors and agents harmless from any claims the midwife may have relating to QMA Professional Liability Reviews, and any reports and recommendations made by QMA relating thereto.

Victoria Taylor, LM, CPM
Revised: April 2, 1998; June 1, 1999; April 8, 2000

PR 1.0 FORMS

PR 1.1 Confirmation of Review Letter
PR 1.2 Self-Evaluation Tool (SET) consisting of the following forms and checklists:
- **1.2.0** Site Review Schedule Request
- **1.2.1** Document Checklist
- **1.2.2** Policy and Procedure Manual
- **1.2.3** Equipment
- **1.2.4** Medications
- **1.2.5** Supplies
- **1.2.6** Office/Clinic Site
- **1.2.7** Annual Statistics
- **1.2.8** Medical Record Review - single chart
- **1.2.9** SET Forms Checklist
- **1.2.10** Requirements for the Conduct of the Site Visit
- **1.2.11** Protocol Manual
- **1.2.12** Medical Record Review - 5 Chart Compilation
- **1.2.13** Recommendations Worksheet

PR 1.3 Post Review Evaluation of the PLR and the site reviewer

PR 2.0 THE REVIEW and THE REVIEWER

When requested as outlined above, a site review shall be performed by QMA. The Self-Evaluation Tool will be mailed to the midwife to be completed and returned fourteen (14) business days before the site visit. A QMA reviewer will review the SET before beginning the site visit to verify that the information, documents and data provided are current, complete and within the timeline specified for the review. The site reviewer, utilizing the SET previously submitted by the midwife under review, will then recheck items while on site for accuracy.

A minimum of five charts shall be randomly selected by the reviewer from the charts of clients delivered within the timeline specified for the review and shall include those reflecting significant morbidity or mortality. Additional charts may be reviewed at the discretion of the reviewer.

A succinct on-site verbal report shall be given at the conclusion of the Professional Liability Review. During the conference the site visitor shall review anticipated findings of fact regarding the midwife's quality related systems, risk management and midwifery practices, and records. The summation conference verifies the reviewer's findings and clarifies any inconsistencies in information with the midwife. The reviewer shall also inform the midwife if she expects to make further recommendations. The reviewer does not make a determination nor provide conclusions regarding the midwife's Professional Liability Review status or eligibility for malpractice insurance.

Victoria Taylor, LM, CPM
Revised: April 2, 1998; June 1, 1999; April 8, 2000, October 5, 2000

The senior reviewer at Quality Midwifery Associates is Victoria Taylor, CPM, a RN with OB hospital and physician office experience and a Licensed Midwife who was in private midwifery practice until 1996. She received training in conducting accreditation site reviews through the National Association of Childbearing Centers, has researched QA/QI issues since 1993, studied the accreditation review process designed by the National Committee for Quality Assurance and is a member of the American Society for Quality.

PR 3.0 DATA COLLECTION

Annual birth outcome statistics are to be made available before the site-visit and each year between site visits as requested. The data submitted for midwifery care provided in an out-of-hospital setting must include:

PR 3.1 Total number of undelivered clients in practice at start date
PR 3.2 Number of new clients accepted during the specified time
PR 3.3 Number of clients transferred/left AP for non-medical reasons
PR 3.4 Number of undelivered clients
PR 3.5 Number of delivered clients
PR 3.6 Number of clients transferred for medical reason antepartum
PR 3.7 Number transported to hospital intrapartum
PR 3.8 Reasons for maternal transport intrapartum
PR 3.9 Number transported to hospital postpartum
PR 3.10 Reasons for maternal transport postpartum
PR 3.11 Number of neonates transported; emergent/non emergent
PR 3.12 Reasons for neonatal transport
PR 3.13 Number of cases of neonatal mortality
PR 3.14 Number of cases of neonatal morbidity
PR 3.15 Number of cases of maternal mortality
PR 3.16 Number of cases of significant maternal morbidity

PR 4.0 PROFESSIONAL LIABILITY REVIEW REPORTS

A confidential copy of the report and any recommendations prepared by the site visitor, if a site visit was performed, or prepared after credentials, statistics and document review and update, shall be submitted to the JUA or a contracting professional liability insurance carrier, or to the midwife contracting as an individual, within 30 days of the review. A confidential copy of all reports and correspondence shall be kept in the midwife's file at the offices of Washington Casualty Company unless otherwise noted.

PR 5.0 MIDWIFE FILE

Midwives must agree to make the requested materials available to QMA for risk management purposes fourteen (14) business days before the scheduled PLR. The PLR recommendations are based on information received from the midwifery practice and do not necessarily address all areas needing improvement. The responsibility for risk assessment and undertaking improvements rests solely with the midwife under review.

PR 6.0 MIDWIFE APPEALS PROCESS

In Washington and states with a JUA, the midwife undergoing a Professional Liability Review may request that the Joint Underwriting Association reconsider any decisions and/or recommendation(s) of the professional liability insurance carrier that she/he feels are unfair or with which she/he is otherwise in disagreement. In the remaining states the appeals process will be consistent with the laws and arrangements of that state.

Victoria Taylor, LM, CPM
Revised: April 2, 1998; June 1, 1999; April 8, 2000, October 5, 2000

RCW Index

7.70.010-030	Actions for Injuries Resulting from Health Care
7.70.060	Consent Form – Contents – Prima facie evidence – Failure to Use
7.71	Health Care Peer Review
18.36	Naturopathy
18.50	Midwifery {includes **18.130** – Uniform Disciplinary Act; regulation of health care professionals}
18.79	Certified Nurse Midwives; Advanced Registered Nurse Practitioners
26.28.10	Age of Majority
26.44.030	Abuse of Children; reports – duty and authority to make
43.70.510; 70.41.200; Title 42; 34.05.482	Coordinated Quality Improvement Program
48.43.045	Every Category of Provider
48.42.100	Women's Health Care Services
48.87	Midwives and Birthing Centers – Joint Underwriting Association
49.17	Washington Industrial Safety & Health Act
70.02.030-120	Medical Records
70.24.090-095	Control and Treatment of Sexually Transmitted Diseases
70.24.310-330	Rules for AIDS Education and Training
70.42	Medical Test Sites
70.54.220	Practitioners to Provide Information on Prenatal Testing
70.58.070-080	Vital Statistics
70.58.320-322	Reports of Sentinel Defects
70.83.010-030	PKU & Other Preventable Heritable Disorders
70.95K	Biomedical Waste

WAC Index

ATTACHMENT A - 4/6

Midwives' Association of Washington State

Qualifications for Professional Membership

1. Active licensure to practice midwifery or nurse-midwifery in the State of Washington.

2. Compliance with legal requirements in Washington state for the practice of midwifery or nurse-midwifery.

3. Compliance with the Standards of Practice as defined by the professional organizations, the Midwives' Association of Washington State (MAWS) or the American College of Nurse-Midwives (ACNM).

4. Current certification in neonatal resuscitation by the American Academy of Pediatrics and the American Heart Association for all members practicing in an out-of-hospital birth setting.

Revised: August 1995

Midwives' Association of Washington State

Standards for the Practice of Midwifery

I. Practitioner

Midwifery Practice:

I.1 Occurs within the parameters of Washington state law.

I.2 Includes maintenance of currency of practice as evidenced by continuing education contact hours as required by the Midwives' Association of Washington State (MAWS) or the American College of Nurse-Midwives (ACNM).

I.3 Demonstrates knowledge, clinical skills and judgment as described in the MAWS Core Competencies for Basic Midwifery Practice or the ACNM Core Competencies for Basic Nurse-Midwifery Practice.

I.4 Fosters the delivery of safe, satisfying and economical maternity services and may extend to certain areas of gynecology, family planning and well baby care according to individual licensure.

I.5 Includes participation in a state sanctioned quality assurance/improvement program for the evaluation of midwives within the setting in which the practice occurs and within legal requirements.

I.6 Seeks consultation for medical conditions outside scope of practice and makes appropriate referrals.

I.7 Elicits client feedback to evaluate and modify clinical services.

I.8 Uses the MAWS or ACNM clinical practice mechanism for introducing new/unconventional clinical practices.

Revised: August 1995

2. ENVIRONMENT

MIDWIFERY PRACTICE:

2.1 MAINTAINS A SAFE ENVIRONMENT BY HAVING THE APPROPRIATE EQUIPMENT AVAILABLE INCLUDING THAT NEEDED TO ASSESS MATERNAL, FETAL AND NEWBORN WELL-BEING; EQUIPMENT AND SUPPLIES TO MAINTAIN CLEAN AND/OR ASEPTIC TECHNIQUE; ANTIHEMORRHAGIC AGENTS; AND, EMERGENCY RESUSCITATION EQUIPMENT.

2.2 ARRANGES FOR 24 HOUR CLINICAL COVERAGE FOR THE MIDWIFERY PRACTICE.

2.3 INCLUDES RISK FACTOR ASSESSMENT FOR INITIAL AND CONTINUING MIDWIFERY SERVICE FOR EACH CLIENT.

3. DOCUMENTATION

MIDWIFERY PRACTICE:

3.1 INCLUDES COMPLETE, ACCURATE, LEGIBLE, UP-TO-DATE AND CONFIDENTIAL RECORDS OF THE CLINICAL CARE PROVIDED BY THE MIDWIFE FOR EACH CLIENT. THESE SHALL BE MADE AVAILABLE TO APPROPRIATE HEALTH CARE PERSONNEL UPON CONSULTATION OR TRANSFER OF CARE. OTHER RECORDS, AS REQUIRED BY LAW, MAWS AND/OR ACNM SHALL BE MAINTAINED AS WELL.

3.2 INCLUDES A SET OF ESTABLISHED, WRITTEN PRACTICE GUIDELINES THAT ARE CONGRUENT WITH THE SCOPE OF PRACTICE AND STATE REGULATIONS FOR THE MIDWIFERY PROFESSION. PRACTICE GUIDELINES SHALL CONTAIN A CLEAR, WRITTEN PLAN FOR REFERRAL, CONSULTATION, HOSPITAL ACCESS AND TRANSFER.

4. CLIENT RELATIONS

MIDWIFERY PRACTICE:

4.1 PROVIDES INFORMED CONSENT AND UPHOLDS CONSUMERS' RIGHTS TO INFORMATION AND SELF-DETERMINATION.

4.2 PROVIDES ACCURATE INFORMATION REGARDING THE SCOPE OF MIDWIFERY PRACTICE, FINANCIAL CHARGES, MEDICAL CONSULTATION ARRANGEMENTS AND THE RIGHTS AND RESPONSIBILITIES OF THE CLIENT.

4.3 FOCUSES ON CHILDBEARING AS A FAMILY-CENTERED LIFE EXPERIENCE AND ENCOURAGES THE ACTIVE PARTICIPATION OF FAMILY MEMBERS IN CARE AS APPROPRIATE.

4.4 INCORPORATES EDUCATION IN CLINICAL CARE AS APPROPRIATE.

4.5 STRESSES CONSUMERS' RESPONSIBILITY FOR ACTIVE PARTICIPATION IN THEIR OWN HEALTH CARE.

4.6 PROVIDES AN AVENUE FOR RESOLVING CLIENT GRIEVANCES.

5. COMMUNITY RELATIONS

MIDWIFERY PRACTICE:

5.1 OCCURS AUTONOMOUSLY/INDEPENDENTLY AS A PROFESSION AND IS INTERDEPENDENT WITH OTHER PROFESSIONALS AND COMMUNITY RESOURCES IN ORDER TO REFER CLIENTS AND MEET THEIR MEDICAL, PSYCHOSOCIAL, ECONOMIC, CULTURAL OR FAMILY NEEDS.

5.2 RECOGNIZES THAT, FOR THE PROTECTION OF THE MOTHER AND INFANT, OR MIDWIFE/MIDWIFERY PROFESSION, IT IS THE RIGHT OF THE MIDWIFE TO REFUSE OR DISCONTINUE HER/HIS SERVICES, AND THE RESPONSIBILITY OF THE MIDWIFE TO MAKE THE APPROPRIATE REFERRALS FOR CONTINUATION OF CARE.

Midwives' Association of Washington State
c/o Seattle Midwifery School • 2524 16th Ave South, Room 300 Seattle, WA 98144
(206) 860-4120

PRACTICE GUIDELINES FOR RISK SCREENING AND INDICATIONS FOR CONSULTATION AND REFERRAL FOR OUT-OF-HOSPITAL BIRTH

Licensed Midwives and Certified Nurse Midwives are specialists in the normal childbearing cycle. When problems arise which deviate significantly from the normal prenatal, intrapartal or postpartum course, midwives consult with a physician regarding the client's care or, in some cases, refer the client to a physician.

Evaluation of the childbearing woman is an on-going process which begins during the initial prenatal consultation and continues through the completion of care in the postpartum period. Risk screening is the assessment of conditions which may indicate a deviation from normalcy and the identification of those conditions which require physician involvement. In making this assessment, a midwife relies on her training, skill, and clinical judgment. There are only a few conditions which are absolute contraindications to out-of-hospital birth. There are other conditions which individually or cumulatively may indicate a trend toward abnormality.

This document is representative and not an exhaustive list of the conditions that a midwife may encounter. This document is not meant to replace the clinical judgment or experience of the midwife. There may be variations based on agreements between individual midwives and their consulting physician. New clinical practices may be undertaken in adherence to the Midwives' Association of Washington State's *Mechanism for Introducing New/Unconventional Clinical Practice,* or the American College of Nurse Midwives' *Guidelines for the Incorporation of New Procedures into Nurse Midwifery Practice.*

I. Pre-existing Conditions

The following maternal conditions existing prior to the current pregnancy require that a physician be consulted and may require physician referral:

1. Cardiovascular Disease/Hypertension
2. Pulmonary Disease/Active tuberculosis/asthma if severe or uncontrolled by medication
3. Renal Disease
4. Hepatic Disorders
5. Endocrine Disorders
6. Significant Hematological Disorders
7. Collagen-Vascular Diseases
8. Neurologic Disorders
9. Cancer
10. Infectious Diseases; the treatment of which is beyond the midwife's scope of practice
11. Current alcoholism or abuse
12. Current drug addiction or abuse
13. Current severe psychiatric illness
14. Isoimmunization
15. Previous C-section with classical incision
16. Inadequate home environment/support structures for mother and infant
17. Other significant deviations from normal as assessed by the midwifery staff

IV. Postpartum Conditions

The following maternal conditions arising during postpartum require that a physician be consulted and may require physician referral.

1. Seizure
2. Significant hemorrhage not responsive to treatment
3. Sustained maternal vital sign instability
4. Uterine prolapse
5. Lacerations, repair of which is beyond midwife's level of expertise
6. Development of any of the conditions listed previously
7. Other significant deviations from normal as assessed by midwifery staff

V. Neonatal Conditions

The following conditions arising in a neonate require that a pediatric physician be consulted and may require referral.

1. Persistent respiratory distress
2. Persistent cardiac irregularities
3. Central cyanosis or pallor
4. Prolonged temperature instability
5. Prolonged glycemic instability
6. Seizure
7. Apgar score less than 7 at five minutes of age
8. Birth weight <2000 grams
9. Significant clinical evidence of prematurity
10. Significant jaundice or jaundice prior to 24 hours
11. Loss of >10% of birth weight/failure to thrive
12. Major apparent congenital anomalies
13. Birth injury requiring medical attention
14. Other significant deviations from normal as assessed by midwifery staff

II. Antepartum Conditions

The following conditions arising during current pregnancy require that a physician be consulted and may require physician referral:

1. Labor before the completion of 37 weeks gestation
2. Presentation other than vertex at term
3. Multiple gestation
4. Significant bleeding
5. Gestational Diabetes Mellitus uncontrolled by diet
6. Severe anemia
7. Evidence of PIH or pre-eclampsia
8. Documented IUGR
9. Thrombophlebitis
10. Known fetal anomalies or conditions affected by site of birth, with an infant compatible with life
11. Fetal demise after 12 completed weeks gestation
12. Abnormal fetal NST
13. Abnormal ultrasound findings
14. Isoimmunization
15. Documented placental abnormalities, or previa
16. Post-dates pregnancy (>42 completed weeks)
17. Positive HIV antibody test
18. Parent(s) ill prepared for out-of-hospital birth
19. Inability of client and midwife to come to an agreement regarding plan of care
20. Development of any of the conditions listed previously
21. Other significant deviations from normal as assessed by the midwifery staff

III. Intrapartum Conditions

The decision to transport at any time during labor or the postpartum period will be based on any serious deviations from the normal course of events. The following conditions arising during labor require that a physician be consulted and may require physician and/or hospital referral. It should be noted that in some intrapartum situations, because of time urgency, it may not be prudent to pause management long enough to seek physician consultation before management is given.

1. Abnormal fetal presentation
2. Maternal fever
3. Hypertension with or without additional signs or symptoms of pre-eclampsia
4. Thick meconium stained fluid with delivery not imminent
5. Persistent and/or severe fetal distress
6. Significant abnormal labor pattern in active labor
7. Abnormal bleeding
8. Maternal seizure
9. ROM > 24 hours with unknown or GBS+ status
10. Prolapsed cord
11. Anaphylaxis
12. Active genital herpes in labor
13. Adhered placenta or retained without bleeding
14. Client's desire for pain medication, consultation or referral
15. Development of any of the conditions listed previously
16. Other significant deviations from normal as assessed by the midwifery staff