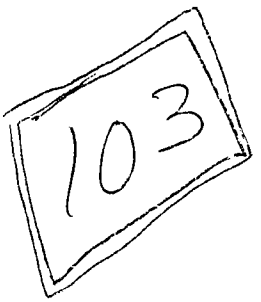

103

A Summary Discussion of Clinical Practice Guidelines and the Impact on Complementary and Alternative Care Providers

Austin McMillin, DC
Private Practice
Tacoma, Washington

Presentation before the
White House Commission on Complementary and Alternative Medicine (CAM)
Seattle, Washington
October 30, 2000

It is an honor and privilege to be invited to briefly offer my views regarding clinical practice guidelines and their impact on complementary and alternative care providers and care delivery. CAM services are clearly in demand in the health care marketplace, and thus far traditional care delivery and reimbursement systems have been struggling to determine how best to include CAM services into those systems. I am grateful to the members of the commission for their time and investigative commitment to help improve the role of complementary and alternative care delivery nationally.
The foundation for my comments includes 11 years of clinical experience in private practice; five years of work done with the State of Washington as a technical advisor for health care reform, with concurrent related studies of chiropractic procedures, descriptions, and value; private consulting regarding CAM services in the insurance arena; consulting work regarding the development and implementation of multidisciplinary practice guidelines; and participation in the Washington State Complementary and Alternative Medicine Clinician Workgroup where guidelines were a primary issue.

The primary intent of clinical guidelines is to integrate and assimilate the knowledge base about given conditions to improve overall patient care and successful outcomes of intervention. Secondarily, guidelines help to influence claim adjudication. They are intended to influence clinical decision making; however, it is difficult for traditional providers to make decisions about the appropriateness of CAM services, or integrate them into guidelines without a working knowledge about assessments and services in those settings. Without such knowledge, how is a traditional allopathic provider to know when to suspect that his patient might have problems with Chi that an acupuncturist may help, or a spinal subluxation that a chiropractor may help? The inability to determine how and when to refer patients cross-professionally into a CAM environment, coupled with lingering skepticisms, often results in no referral at all. This problem is much less prevalent with care coordination from CAM providers into allopathic settings. Theoretically, true multidisciplinary practice guidelines would facilitate proper referrals and care coordination between CAM and traditional provider groups.

Although good in their intent, guidelines pose several significant problems for CAM providers. These relate to the guideline development process, implementation, altering practice patterns of health care providers in general, and the impact of guidelines on policy and reimbursement. I believe that the Federal government can be instrumental in improving overall patient care by taking positive action in these areas.

Problems relating to guideline development:

Various clinical practice guidelines have been developed, revised, and redeveloped over the years in an effort to describe and improve care pathways for patients. The design of these care pathways has been necessarily condition-specific rather than provider-specific, and the vast majority have been put forth from traditional allopathic groups.

The first major problem lies within differing perspectives about the conditions for which guidelines are being developed, beginning with how each profession arrives at a diagnosis/impression. The most obvious example is apparent when comparing the diagnostic impression of acupuncturists as compared to traditional medical diagnoses. Not only are the assessment methods radically different, but reporting of the final impressions are not even remotely similar. It is challenging at best to discuss integrated guidelines of care with any meaning without developing new, common frames of reference that can be understood and agreeable to all providers. Without such a framework, guidelines are reduced to symptom management guidelines that are provider- specific and lack true integration of the range of care alternatives. Further, some CAM provider groups lack diagnostic authority under their scope of practices, and therefore have less direct influence over guideline recommendations relating to their professions. There is also a strong emphasis on health and wellness with CAM groups in general, and these concepts fall outside of condition-based guideline development.

With those guidelines that have been proposed, few have included CAM providers in the process of guideline development. As such, CAM procedures have been either been neglected entirely or inadequately represented within those pathways. There also has been a history of vocal cross-professional challenges to care pathways that recommend CAM-type procedures, such as in the case of the AHCPR Guidelines for the Treatment of Acute Low Back Pain in Adults. Further, opponents of one set of guidelines are free to develop care pathways that more adequately support their respective position. Treating providers are left wondering which guidelines are the more appropriate to follow.

Once invited to participate, CAM groups are often asked to "prove" their approach, ultimately as judged by the traditional medical profession.. Often the threshold for the level of evidence is quite high and overly rigid, excluding all but the most stringent study data. This is especially problematic for CAM providers. It is typical for them to be asked for randomized, controlled studies (RCTs) citing the efficacy of CAM procedures for them to be considered for inclusion. Studies of such magnitude have largely been lacking for CAM interventions, largely attributable to poor funding and research inexperience. Further, research is always subject to design imperfections and slanted interpretation. As evidenced by the CAM

Clinician Workgroup here in Washington State, CAM providers are solidly committed to working at improving the level and quality of information regarding their approaches, and interfacing with the traditional medical system. Absent RCT quality data, CAM providers have encouraged the use of other available information, such as case studies, clinical expertise, and concensus to develop "seed" pathways to encourage best practice strategies.

Guidelines overly slanted toward RCT bias while excluding other viable sources of practice information may be viewed as controversial and met with resistance by the various provider communities. In opposition are guidelines with an over reliance on theory or misrepresentation of available data, leaving them overly generalized leaving no clear influence on decision making or adjudication, and also ultimately controversial. For one reason or another, there is a lack of universal support for those guidelines that have been developed to date. Even though guideline development is a long, arduous, exhaustive, and expensive process, those in disagreement with the end result can abandon existing guidelines and create their own.
At the federal level, strong support of true multidisciplinary best practices (e.g.; those that are effective, have good outcome, are cost effective, and enjoy high patient satisfaction) will positively influence the guideline development process nationally. Resisting endorsing those with poor design or those that have neglected the input from stakeholders is an effective start. Improved funding to CAM provider groups earmarked for research would also be highly beneficial, as would support for multidisciplinary research efforts. It would also be beneficial to support ongoing task forces/agencies with diverse and unbiased multidisciplinary provider participation in guideline and practice recommendation development.

Problems relating to the logistics of implementation:

Currently, guidelines are developed, posted by supporting associations or constituents, and possibly posted at the National Guideline Clearinghouse. In rare cases, copies of Guidelines are made available to members of select professions, but not all groups effected by the guideline itself. They are simply made available. There is no actual plan of implementation into the provider community.

As clinical information becomes increasingly accessible and clinical problems, including those managed in CAM settings, are more highly scrutinized, practice guidelines will need to be rapidly modified to keep pace with new developments and greater levels of understanding. Intuitively, practice recommendations need to rely contemporary thinking, yet there is no reliable process in place to ensure that guidelines are regularly revisited once created. Additionally, given all of the possible conditions for which practice guidelines could be conceivably developed, dissemination to all stakeholders becomes potentially monumental.

I would encourage either Federal support to commit agency resources to multidisciplinary guidelines development, such as that formerly in place under the

Agency for Health Care Policy and Research, or support for guideline development privately in academia. The range of CAM provider input is vital. Either avenue could avoid political slowing of guideline development processes and revisions. Efficiency of information dissemination could be achieved through electronic exchange, and "packaging" multiple guidelines together in care pathway algorithms. Ultimately, base guidelines and revisions need to be disseminated to all stakeholders.

Lastly, there should be some process to accumulate actual provider feedback over time in an effort to improve initial recommendations and reduce undue burden on providers.

Problems relating to altering past practice patterns:

There is ample evidence to suggest that the practice patterns of individual care providers is difficult to change. Just because a guideline is published does not necessarily mean that it will have any subsequent impact on patient care delivery. The chiropractic profession saw this first hand after the publishing of the AHCPR Guidelines for Acute Low Back Pain in Adults. Given the high statistics of presentations to physicians for low back pain in the general population, one would have expected there to have been a sharp rise in the volume of referrals to chiropractic providers for care including spinal manipulative or adjustive therapy, and rehabilitative exercise and reactivation. Yet most chiropractors saw little if any change in incoming medical referrals.

Failure to modify practice behavior regarding CAM services is thought to be attributable to case management habits, poor education about CAM providers and services, and mistrust due to lack of communication or personal relationship building.

Although Federal influence may not be able to build personal relationships, it may help promote an environment with will facilitate improved interprofessional relations. Funding for education at both the pre-doctorate and post-graduate levels is an important first step, especially as it relates to interprofessional interaction with CAM groups by traditional allopathic providers. Advancing interprofessional skills can be accomplished by integrating protocol and communication strategies within competency and licensure testing. Additionally, developing incentives to promote "best practice" care pathways that include CAM options and allow patients to pursue CAM care if it is their preference will help open the door to more

practice

developed.

Challenges relating to policy and reimbursement:

By far, one of the greatest dilemmas is how to successfully use guidelines to set policy and reimbursement strategies. The Federal government clearly sets precedent in this area, as state and private institutions look to action and policy set at the national level as their template for local policy. In working with the Techni Advisory Group for Washington State Health Care Reform RBRVS Steering Committee, we frequently received reports of national policy prior to considering

what to do with our local policy decisions. The private payer community also looks to national policy to design coverage and reimbursement limitations.

Because of the influence the Federal government has over the rest of the adjudication and administration arenas, great care need to be exercised when supporting specific guidelines. Full explanations need to be offered regarding guideline selection, interpretation, and use.

Perhaps even more fundamentally, strong support at the Federal level for equitable benefits and coverage consistent with CAM scopes of practice is vital. Even if guidelines are developed showing favorable integration and use of CAM services, access will be limited or even discouraged with continued poor and inequitable reimbursement policies.

Of the guidelines that are present today, many have been used by the payers and policymakers to override the clinical judgment of the provider, as though the guideline has predicted ever practice presentation permutation. There have also been attempts at suggesting that guidelines imply a standard of care, and that practices outside the guideline should be subject to punitive action, despite the fact that clinical guidelines capture only the most common encounters and fail to capture the range of more complicated "outlier-type" presentations. An example that applies to my own profession again can be shown with the AHCPR Guidelines for Acute Low Back Pain in Adults. In that guideline, recommendations are made for acute back pain, most case of which are said to resolve in 6 weeks. The guideline cautioned against major signs of greater problem, and failed to make specific recommendations for those cases that, in fact, did not resolve according to the guideline. It is exactly these unresolved. Case that are so costly to our society. It also failed to comment on recurrences, which are common. And after guideline publication, intermediate level complicating factors, referred to as "yellow flags" were put forth with no integration into the initial guideline. It was not helpful that the commissioning agency was eliminated in the interim. Providers were left to manage for themselves without guidance.

It would be extremely beneficial for the Federal government to support fair and equitable coverage of services for all providers, and ensure equal reimbursement for services of essentially the same nature. Finally, it should be acknowledged that policy is often difficult to change once set, and therefore caution and formal process should be exercised in all policy development processes.

#105

Sheila Quinn
Town Hall Meeting, Seattle, WA
October 30-31

ACCOUNTABILITY in an IMPERFECT WORLD

- DATA/RESEARCH
  Controlled clinical trials, bench research, outcomes research, patient satisfaction measures, utilization data, cost effectiveness data, health services and field research, best cases data
- CREDENTIALS
  Professional education, accreditation, testing for board exams and certification, specialty training, continuing education
- GOVERNMENTAL REGULATION
  Certification, registration, licensure, peer review, scope of practice, public health laws, OSHA laws
- PROFESSIONAL SELF-REGULATION
  Association eligibility criteria, peer review for complaints, position papers, expert consensus, continuing education, specialty training, practice guidelines, clinical standards, quality improvement plans
- TRUST AND ETHICS
  Patient-provider relationship and communication; ethical practices training and ethics review processes
- PRINCIPLES AND PHILOSOPHY
  Significantly better patient outcomes with providers trained in whole systems than with providers trained in modalities only (acupuncture research)
- FREQUENCY OF PROVIDER USE OF DIAGNOSTIC AND TREATMENT TECHNIQUES
  Higher frequency generally improves provider performance and patient outcomes for certain procedures and services.
- PROFESSIONAL LIABILITY RECORDS
  Malpractice claims, licensing board complaints, state association complaint history

Bruce Millman
~~Land Navigator~~
Ray will navigate
you to Country
Doc Steve, Bruce, Ming,
Veronica, Chris
(Gerry will have to come w/ me...)

Are there 4 or 5 people
we should really
recognize for their
efforts at the end of
the meeting, a minute
each for them to say
something? Sheila,
Laurel, Pam, Thats it.

110. David A. Butters, DC

111. Christopher Huson, LAc
Acupuncture Association of Washington

QUESTIONS FROM COMMISSIONERS

112. ERICA OBERG - STUDENT -

1:15 p.m. - 2:00 p.m. 113. KAYCIE ROSEN - STUDENT -

114. JOHN BRIGANTI - MAHARISHI VEDIC APPROACH TO HEALTH

Walk-in (On-site Registrants in the order received and at the discretion of the Chair)

2:00 p.m. ADJOURN

115. BRIAN FENNEN
AMER. ASSOC OF ORIENTAL MEDICINE

116. DONALD DOWNING
WASHINGTON ~~STATE~~ PHARMACISTS ASSOC

- The White House Commission on Complementary and Alternative Medicine Policy thanks you for your participation in this Town Hall Meeting. In 3-4 weeks, a transcript of these proceedings will be available on our website:

117. RICHARD WARNER - CITIZENS COMMISSION ON HUMAN RIGHTS

http://www.whccamp.hhs.gov

118. JANE SAXTON - STUDENT

- You are invited to submit written comments at these sessions, or to send them to us by logging onto our website. More information about our activities, including other Town Hall Meetings, also can be found on our website.

119. JUDY ZEIGLER - STUDENT

120. TUCKER MEAGER - STUDENT

121. DOUG NORDSTROM (Comments)
AMERICAN CHIROPRACTIC ASSOCIATION

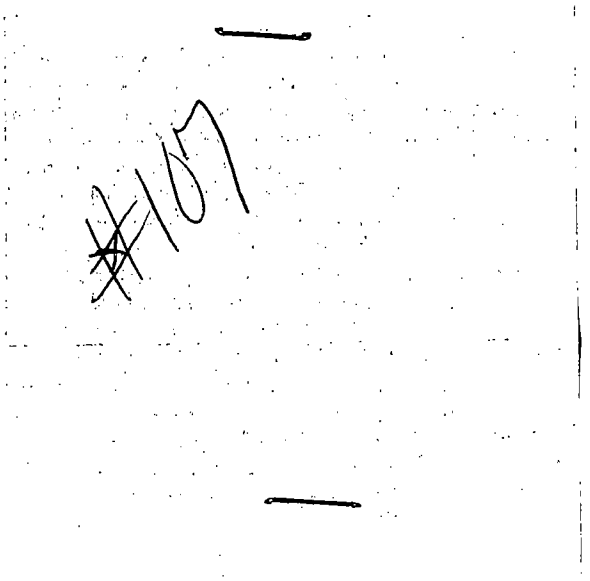
122. MERRILY MANTHEY

* Scheduled times listed here are estimated. Speakers are asked to be present in the Hall at least 20 minutes before their panel is called.

end up where we are
Starting with
Opportunity for

Complexity of Issues
Report Writing

As I said in my opening remarks. We need you to educate us
Without you, we don't know & we don't grow.


#107

MEDICAL
ACUPUNCTURE
Research
FOUNDATION

Comments by the President: James K. Rotchford, MD MPH
To the White House Commission on Complementary and Alternative Medicine Policy (WHCCAMP)
Seattle Town Meeting: October 31st 2000

MARF Background (Please see attached detailed information sheet)

1. Research arm of the American Academy of Medical Acupuncture an organization of over 1700 licensed physicians who have integrated medical acupuncture into their clinical practices.

2. Has played an important role as advocate to research regarding acupuncture:

a. Has convened several major research conferences.

b. Annual Research contest
   i. $10,000 in awards

c. Instrumental in establishing annotated bibliography of acupuncture references. It's work was instrumental in the formulation of the bibliography for the1997NIH consensus conference on Acupuncture.

d. Published grant resources available for those interested in research in Acupuncture.

e. Advises AAMA members interested in research endeavors.

3. Online **MARF Database of Acupuncture References**
   a. WWW.ACUBRIEFS.COM
      i. Over 12,000 citations
      ii. Many of the references from generallly non-indexed journals have annotated abstracts
      iii. Monthly annotated abstracts of current literature published in subscription free newsletter. Visit www.acubriefs.com

RESEARCH STRATEGIES:
1. Emphasize outcome studies.
   a. We are too ignorant of specific mechanisms involved.
   b. Specific Mechanisms are not what we need to initially pursue.
   c. Process and Context may be defining issues.
   d. We might find consensus with regard to what constitutes a favorable outcome. Outcomes/observations should drive process/theoretical models, not vice versa.
2. How one defines the problem has implications on what solutions will be found.
   a. Example Osteoarthritis
3. Problem with definitions
   a. imprecise: Acupuncture

(Over)

5820 Wilshire Blvd.
Suite 500
Los Angeles
California 90036

323.937.5514
323.937.0959 FAX

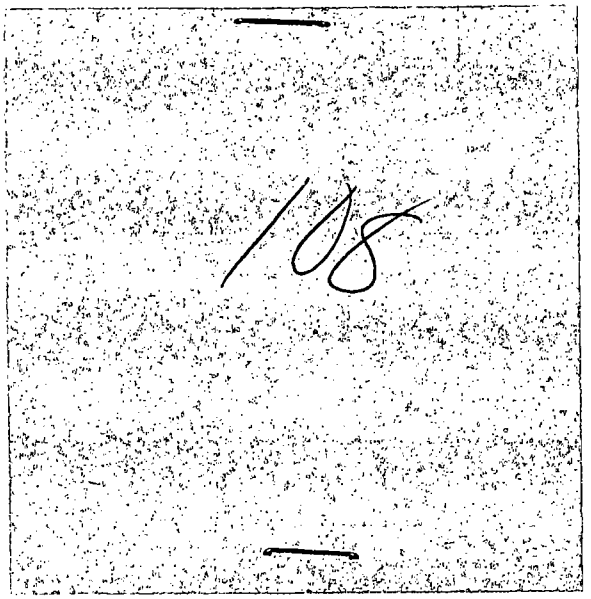
b. confounding: Placebo Effect
c. adverse event: Subjective/contextual especially in non-linear models of medicine.

4. Recommend randomized studies comparing head to head different alternative and complementary approaches as adjunctive to standard medical care with regard to common presenting "symptoms". My "belief" is that all the interventions are best in the context of patients benefitting from the best of all worlds if evidence supports such. Also medical doctors are more likely to make objective diagnoses that would enhance the eventual interpretation of the data. Also medical doctors are more likely to be part of large institutions where such studies could be done.

Example: All adult patients presenting to outpatient clinics for knee pain would be randomized to standard western medical care and physical therapy, standard care and practitioner of acupuncture, standard care and practitioner of homeopathy, standard care and practitioner of naturopathy, standard care and practitioner of chiropractic. This study would be preceded by pilot studies to assure that there is no major variation amongst outcomes of practitioners within each group. If significant variations present, practitioners would be selected based on their background, style of practice, and likelihood of being helpful. No practitioner would be required to do anything specifically. They could choose to see the patient daily if they felt the condition warranted it and was part of their standard of care. On the other hand if the patient went to see let's say the chiropractor and the chiropractor felt there was nothing they could do for the individual's knee then OK. Outcomes at 4, 8, 26, and 52 weeks would be evaluated using reliable and valid outcome measures for pain and disability. Direct costs as well as indirect costs to patients would be included eg: Number of visits, extra travel, etc.. I think compliance is an important variable as well.

Once we get a better idea of what works then we can start to design studies which start to answer why?

JK Rotchford, MD, MPH
President of MARF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Good ~~morning~~ afternoon. I'd like to thank the Commission for inviting me to present testimony today. My name is Mitchell Stargrove, I'm a naturopathic physician and acupuncturist with a private practice in Beaverton, Oregon. I'm also the Founder and Chief Medical Officer of Integrative Medical Arts Group, Inc., a market leading electronic publisher of information on CAM therapies and herbal interactions.

Thanks to the advent of the Internet, consumers are educating themselves about CAM so fast that their physicians have a hard time keeping up. Consumers want to know which therapies and supplements can complement their conventional treatments or when used preventatively will mitigate potential disease risk. Their quest for a full spectrum of care, from advanced medical technologies to complementary approaches has never been more active. Most consumers indicate that they want their doctors to advise them on the use and risks of these alternative options. Unfortunately today, due to the lack of knowledge among conventional physicians about these therapies, we find consumers turning to a wide variety of information resources with friends and family topping the list.

Today, information available to the public about what has interchangeably been termed natural or complementary and more recently integrative medicine is fragmented, inconsistent and incomplete. Unlike conventional medicine, which has always been founded on scientific evidence, CAM incorporates healing modalities from around the world, many of which pre-date the emergence of mechanical or western medicine in the ~~late 1800's~~ early 1900's. Despite this information void, CAM continues to be among the fastest growing health care ~~spaces~~ approaches worldwide. Looking forward however, CAM must cross the threshold into mainstream practice, and to drive that change we in the CAM community must take active measures to unify, validate and standardize the information resources

available to the public. We must transform our system from two competing forms of medicine, to one integrated form of wholeperson care, which recognizes a common framework of scientific evidence and quality of care.

At IMA, we have defined three initiatives that can help us reach this goal:

1. Promoting communication between patients and their health care providers about the use of alternative therapies;
2. Educating practitioners and consumers about efficacy of and research on natural medicine; and
3. ~~Promoting~~ Facilitating collaboration among various types of professionals in the health care system.

All of our work attempts to address these initiatives. First, IMA has developed a comprehensive CAM database, the Integrative BodyMind Information System, or *IBIS*. This is the first and most comprehensive CAM database to be developed by uniting clinical practice and scientific evidence. But in order for such databases to succeed, they *must* earn the trust of doctors, practitioners and patients alike, by clearly communicating the level and limitations of scientific and clinical research behind all of the information, and by providing tools to confirm the validity of the clinical options they offer. IBIS begins to address these issues by incorporating a Patients and Visits module for recording outcomes of multifactorial clinical interventions. These functions need to be improved and extended onto the Internet as a patient records and outcomes research data-gathering tool.

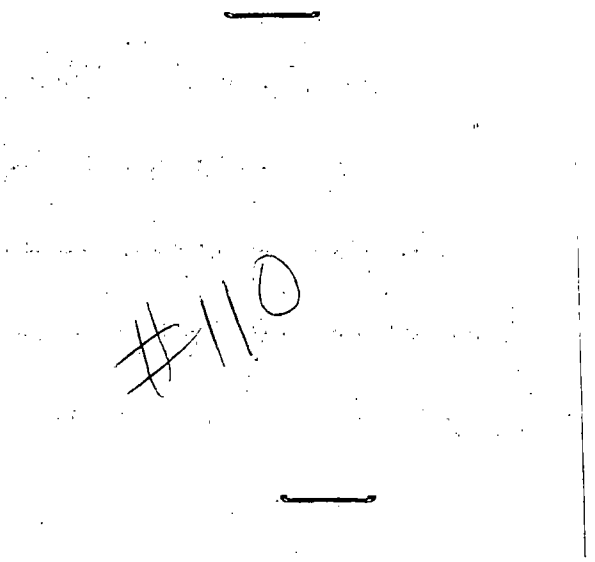
Recent media scrutiny of the popular herb Saint John's Wort and its interactions with some protease inhibitors used to treat HIV is a prime example of the pitfalls of incomplete and inconsistent information resources in the CAM space. To answer this concern IMA has created, and is continuing to develop a database of interactions and adverse reactions involving herbs and nutritional supplements. The database, called simply *Interactions*, represents a thorough compilation of data on drug-herb and drug-nutrient interaction, designed to help both practitioners and consumers determine areas of concern, assess the relative strength of relevant literature, and the practical implications of the potential interactions. It's imperative that this database, and others like it, continuously grow in size and substance as we extend our research and stay current with the scientific and medical literature.

A critical path to spur this expansion is through events reporting. In researching the medical literature on interactions we found that too many citations were based on very small studies, individual case reports, and downright erroneous or incomplete data. As a result, we built a tool that enables patients and practitioners to report interactions and adverse events involving herbs and nutritional supplements. We've launched a parallel website at InteractionReport.org to provide access to resources on interactions issues, tools for reporting potential events, and an archived Q&A forum. We have since invited academic institutions, organizations of health care professionals, and natural products businesses to join a consortium around this resource.

In order for the emerging paradigm of integrative medicine to take root, it is essential that we raise the standard of information available to doctors, practitioners and patients, to the same level of consistency, accuracy and integrity found in conventional Western medicine.

Through IBIS and Interactions, we have begun this process, working to provide up-to-date, scientifically-based clinical information to enable health care providers to understand and implement elements of natural medicine practice. Furthermore, sophisticated tools must be developed to gather and analyze data to help us determine efficacy and refine clinical practice. Likewise, we must build resources, such as InteractionReport.org, to help gather new information on interactions and adverse reactions and promote communication and collaboration around these pivotal issues of safety and effectiveness.

Information is the key to proving the medical arts of CAM should stand next to, not behind, conventional Western practice.


#110

David A. Butters, D.C., P.S.

Dr. David A. Butters, Dr. Eric D. Hansen
5201 M.L. King Jr. Way S.
Seattle, WA 98118

Phone: (206)723-2820
Fax: (206)722-3664

Good afternoon. My name is David Butters. I am a chiropractor and I have practiced in the Seattle area for over 25 years. I appreciate the opportunity to offer some brief remarks at this meeting and wish to thank the Metropolitan King County Commission for the invitation to be here.

Our population has voiced its desire for a new approach to health care with its unprecedented embrace of what has come to be known as "alternative care". I see three key advantages for the public in an expanded health care system with significant alternative care elements in this country:

1. The definition of health in America has changed and this change has resulted in the evolution of mind-body-spirit related health care. We have an opportunity to fashion a system for the 21st century and beyond that embraces the needs of this new definition. If the health care system fails to address these needs it will be set aside as an anachronism of the 20th century.

2. Health care must be delivered in an atmosphere of fiscal responsibility. Cost effectiveness must be examined in the context of quality of life as opposed to a dose specific view of health care and its outcomes. The cost replacement value of alternative care must be evaluated and understood.

3. Policy making in health care in America must reflect the spectrum of health care providers and of health care consumers. Health care in the 21st century will be a balanced equation not a continuum of the patriarchal model we have known in America.

I am concerned about the future of health care in the United States as you are but as a result of my role in health care delivery as an "alternative provider" I think I can offer you some cautions regarding pitfalls that lie before you, please consider:

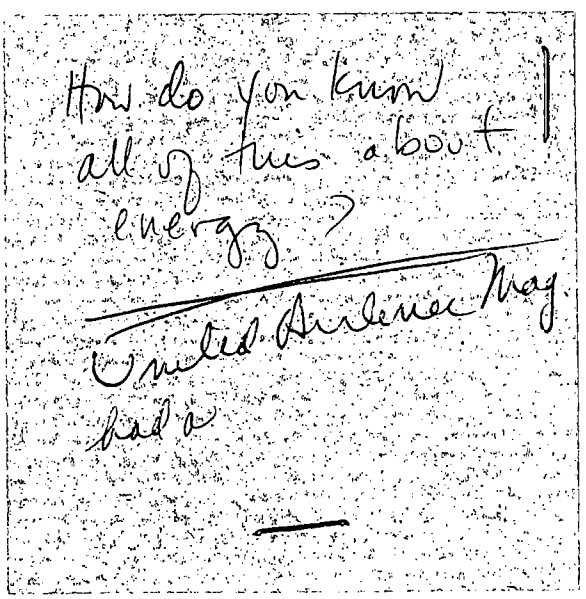
1. The thought that health care equals the practice of medicine and that other systems and approaches can be reduced to a subset of medicine is folly. For all the good biomedicine has accomplished it has failed to meet the needs of health care consumers. For example, if spinal adjusting or acupuncture are added to the armamentarium of medicine without understanding the systems that form the foundation for each approach, it will be a waste of time failing to capture the greatest good offered by either system.

2. The public is calling for recognition of different systems of health care and the delivery of that care by the most qualified within each system. A general surgeon could perform a heart by-pass but would you want to receive it from a generalist or a specialist? Alternative care providers have developed unique skills in applying specialized forms of care that should unquestionably be provided by the most qualified persons available.

3. Policy discussions must include providers of alternative care. Relying on medical physicians, who generally do not understand and appreciate the interface of various forms of alternative care, in which they are not primarily trained will simply result in a "same song, different verse" outcome.

On behalf of the men and women who long to have a greater opportunity to assist in the improvement of the human condition in America and on behalf of the persons who desire that improvement in their lives I thank you.

#78


How do you know
all of this about
energy?
United Airlines Mag
had a

Homeopathy in the United States

Jennifer Jacobs, MD, MPH, Department of Epidemiology, University of Washington, Seattle

I am a conventionally trained family physician who has been using homeopathy in my practice for nearly 25 years. I also do clinical research in homeopathy at UW. I have seen many patients helped by this practice, without the high cost and dangerous side effects of conventional medications. I believe that the best way for homeopathy and other CAM modalities to be integrated into the health care system is to train physicians like myself to use it in their medical practices.

Homeopathy is the primary CAM modality being used in Europe. In the US, the use of homeopathy has increased five-fold in the past 10 years. Homeopathy is used mostly by upper-middle class patients for chronic health problems not helped by conventional medicine.

Except for three states, there is no specific license in homeopathy. Homeopathy is practiced by a wide variety of licensed providers including MD's and DO's, PA's and nurse practitioners, chiropractors, and naturopaths. There are a growing number of non-licensed homeopathic practitioners, whose legal status is undetermined. There are three certification boards for homeopathy, one for the medically licensed, one for naturopaths, and one that is open to all. Some health insurance companies offer optional coverage for homeopathy, but most patients pay out of pocket.

Homeopathy is not taught in any US medical schools, although it is often included in courses on CAM and it is taught in naturopathic schools. Most practitioners study homeopathy in postgraduate courses run by private institutions. The American Institute of Homeopathy is the professional organization for medically trained homeopaths and sponsors educational programs, research, and interfaces with government agencies.

Research opportunities for homeopathy in the US are few, due to the generic nature of the medicines, which cannot be patented. The NIH has funded several homeopathic studies and is now requesting new proposals for funding. Currently, I am heading up a study of homeopathy for hot flashes in breast cancer patients funded by the Department of Defense at Providence Medical Center in Seattle.

Actions that can improve access to homeopathy include:

1) Establish Departments of CAM in medical schools and residency programs where homeopathy can be taught
2) Cost effectiveness research to document the 15% cost savings of homeopathic physicians in France
3) Reimbursement policies that allow adequate time for homeopathic consultations
4) Inclusion of homeopathy in low-income clinics
5) Hospital privileges for homeopathic physicians
6) Licensing of non-medically trained homeopaths, to work legally under the supervision of a physician

As the President of the American Institute of Homeopathy, I hope to speak with you in more depth at a later meeting.

#122

White House Commission on Complementary and Alternative Medicine Policy

Town Hall Meeting
October 30-31, 2000

Statement of

Merrily Manthey, MS

My name is Merrily Manthey.

A special thank you to Chair Gordon for allowing me to speak before this Commission today.

Special greetings to Commission Members and congratulations on being selected for this all-important role.

I guess by now you realize you've been exposed to the GROUND ZERO for 21st Century medicine.

I am the initiator (some refer to me as the "Godmother") of the landmark King County Natural Medicine Clinic in Kent, Washington. It is true, I developed the idea for the highly-publicized and successful clinic and I assembled the initial team of experts who, through their compelling testimony, convinced the policy makers to unanimously endorse the creation of the first clinic of its kind in the US. The policymakers, through their leadership, created the circumstances for providing access to effective, natural treatments for the underserved population in King County ... and by so doing, created a model for publicly-funded integrative clinics that is the equivalent of breaking the four-minute mile ... and being duplicated throughout the country.

As you have discovered throughout this Town Hall Meeting, many brilliant leaders have helped bring this outstanding model of the best of both worlds to reality. Without them, my idea would have remained simply an idea.

With that said,

As one who has worked for the recent passage by the King County Council of the mental health accountability and measurement ordinance sponsored by Dr. Kent Pullen,

As one who created and produced the award-winning film, "A Message of Hope," featuring natural treatments for the treatment of mental conditions,

As one who has known nearly 30 years and has worked with Dr. Abram Hoffer, MD, Ph.D., pioneer of orthomolecular treatment for bi-polar and schizophrenia,

As one who brought actor Margot Kidder to Seattle in support of the recent mental health ordinance to tell of her model recovery using natural treatments after 30 years of failed conventional approaches,

As one who is the only person in the US is on a nationally-respected teaching hospital and medical center board, Harborview, and was on the board of Bastyr University at the same time,

As one who is presently starting my 9th year as a member of Harborview Board of Trustees and has urged such research as our exciting antioxidant study for trauma patients in the ER,

As a clinician working 30 years in my private clinic,

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As a pioneer in teaching Stress Management concepts and application, who, nearly 30 years ago, initiated and taught the first course on managing stress in the State of Washington college system ... trained as a psychotherapist using principles of psychology, biofeedback, meditation, optimum lifestyle;

As an educator, producer of videos, handbooks, and general all-round busy body,

I see great opportunity for a revolution in mental health through the advocacy of this commission.

When the experts tell us that mental health issues have a basis in the individual's biochemistry, it's easy to see how natural medicine is so logical for the mental health world. Yet, when you ask mental health professionals what tests they ran for each client to determine the individual biochemical situation that could be causative and/or contributory, they stare blankly. Candace Pert reminds us it's "Body/Mind" and not the other way around. We once thought neurons were only in the brain. Now we know, neurons are everywhere in the body. The Error of Descartes led early healers off track by splitting the Mind from the Body. A nifty little plea-bargain with the religious leaders of the time. Now we need to plea bargain with the doctors to get back to science and the reality of "molecules of emotion."

Mental health professionals should want to know such things as:

Is the person too high in lead?
Too low in copper?
What is the functioning of their thyroid?
What about their histamine levels?
Do they have too much or too little niacin?
What about food allergies?
Could there be amino acid imbalances?
and more .....

We have created untold misery and suffering by conventional approaches to mental health treatments. I was shocked to learn, as I compiled research for the film, "A Message of Hope," 90% of acute schizophrenic episodes quickly respond to low-cost, effective natural treatments ... over 50% of chronic cases get well .... Getting people well, by my definition here means: having a good relationship with one's family, one's community, holding a job, and paying taxes.

Conventional treatment for people who are simply deficient in niacin or who have amino acid imbalances is wrong.

CONCLUSION.

When you review the tapes and notes from this Town Hall meeting, I urge you to put major focus on natural medicine MENTAL HEALTH policy, research on treatments that help people get well, and protocol to include such in national guidelines.

I stand ready to assist you as you prepare the Manifesto for Effective Health Care ... I hope you will be bold, synergistic, inclusive, and creative beyond all your previous action.

Naturally yours,

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Natural Medicine Handbook© for People Over 50

Compiled by Merrily Manthey, M.S.

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American Chiropractic Association

DEDICATED TO IMPROVING THE HEALTH AND WELLNESS OF AMERICA, NATURALLY.

Statement
of the
American Chiropractic Association
before the
White House Commission on Complementary and Alternative Medicine Policy
October 2000
Seattle, Washington

Good Afternoon, my name is Doug Nordstrom I am a practicing doctor of chiropractic in Marysville, Washington. I am also the Washington delegate to the American Chiropractic Association (ACA). The ACA is the largest professional organization representing the chiropractic profession. The ACA stands ready to assist the Commission with any chiropractic-specific recommendations as you move forward on developing your formal recommendations. We are encouraged that during this town hall meeting, the Commission will hear testimony from numerous chiropractic representatives on issues relating to reimbursement, education and research. Today, I will focus my comments on education, scope, and the difficulties the profession faces in providing a full range of services to its patients.

As you are well aware, chiropractic is the third largest doctoral-level health care profession in the western world after medicine and dentistry. In addition, recent studies have found that chiropractic care is one of the most popular alternative health care treatments available to consumers. The chiropractic profession has a long history of being recognized as a vital part of an integrated health care system. Yet even today, as much as chiropractic has been proven effective, patients are still being denied access to chiropractic care in both federal and private health care plans.

Education

In order to be licensed as a doctor of chiropractic, students attend chiropractic colleges that provide a rigorous curriculum that prepares them to be portal-of-entry health care providers. The Council on Chiropractic Education, through the U.S. Department of Education, accredits all chiropractic colleges. A chiropractic college curriculum consists of a minimum of four academic years of professional education averaging a total of 4,822 hours. There are five curricular areas that are emphasized in chiropractic education: adjustive technique/spinal analysis, averaging 555 hours of the clinical program: principles/practices of chiropractic, averaging 245 hours, and biomechanics, averaging 65

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hours. Under the auspices of all chiropractic colleges, students are required to pass a practical examination on their manipulation skills and a clinical competency exam prior to internship. In addition, the chiropractic profession is held to rigorous skill testing for licensure. The principal-testing agency for the chiropractic profession is the National Board of Chiropractic Examiners. There are four parts to its examination: basic science, clinical subjects, written clinical competency, and special purposes examination for chiropractic. In addition, all states require a practical examination prior to licensure. This state-licensing skill testing includes diagnostic imaging, differential diagnosis, chiropractic technique and case management.

Scope

Doctors of chiropractic are licensed in all fifty states. It should be noted that practice acts differ state by state. However, to give the commission an example of what doctors of chiropractic may be able to provide to their patients, I will describe to you to Washington State Chiropractic Practice Act, which recognizes doctors of chiropractic to perform the following procedures:

18.25.005. **"Chiropractic"** defined

1. Chiropractic is the practice of health care that deals with the diagnosis or analysis and care or treatment of the vertebral subluxation complex and its effects, articular dysfunction, and musculoskeletal disorders, all for the restoration and maintenance of health and recognizing the recuperative powers of the body.
2. Chiropractic treatment or care includes the use of procedures involving spinal adjustments, and extremity manipulation insofar as any such procedure is complementary or preparatory to a chiropractic spinal adjustment. Chiropractic treatment also includes the use of heat, cold, water, exercise, massage, trigger point therapy, dietary advice and recommendation of nutritional supplementation except for medicines of herbal, animal, or botanical origin, the normal regimen and rehabilitation of the patient, first aid, and counseling on hygiene, sanitation, and preventive measures. Chiropractic care also includes such physiological therapeutic procedures as traction and light, but does not include procedures involving the application of sound, diathermy, or electricity.
3. As part of a chiropractic differential diagnosis, a chiropractor shall perform a physical examination, which may include diagnostic x-rays, to determine the appropriateness of chiropractic care or the need for referral to other health care providers. The chiropractic quality assurance commission shall provide by rule for the type and use of diagnostic and analytical devices and procedures consistent with this chapter.
4. Chiropractic care shall not include the prescription or dispensing of any medicine or drug, the practice of obstetrics or surgery, the use of x-rays or any other form of radiation for therapeutic purposes, colonic irrigation, or any form of venipuncture.

Reimbursement

Doctors of chiropractic continue to be treated unfairly in reimbursement for the services they provide their patients. One prime example is the Medicare program. Currently, HCFA only recognizes doctors of chiropractic for manual manipulation of the spine to correct a subluxation. Medicare does not even reimburse a doctor of chiropractic for diagnostic services. As mentioned above, doctors of chiropractic are trained and educated to perform a multitude of other services. However, regulations, written at the height of an anti-chiropractic movement within the medical community severely restrict reimbursable services under Medicare. The ACA continues to work on all levels to ensure that doctors of chiropractic be reimbursed for all Medicare-covered services they provide.

Reimbursement disparities are also occurring in alarming rates with private insurers. Some of the problems that the ACA has heard include; systematic attempts to exclude chiropractic care from insurance industry products, reimbursement comparisons to non-physician providers, withholding of chiropractic network information from insured patients, reimbursement "standards per visit" levels which are unfair and do not adequately reflect the business expense of the provider, and failure to conduct proper claim investigation as is required by the Fair Claim Practices Act.

Access to Chiropractic Services

In addition to the problems faced by doctors of chiropractic in being reimbursed for the services they provide, consumers seeking chiropractic services – especially through federally funded programs – are finding it increasingly difficult to access chiropractic services.

I would like to provide the commission with a few examples.

Medicare

In 1972, Congress recognized doctors of chiropractic as physicians in the Medicare program for treatment by means of manual manipulation of the spine to correct a subluxation. It is the view of the ACA that implicit in the word "treatment" is the full clinical approach that constitutes chiropractic treatment of a Medicare beneficiary. The statute does not simply state chiropractors are physicians only for the purposes of "manual manipulation of the spine" and nothing else, but rather clearly identifies treatment of the patient by means of "manual manipulation of the spine" and all the related physician services and ancillary physician services that are integral in such treatment.

Unfortunately, as the regulations are written, doctors of chiropractic are currently only recognized for the one procedure, "manual manipulation of the spine". No other services are covered including the initial evaluation of the patient. HCFA refuses to change its position on this issue, and currently the ACA is pursuing a legislative remedy to ensure

that the full scope (as determined by state law) of a chiropractor's services are reimbursed under the Medicare program.

The Health Care Financing Administration (HCFA) has gone one step farther in limiting Medicare beneficiary access to doctors of chiropractic. In 1997, Congress created the Medicare+Choice program as an additional avenue for Medicare beneficiaries to receive care. The statute stipulates that all Medicare Part A and B benefits be provided to those patients seeking care through Medicare+Choice programs. Manual manipulation of the spine to correct a subluxation, which is a uniquely chiropractic service, is a guaranteed part B benefit. Patients in the Part B program can freely access doctors of chiropractic. Unfortunately, in its final regulations for the Medicare+Choice program, HCFA has issued a rule that allows these plans to exclude doctors of chiropractic from participating in the Medicare+Choice program.

The ACA has filed suit against the Department of Health and Human Services to assure that Medicare beneficiaries are provided the opportunity to seek the care of a doctor of chiropractic in the Medicare+Choice program.

Veterans Administration

Last November, President Clinton signed into law the Veterans' Millennium Health Care Act (PL 106-237). This Act, among other things, included a provision requiring the Department of Veterans Affairs to develop a policy with regard to chiropractic care in the DVA health care system. More specifically, the law required that within days after the enactment of the Act, the Under Secretary of Health, after consultation with chiropractors, shall establish a policy for VHA regarding the role of chiropractic treatment in the care of veterans.

The VA was not forthcoming in the development of this policy. In fact, the ACA had to request congressional intervention to get the VA to agree to meet with the chiropractic groups, as required by statute. At this meeting, the ACA, along with the Association of Chiropractic Colleges (ACC), provided to the VA a detailed report to assist in the development of a comprehensive chiropractic policy. In short, the VA ignored the recommendations provided by the chiropractic professions and developed a policy that severely limits a veterans access to chiropractic. The ACA is committed to returning to Congress next session in order to again mandate that the VA provide our nation's veterans with quality access to chiropractic care.

Conclusion

These are just two examples of the problems faced by doctors of chiropractic in providing care to their patients. Although various statutes call for the inclusion of chiropractic care in federal programs, federal agencies such as the VA and HCFA continue to drag their feet in providing chiropractic care to their constituencies. In advocating for the profession and the chiropractic consumers, the ACA has been forced to file suit in federal court, as well as work with members of Congress in passing stronger mandates to ensure

that chiropractic services – already mandated by law – are actually provided to consumers.

In developing recommendations to Congress, this Commission needs to consider what the real problems are. In the case of chiropractic, there are laws that have been passed. It's the continued stonewalling of federal agencies that continues to provide access problems for consumers. The Commission needs to ensure that once laws are in place, those laws are accurately implemented in regulations and policy. The Commission must recommend that federal agencies consult with the complementary and alternative therapy community in the development of policy by contracting or hiring CAM providers as part of their health care policy teams. Unless federal agencies like HCFA and the VA begin to look outside the medical model, and accept complementary and alternative practices, federal laws will continue to be watered down. The result, continued barriers to CAM practices, and fewer choices for providers.

Thank you for the opportunity to present the views of the American Chiropractic Association. I would be happy to answer your questions.