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V

Divider Title: _____

CONTENTS

SESSION V:

Meeting Public Needs/

Systems of Delivery

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Session V: Meeting Public Needs/Systems of Delivery
8:00 a.m. - 12:00 p.m. on Tuesday, December 5.

ROBERT ATKINS: PRIVATE PRACTICE

1. As a solo practitioner in private practice, what has worked for you in terms of delivering your type of CAM and why has it worked?

2. What barriers have you encountered in delivering your type of CAM and how have you overcome them?

3. Based on your lessons learned, what policy recommendations do you have for the Commission? Please include your view on whether CAM should be accessed and delivered as a stand-alone or integrated with conventional care and why.

CHARLOTTE ELIOPOULOS–NURSING

1. Recognizing the multiple types of nurses, what, in your opinion, is the role of the nursing profession in access to and delivery of CAM products and practices?

2. What can nurses do to improve the access to and delivery of CAM products and practices?

3. What policy recommendations do you have for the Commission? Please include your view on whether CAM should be accessed and delivered as a stand-alone or integrated with conventional care and why.

MORT ROSENTHAL–STAND ALONE CAM CENTER

1. As an example of a free-standing for-profit CAM center, what has been the key to your success (both financial and clinical)? In other words, why has you CAM center succeeded and what have you done differently?

2. What unique insights have you gained about access to and delivery of CAM products and practices can share with the Commission?

3. What policy recommendations do you have for the Commission? Please include your view on whether CAM should be accessed and delivered as a stand-alone or integrated with conventional care and why.

THOMAS TROMPETER – COMMUNITY HEALTH CLINICS

1. As an example of a community health center (and all that it entails relative to the medically underserved), why and how did you decide to provide CAM products and practices?

2. How did you determine which CAM products and practices to make available and for which conditions, where (on-site or off-site referral) and by whom should they be provided?

3. What barriers did you encounter and how did you overcome them?

4. What is the role of nursing in access to and delivery of CAM products and services in a community health center?

5. What policy recommendations do you have for the Commission to improve access to and delivery of CAM products and practices by community health centers?

SYLVER QUEVEDO – HOSPITAL-BASED CENTERS

1. As an example of a community hospital-based CAM center, why and how did you decide to open your center in a community-hospital?

2. How did you determine the staffing and CAM service mix?

3. What is the role of nursing in the access to and delivery of CAM products and practices in a community-hospital-based CAM center?

4. What are the keys to your success?

5. What have you done to improve access to and delivery of CAM products and services to the underinsured, uninsured, and medically underserved in your community?

6. What policy recommendations do you have for the Commission? Please include your view on whether CAM should be accessed and delivered as a stand-alone or integrated with conventional care and why.

WOODSON MERRELL – ACADEMIC CENTERS

1. As an example of a CAM center in an academic medical center, why and how did you decide to open your center in an academic medical center?

2. How did you determine the staffing and CAM services mix?

3. What is the role of nursing in access to and delivery of CAM products and practices in your center?

4. To what do you attribute your center's success?

5. What lessons can be learned from your financially-unique situation and applied to other

less well-financed centers?

6. What have you done to improve access to and delivery of CAM products and services to the underinsured, uninsured, and medically underserved in your community?

7. What policy recommendations do you have for the Commission? Please include your view on whether CAM should be accessed and delivered as a stand-alone or integrated with conventional care and why.

JAMES DILLARD:

As an example of a managed care organization (MCO) offering CAM:

1. Why and how did your MCO decided to offer CAM products and services?

2. How did your MCO determine which CAM products and practices to cover/offer?

3. How did your MCO decide for which conditions, where, how, and by whom these CAM products and practices should be provided?

4. How much does it cost your members to access these CAM products and how were these rates established?

5. What is the role of CAM in self-care in your MCO?

6. Has your MCO collected and cost-effectiveness or patient satisfaction data? If so, what are the results?

7. Have any of your members had difficulty with access to or payment for CAM products or services? If so, please specify the difficulty and how it was resolved or should be resolved?

8. Based on your experience, what policy recommendations do you have for the Commission? Please include your view on whether CAM should be accessed and delivered as a stand-alone or integrated with conventional care and why.

LORI BIELINSKI:

From your perspective in Washington State Office of the Insurance Commissioner:

1. Should there be access to CAM products and practices? If so, to which products and practices and for which conditions should there be access and where, how, and by whom should these products and practices be delivered?

2. What should be done to make the CAM products and practices culturally and linguistically appropriate for CAM users?

3. Describe any data you have collected on clinical effectiveness, cost-effectiveness, patient satisfaction, or quality and describe what the data show.

4. What should be done to improve access to and delivery of CAM for the under-insured, uninsured, poor, and medically underserved?

5. Based on your experience, what policy recommendations do you have for the Commission? Please include your view on whether CAM should be accessed and delivered as a stand-alone or integrated with conventional care and why.

ANNA SILBERMAN:

1. Why and how did you select the Ornish program?

2. Describe any data collected on its clinical effectiveness, cost-effectiveness, or patient satisfaction; what did these data show?

3. How much does it cost your members to participate in this program?

4. Based on your experience with the Ornish program and other CAM products and practices, what policy recommendations do you have for the Commission?

ROBERT SCHNEIDER – AYURVEDA

1. Describe data on the clinical effectiveness, cost-effectiveness, or patient satisfaction (if possible, please provide references). Specifically, what did these data show? For which conditions and for whom was Ayurveda most effective?

2. Who should be providing ayurvedic products and practices?

3. Should Ayruveda be accessed and delivered as a stand-alone system or should it be integrated with conventional medicine and why?

4. What policy recommendations do you have for the Commission?

TORI HUDSON – NATUROPATHIC MEDICINE

1. Should naturopathic medicine in general be accessed and delivered as a stand-alone system or integrated with conventional care and why? Are there medical conditions or situations when this shouldn't be the case? Are there any data to support your position?

2. Should naturopathic health care for women be accessed and delivered as a stand-alone system or integrated with conventional care and why? Are there medical conditions or situations when this shouldn't be the case? Are there any data to support your position? Is there a documented patient preference for a stand-alone or integrated approach to naturopathic women's health care?

3. Based on your experience, what policy recommendation do you have for the Commission?

ROBERT DUGGAN – TRADITIONAL CHINESE MEDICINE

1. Should Traditional acupuncture be accessible and delivered as a stand-alone system or should it be integrated with conventional medical care and why?

2. Should Traditional acupuncture be accessible and delivered apart from or in conjunction with the other modalities of Oriental Medicine and why?

3. Based on your experience, what policy recommendation do you have for the Commission?

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Divider Title: Atkins

Robert Atkins MD

WHITE HOUSE COMMISSION OF COMPLIMENTARY MEDICINE

RESPONSE TO PANEL QUESTIONS

Submitted by The Atkins Center
November 29, 2000

Question 1. What has worked for you in terms of delivering your type of CAM and why has it worked?

Response:

1. **Individualized treatment programs.** We do a complete evaluation and medical assessment to consider all aspects of the patient's condition. By treating the patient as a whole rather than by treating the symptoms or using a standardized treatment protocol for a single illness, we establish a more comprehensive treatment protocol. Medications standard for one condition frequently produce negative results in other conditions. Dealing with all findings simultaneously avoids such conflicting interactions.

2. **Elimination or reduction of prescription medications.** Such drugs have the potential for adverse side effects, so we ease patients off them by finding safe, effective natural alternatives. This allows the practitioner to offer treatment with a higher benefit to risk ratio.

3. **Individualized dietary plans.** A number of disorders are diet related. The most prevalent include metabolic imbalances, nutritional deficiencies or overloads, etc., which center on glucose and insulin metabolism. These disorders lead to diabetes, obesity, hypertension, cardiac-risk factors, breast cancer-survival variations, polycystic ovary syndrome, inflammatory bowel disease, food allergies, and more. By modifying carbohydrate intake and decreasing excessive insulin secretion, these metabolic imbalances stabilize. A lowered carbohydrate intake corrects many of these disorders.

4. **Strengthening the host.** Historically, medicine has approached illness by attempting to both weaken the disease and strengthen the host. Some medical specialties, oncology being a striking example, have deviated from this idea by failing to provide a host-strengthening protocol. CAM returns to the basic principle of strengthening the host, rather than focusing only on destroying the illness.

Question 2. What barriers have you encountered in delivering your type of CAM and how have you overcome them?

Response:

1. Insurance companies usually deny coverage for CAM procedures (i.e. allergy testing, chelation therapy, high resolution microscopy, nutrition counseling, vitamin therapy), claiming that they are "not usual and customary" or "not medically necessary." We are required to have patients sign release forms and request that they pay out of pocket since reimbursement is not possible; however, this does not overcome the barrier.

2. A small group of mainstream doctors has organized, calling themselves "quack busters." They have classified CAM practices as "questionable medical therapies." This group has become consultants for the FTC, the Federation of State Medical Boards, and the Association of States Attorneys General. Policies were created that would allow physicians who offer CAM to their patients to be prosecuted by their home state's medical boards. This problem that has not been resolved to date.

3. Medicare and most other insurers do not recognize the services of CAM physicians or pay for most aspects of CAM. The Current Procedures and Terminology codebook, published by the AMA, has no CAM codes. If a doctor chooses a code that he believes is close to his procedure, he may be accused of fraud and fined more than $100,000.

4. Mainstream leaders are trying to redefine CAM to incorporate prescription drugs and invasive procedures. CAM practitioners generally agree that their approach involves familiarity with all the healing arts and devising therapeutic strategies that incorporate those modalities with the highest benefit-to-risk ratio. While we certainly want CAM to become mainstream, there is a danger that its very principles can be compromised in this process period.

We have offered specific scientific research, long-term practice, and clinical experience demonstrating the effectiveness and long-term safety of CAM. We have presented existing evidence of CAM's success at industry conferences and professional seminars. Notwithstanding our efforts and those of other CAM providers, these barriers continue to exist.

Question 3. Based on your lessons learned, what policy recommendations do you have for the Commission? Please include your view on whether CAM should be accessed and delivered as a stand alone or integrated with conventional care and why.

Response:

1. If the ACCESS TO MEDICAL TREATMENT ACT currently in Congress were passed, doctors would not be prosecuted for offering therapies approved in other countries but not recognized by mainstream practitioners in the United States.

2. Increase NIH funding for CAM, including protocols that include more than one or one therapeutic modalities.

3. CAM codes need to be included in CPT books.

4. State legislatures will need to recognize CAM as an acceptable medical practice in all states.

5. Mandate that at least one member of the Federation of State Medical Boards be a CAM physician.

6. Follow the lead set by the New Jersey Supreme Court and recommend that adequate informed consent must include all choices of therapies (CAM and conventional), even if the doctor does not personally advocate the therapy.

7. Find funding for research in which the total individualized approach of CAM is compared to a matched group treated by the total mainstream approach. This would serve to answer the question of how the two medical systems compare to one another. Should CAM prove superior, then further point-by-point investigations would follow.

With respect to whether CAM should be accessed and delivered as a stand-alone system or integrated with conventional care, I believe CAM should be defined as using the best possible options chosen from all the healing arts, including both mainstream and alternative therapies. The goal of excellence in medical care in the coming decades should be achieved through an informed choice from an array of all possible therapies. We recommend that a total and individualized approach to each patient become the standard of *all* medical care in the future.

Combining the best of conventional and alternative medicine, Complementary medicine is a comprehensive approach that has proven to be innovative and effective in treating the patient as a unique individual. The Atkins Center's "no stone unturned" approach uses all of the healing arts to treat patients – physically, biochemically, nutritionally, environmentally and behaviorally. While conventional medicine often treats only symptoms, Complementary Medicine focuses on reversing the underlying illness, and on prevention.

More than 60,000 patients have been treated at the Atkins Center for conditions including heart disease, blood pressure and circulatory problems, diabetes, hypoglycemia, and hyperinsulinism, fatigue, arthritis, headache, allergies, gynecological disorders, immune disorders, Crohn's, colitis and GI problems, prostate disease, multiple sclerosis and weight loss.

Patients are fully involved in the decision-making process at The Atkins Center. Together, decisions are made concerning testing, dietary and lifestyle modifications, all with the goal of strengthening the body as a whole. The Atkins Center offers a number of treatment methods and options.

Our innovative treatment methods include:

1. customized variations of The Atkins Diet – a lifetime nutritional philosophy that focuses on the consumption of nutrient-dense unprocessed foods and the restriction of processed and refined carbohydrates, such as high-sugar foods, breads pasta and cereals.
2. vita-nutrient/orthomolecular therapy – involving the use of vitamins, minerals, herbs, amino acids and antioxidants designed to help patients achieve optimal health
3. Heart disease management and prevention – the division of cardiology blends the use of the most technologically advanced diagnostic tools with an individualized diet, nutrition and exercise program.
4. Oxidative therapies – to restore and invigorate the processes necessary for oxidative phosphorylation (energy production) The Atkins Center uses a variety of oxidative therapies to remove toxic substances from the body.
5. Behavioral medicine/stress management – The ever-growing demands of balancing work and family life have led us to incorporate a psychotherapeutic component in our patient treatment as well

Atkins Center patients benefit from a diverse group of dedicated practitioners, that encompasses conventionally trained physicians, nurse practitioners and physician assistants, nurses, medical assistants, nutritionists and pain management professionals. Additionally, a fully certified laboratory, staffed by experienced technicians, is maintained on the premises.

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2. What can nurses do to improve the access to and delivery of CAM products and practices?

There are a variety of actions nurses can take to improve access and delivery of CAM products and practices, including:

- increase their own knowledge base. A unique body of information and skills exist within the realm of CAM and nurses must obtain education to enable them to competently assist clients. This suggests that continuing education must be provided for the current workforce of nurses and content must be incorporated into undergraduate nursing education programs.
- stimulate the develop of systems to support the effective access and delivery of CAM products and practices within their existing work settings. Nurses must evaluate existing assessment tools, care plans, policies, procedures, and practices to assure CAM products and practices have been included, and where necessary, assist with the develop of systems and practices to support them.
- advocate for and demonstrate a holistic approach to the delivery of CAM products and practices. The interconnection of body, mind, and spirit cannot be ignored in clients' health status and healing process. Providing a CAM product or therapy without assessing and addressing the total needs of clients risks perpetuating a system of fragmented care and dilutes the potential beneficial outcomes.
- develop private practices that allow them to provide CAM practices for which they are qualified to offer as part of a holistic nursing practice to assist clients in establishing healthy lifestyle practices, using natural approaches to manage diseases, and coordinating services obtained from other health care providers (conventional and CAM therapists).

3. What policy recommendations do you have for the Commission? Please include your view on whether CAM should be accessed and delivered as a stand-alone or integrated with conventional care and why.

The AHNA supports an integrated approach to the delivery of CAM products and services. This is consistent with a holistic approach that respects the interrelationships of the bio-psycho-social-spiritual dimensions of the person and recognizes that the synergy of the various components working together produces results greater than the sum of its parts.

AHNA recommends:

- reimbursement and other policy decisions be made to foster the implementation and utilization of CAM products and practices in every clinical setting. This reimbursement should include the cost of nursing services to assess, assist, counsel, educate, coach, and monitor clients as they integrate CAM into their total care, as well as to provide CAM therapies that fall within the realm of nursing (see attached listing).
- nurses be considered as well-prepared, cost-effective coordinators and evaluators (e.g., "gate-keepers") of these services
- holistic nurses be represented on the Commission due to their presence in diverse clinical settings, their comprehensive and extensive education and preparation, and their allegiance to the holistic care of clients rather than to a specific product or practice.

Clients require and have the right to care that uses the most appropriate, effective, and economic products and practices available. Using this principle, sometimes the best approaches to assist clients will be available from conventional (allopathic) medicine while at other times CAM will provide the most appropriate interventions. An integrated approach fosters consideration and eases the utilization of a wide range of options.

CAM Therapies Most Frequently Practiced by Holistic Nurses

acupressure
aromatherapy
art therapy
biofeedback
cognitive therapy
counseling
exercise and movement
goal-setting and contracts
guided imagery
healing presence
healing touch modalities
holistic self-assessments
humor and laughter
journaling
simple massage
meditation
music and sound therapies
nutrition counseling
play therapy
prayer
reflexology
relaxation modalities
self-care interventions
self-reflection
therapeutic touch

Data from Dossey B, et al. Evolving a Blueprint for Certification: Inventory of Professional Activities and Knowledge of a Holistic Nurse, *Journal of Holistic Nursing*, 16(1): 33-56, 1998.

AMERICAN holistic nurses ASSOCIATION

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American Holistic Nurses Association Description

In 1980, the American Holistic Nurses' Association was founded by a group of nurses dedicated to bringing concepts of holism to every arena of nursing practice and since that time, has grown to be a major voice in the nursing profession. The AHNA emphasizes healing of the whole person from birth to death. Healing does not mean cure, although the two can be synchronous, but rather, a state of harmony and integrity of the individual. Implicit in this view is the reality that individuals can achieve a high quality, meaningful life amidst the illnesses, crises, and challenges they experience. Holism involves the interrelationships of the physical, psychological, social, and spiritual dimensions of an individual, with the recognition that the whole is greater than the sum of its parts. The AHNA believes nurses play a major role in facilitating harmony, unity, and healing of the whole individual. In an era in which technology and cost-containment often cause impersonal, fragmented care, AHNA reminds nurses of the need to reclaim the healer role upon which their profession was founded.

In addition to concern for the care of clients/patients, AHNA highlights the need for nurses to integrate self-care practices into their own lives in order to be effective healers. The strong emphasis on "nurturing the nurse" is one of the major aspects that sets the AHNA apart from other nursing associations. Nurses are encouraged to engage in self-care strategies to enhance their own physical, psychological, sociological, and spiritual well-being. Also stressed is the importance of consciously cultivating awareness and understanding about the deeper meaning, purpose, inner strengths, and connections with self, others, nature, and a higher power.

Holistic nurses practice in a wide range of clinical settings, blending technology with caring, compassion, and creativity, to assure that all aspects of the individual---body, mind, and spirit---are being addressed. Many use complementary and alternative therapies to expand the strategies available to promote holistic care and healing.

The AHNA has developed Standards of Holistic Nursing Practice; offers certification in holistic nursing through the American Holistic Nurses' Certification Corporation, a credentialing body that it has developed ; publishes a newsletter, *Beginnings,* and the peer-reviewed *Journal of Holistic Nursing,* provides scholarships and research grants to holistic nurses; and holds an annual conference in which nurses can gather for education, networking, fellowship, and some truly unique experiences.

"It is the mission of the American Holistic Nurses Association to unite nurses in healing."

AMERICAN holistic nurses' ASSOCIATION

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"It is the mission of the American Holistic Nurses' Association to unite nurses in healing..."

(Draft)

AMERICAN HOLISTIC NURSES' ASSOCIATION

POSITION ON THE ROLE OF NURSES IN THE PRACTICE OF COMPLEMENTARY AND ALTERNATIVE THERAPIES

Overview

Complementary and alternative modalities (CAM) offers therapies that supplement conventional medical care. The National Center on Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health has categorized five major domains of CAM practices:

Alternative Medical Systems including acupuncture, Ayurveda, homeopathic medicine, naturopathic medicine
Mind-Body Interventions including meditation, certain uses of hypnosis, dance, music, and art therapy, and prayer
Biologically-Based Therapies, including herbal, special dietary, orthomolecular, and individual biological therapies
Manipulative and Body-Based Methods, including chiropracty and osteopathy
Energy Therapies, including Qi gong, Reiki and Therapeutic Touch

Holistic care refers to approaches and interventions that address the needs of the whole person: body, mind, and spirit. *Healing arts* are those interventions that foster an individual's healing process, i.e., a return of the individual toward a state of wholeness in which body, mind, and spirit are integrated and balanced, and the person is able to reach deeper levels of personal understanding. Healing does not equate to curing, although they can be synchronous. The nursing profession has a long history of caring for individuals in a holistic manner and integrating the healing arts with conventional treatments. Florence Nightingale recognized the importance of caring for the whole person and encouraged interventions that enhanced individuals' abilities to draw upon their own healing powers. She considered touch, light, aromatics, empathetic listening, music, quiet reflection, and similar healing measures as essential ingredients to good nursing care. Today's education of registered nurses is built upon these same principles.

The American Holistic Nurses Association (AHNA) is a professional nursing association dedicated to the promotion of holism and healing. The AHNA believes that nurses enter therapeutic partnerships with clients, their families, and their communities to serve as facilitators in the healing process. The holistic caring process supported by AHNA is one in which nurses:

- acquire and maintain current knowledge and competency in holistic nursing practice, including CAM therapies and practices integrated within that practice
- provide care and guidance to persons through nursing interventions and therapies consistent with research findings and other sound evidence

- hold to a professional code of ethics and healing that seeks to preserve wholeness and dignity of self and others
- engage in self-care and further develop their own personal awareness of being an instrument of healing
- recognize each person as a whole: body-mind-spirit
- assess clients holistically, using appropriate traditional and holistic methods
- create a plan of care in collaboration with the clients and their significant others consistent with cultural background, health beliefs, sexual orientation, values, and preferences that focuses on health promotion, recovery or restoration, or peaceful dying so that the person is as independent as possible

Nursing and CAM

The AHNA believes in the integration of CAM into conventional health care to enable the client to benefit from the best of all treatments available. In their provision of holistic care, nurses employ practices and therapies from both CAM and conventional medicine. The AHNA recognizes CAM most frequently used in nursing practice to include:

acupressure, aromatherapy, art therapy, biofeedback, cognitive therapy, counseling, exercise and movement, goal-setting and contracts, guided imagery, healing presence, healing touch modalities, holistic self-assessments, humor and laughter, journaling, massage, meditation, music and sound therapies, nutrition counseling, play therapy, prayer, reflexology, relaxation modalities, self-care interventions, self-reflection, smoking cessation, therapeutic touch, and weight management.

Consistent with conventional nursing practice, nurses must be competent in the CAM therapies and practices they use. The AHNA believes nurses integrate these practices into conventional care as part of a holistic practice. In addition, nurses support and assist clients with their use of CAM provided by other practitioners by:

- identifying the need for CAM interventions;
- assisting clients in locating providers of CAM interventions;
- facilitating the use of CAM interventions through education, counseling, coaching, and other forms of assistance;
- coordinating the use of CAM among various health care providers involved in clients' care; and
- evaluating the effectiveness of clients' complete care (conventional and CAM).

AHNA's Position

The AHNA believes that although selected CAM are appropriate interventions for use by nurses, the use of these interventions must be integrated into a comprehensive holistic nursing practice. Practicing within a holistic nursing framework does not imply competency in effectively and safely utilizing CAM therapies and practices. Nurses must be responsible for seeking, when necessary, additional education and experience and demonstrating clinical competency in all interventions used in their nursing practice.

American Holistic Nurses' Association
Position on the Role of Nurses in the Practice of Complementary and Alternative Therapies

All nurses must adhere to the Nurse Practice Acts of the states within which they are licensed. The AHNA believes that nurses who identify themselves as therapists of a given modality for which certification, licensure, and/or special or advanced preparation are necessary must fulfill the requirements of the licensing or certifying body representing the modality.

AHNA views nurses as being in a unique position in the implementation of CAM throughout the health care system in that registered nurses:

- represent the greatest number of health care professionals, representing more than 2.1 million health care professionals) and are employed in more diverse clinical settings than any other health care professional;
- are uniquely prepared to differentiate normality from illness, provide interventions for health promotion and illness-related care, and use a wide range of medical technology and the healing arts;
- are advocates for clients rather than specific products or practices, therefore are in an excellent position to assure appropriate and adequate use of all types of services; and
- are trusted and held in high esteem by consumers.

These factors support nurses holding a leadership role in the implementation of CAM in various service settings and the coordination of CAM utilization by clients as part of an integrated approach to care.

CLINICIAN PROFILE

Women's Healthcare: A Holistic Nurse Practitioner's Integrated Approach

By Wendy Wetzel, RN, MSN, FNP, CHTP, HNC

I DID NOT ALWAYS HAVE THE LANGUAGE to describe what I felt about healthcare, but I long knew that there was more than the conventional approach. An opportunity to implement what I came to understand as holistic nursing principles and to integrate alternative therapies into my practice came when I began practicing ambulatory nursing in a OB-GYN office. Within an outpatient setting there are ample opportunities to address the whole person. Rather than a crisis orientation, the focus is on wellness, prevention, and education. Clients present for health maintenance visits and minor illnesses, rather than life threatening ones. As my love of women's healthcare grew, I found a natural path in becoming a nurse practitioner.

The practice in which I work is a multi-provider group located in the mountains of Northern Arizona. As OB-GYN specialists, we have each found a niche that not only appeals to our own styles and preferences, but also serves the practice and the community. I actually was hired for my holistic approach and knowledge of alternative therapies. At various times, I have been called upon to provide Healing Touch for apprehensive pregnant women or pre-operative patients, to work with breast cancer survivors to provide relief from menopausal symptoms, or to just be a sounding board for women in crisis. But whether by design or chance, my most treasured role is that of "Hormone Queen of Flagstaff." As I approached my own menopause and sought information and alternatives, I brought that information to my clients, offering a variety of both standard and complementary treatments.

Some clients find their way to our door after becoming dissatisfied with other providers. They often relate a desire to use "natural" hormones instead of equine-based and/or synthetic hormones. Frustration with other providers who have turned a deaf ear or refused to listen to their beliefs and wishes is a commonly expressed theme. These women are often concerned that their current hormone prescriptions leave them with uncomfortable side effects, and many are concerned about the risk of breast cancer that they often hear discussed in the media.

Before proposing a change in hormonal profile, I take a detailed history from clients, paying particular attention to their needs, desires, and lifestyle demands. Some women prefer oral agents, while others request transdermal products. A busy career woman may not remember a twice-daily dosing schedule and want a simpler regimen. Others may want more reassurance that their choice is botanical in its origin, or as close to "natural" as possible.

Because of many misunderstandings about what "natural" actually means, I ask clients for their own definition. This helps me decide what regimen I select for each individual. And to clarify the different types of hormone products, I choose the term "human identical hormones" (HIH) to describe plant-based products that are chemically and functionally identical as human hormones. These seem to be the ones most often chosen by those women who seek a natural profile.

Each woman is treated as a unique individual. While pharmaceutical companies tend to promote a "one size (or drug) fits all" approach, we tailor the treatment to the client, taking into account her needs, physical and emotional health, lifestyle, and belief system. We provide extensive counseling about the nature, risk, and benefit of each treatment, and encourage the client to make the final decision.

In specific instances, I also recommend a variety of herbal and dietary supplements to assist with menopausal concerns. Breast cancer survivors are referred to our practice as they experience menopausal symptoms during their therapy. We assist these women with non-hormonal treatments, including herbs, diet changes, exercise programs, and referral to other alternative practitioners, including naturopaths, homeopaths, and acupuncturists.

In conjunction with hormonal treatment, we stress healthy lifestyle choices in terms of diet and exercise. Stress reduction activities are also promoted as are activities that promote social, emotional, and spiritual health. We have made every effort to promote client comfort, providing flannel exam gowns, warmed instruments, and an office decorated with soft colors and a variety of handmade quilts. Our waiting room has comfortable couches instead of institutional chairs. We begin interviews with the client fully clothed, and have her undress only after we have taken her health history and discussed current concerns. Our clients are truly partners in healthcare, not passive recipients.

Our practice reflects the integrated approach to healthcare, blending the conventional and alternative into a comprehensive program. As practices like this spread, nurse practitioners will need to understand and use alternative therapies within a framework of holistic care in order to promote care of the whole woman. ■

Wendy Wetzel RN, MSN, FNP, CHTP, HNC, is a nurse practitioner at A Woman's Place, Flagstaff AZ.

FOR ADDITIONAL INFORMATION

Wetzel W. Human identical hormones: real people, real problems, real solutions. *Nurse Practitioner Forum.* 1998;9(4):227-234.

Wetzel W. Micronized Progesterone: a new perspective for women's healthcare, a case study review *Nurse Practitioner* 1999,24(5):62-76.

CLINICIAN PROFILE

The Nurse as a Healing Tool

By Jeanne Colbath, RNC, MS, ANP, HNC, St Elizabeth's Medical Center, Boston

MY PATH TO INTEGRATING CAM into my professional practice began in the mid-80s and has been evolving ever since. At that time I was working in a combined Coronary Care/Step-Down Unit. Although I always had been concerned with the psychological impact of hospitalization on patients with acute coronary syndromes, I had no special tricks up my sleeve to help them cope. One day, a man I cared for who had survived resuscitation pulled me close to him so I could hear his whispering speech. He recounted having had a near death experience of feeling peaceful, seeing lights at the end of a tunnel, and not wanting to return. With frightened and pleading eyes, he asked me if I thought he was crazy. I reassured him that I did not think he was crazy, while in my own mind I recognized that I did not have a clue as to what he was talking about. This pivotal experience launched me on a new educational path in the area of stress reduction that was 180 degrees opposite to the high-tech courses of acute cardiac care that had prepared me for medical practice.

My introduction to stress reduction began with hearing a colleague of Dr. Herbert Benson speak on the Relaxation Response. During the presentation I had the opportunity to experience this calming exercise. Returning to work I began to use this simple but powerful exercise with my patients and found it helpful in diminishing anxiety and promoting rest. I believed that the information I was gathering was just for my patients' benefit, as I had yet to consider that I should work on my own self-care needs.

NUTRITIONAL GUIDELINES AND MEDITATION

After graduate school, my career path changed when I became the director of a new cardiac rehabilitation outpatient program. In this position, I not only had to learn about all the insurance regulations, but also how to teach practical tips on making lifestyle changes in diet, exercise, and stress management. With the help of a colleague, I developed nutritional guidelines that went beyond the traditional advice of limiting eggs, butter, and red meat to emphasizing an abundance of fruit, vegetables, whole grains, fish, and the right amount of "good" fat daily; antioxidant supplements also were recommended. (These guidelines may not seem earthshaking by today's standards, but in the 80s, this was novel thinking.) Around this time I discovered that short-focused meditation breathing techniques in conjunction with nitroglycerin helped to shorten episodes of angina and make patients feel more in control, so I began teaching patients to use slow diaphragmatic breathing alone or with an affirmation tailored to their individual needs. I saw that involving patients in a partnership treatment plan enhanced optimal healing for patients and satisfaction for the practitioners. As time progressed, I added other therapies to my practice, including Healing Touch (HT), Reiki, massage therapy, aromatherapy, meditation, and herbal medicine. I have found that since I began to use HT, I no longer miss the vein when drawing blood and that the site heals without any bruising. My patients tell me that they feel less pain when I draw their blood compared to when blood is drawn at their doctors' offices.

Like many nurses who have begun to integrate CAM therapies into their practice and have moved toward a more integrative model of care, I have gained important insights into myself and my nursing role. The most important is the recognition that I am a healing tool. Having now learned to "walk my talk," I have learned how to be compassionate and present in my relationships, while at the same time honoring my own needs. Being a role model is critical to the integration of CAM into practice.

LEAVING THE COMFORT ZONE

For nurses educated in the conventional medical system who work in acute care settings, the world of CAM may be foreign and intimidating. But growing research shows that these therapies are effective and well-received by patients. Searching literature beyond the mainstream medical/nursing journals can be helpful to learning about CAM, as may attending workshops on CAM topics. It may mean leaving one's comfort zone and having to experience some personal changes, but it opens the doors to an exciting new healing path for oneself and patients.

> *"BEING A ROLE MODEL IS EXTREMELY CRITICAL TO THE INTEGRATION OF CAM INTO PRACTICE."*

As I reflect on my initial holistic path, I never would have dreamed that I would have been so blessed to work in an environment that has allowed me to use these skills. It is important to approach the desire of integrating CAM into practice with a great deal of gentleness and patience and to recall that this holistic way of being has to be lived first before it can be shared. ■

Assuring We Do No Harm

By Charlotte Eliopoulos, RNC, MPH, PhD

DO NO HARM . . . THIS SIMPLE expression of the ethical principle of nonmaleficence guides all nurses who strive to practice with compassion and competence. Most nurses entered their profession to help, not harm, so it may appear unnecessary for them to be reminded of this basic truth. Yet, as nurses integrate complementary and alternative medicine (CAM) therapies into their practices, there are new opportunities to threaten the health and well-being of patients.

With the rapidly growing interest and promotion of CAM, many patients and nurses are eager to try these therapies. Many of these therapies are new and different (to Western thinking, at least), and therefore attractive to persons, particularly Baby Boomers, who challenge traditional ways of doing things. The mystical overtones of some CAM therapies appeal to persons exploring nontraditional spiritual paths. Some individuals have a preference for practices that are natural over those that are high-tech or synthetic-based. Further, many CAM therapies are more pleasurable to use than conventional ones. But, new, natural, mystical, and enjoyable does not necessarily mean effective and beneficial. By lacking adequate knowledge to inform patients about the appropriate use and limitations of CAM therapies and neglecting to counsel patients in effective integrative practices, nurses can contribute to patients postponing necessary treatment and wasting time and money as they pursue CAM remedies when conventional care would be superior. CAM must be viewed not as a substitute, but as a partner with conventional medicine in an integrative model.

While being cautious to assure that patients don't use CAM therapies when conventional treatments are superior, the flip side holds true too. It is unethical for nurses to fail to advocate for the use of CAM when evidence supports that it offers a more effective and safe treatment option. If echinacea can help a patient manage a minor infection and avoid the use of an antibiotic, or if a patient's pain can be managed by the use of touch and humor therapy rather than a narcotic, it is responsible to recommend the lower-risk alternative.

Many patients explore the use of CAM after unsuccessfully managing health conditions through conventional health practices. They may have reached a plateau in their health status, suffered uncomfortable side effects, or become frustrated with care that they perceive to be impersonal or unresponsive to their total needs. When these patients stumble upon a nurse who takes a holistic approach and partners with them to integrate CAM and conventional therapies, they may be like thirsty people who have been given a pitcher of cold water. They feel important, valued, heard, and nurtured. Someone is listening to their problems and stories, and exploring all aspects of their being. They may learn to adopt lifestyle changes and experience new therapies that cause them to feel and function better than they have in a long time. Some of these patients may be convinced that they have found the answer; they may view the nurse as their savior. Such a reaction from patients can be flattering to the nurse, and perhaps deeply appreciated and welcomed in a healthcare system in which the nurse isn't always made to feel important. It can be tempting to reinforce patients' beliefs that it was the power of the nurse rather than their own efforts that affected their healing; the temptation may be even greater if the nurse relies on patients' fees. By reinforcing this thinking, the nurse is harming patients by fostering dependency, weakening self-care abilities, and by misleading them as to the true source of healing.

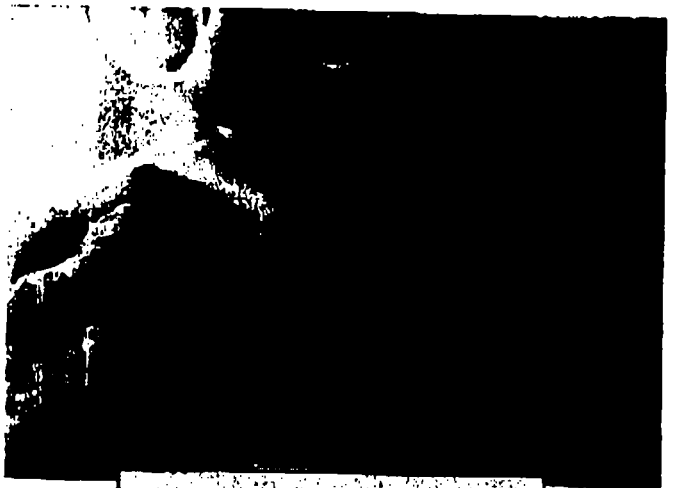
Inadvertent harm can result when CAM therapies conflict with patients' cultural or religious beliefs. For instance, some patients may object to touch therapy and Reiki because they believe healing from any source other than God is sacrilegious. In their enthusiasm to integrate CAM, nurses may promote practices that cause patients psychological or spiritual distress. This reinforces the importance of understanding cultural and spiritual implications of various therapies, and assuring that cultural and spiritual histories are essential components of all assessments.

While still in its early phase of integration into conventional medicine in the United States, the users of CAM need guidance from responsible professionals. Nurses are challenged to exercise leadership to assure that CAM therapies are used responsibly and appropriately to improve health status, foster self-care, empower patients, and, importantly, to do no harm. ■

"CAM MUST BE VIEWED NOT AS A SUBSTITUTE, BUT AS A PARTNER WITH CONVENTIONAL MEDICINE AS PART OF AN INTEGRATIVE MODEL."

Description of Complementary Medicine Center
Coordinated by RN & AHNA member Pat Merritt

Complementary Medicine: Caring for the Mind, Body and Spirit



Feeling stretched and frazzled by the stresses of modern life? Coping with the impact of serious illness or major life change? Looking for ways to improve your health and your sense of well-being?

Saint Clare's Center for Complementary Medicine can give you the means to restore health, to prevent disease and achieve optimal wellness.

As the name implies, complementary medicine supplements and enhances standard health care and helps patients reap the benefits of both. The field includes a wide range of philosophies and therapies that are based on a common premise: healing requires care for the whole person - the body, the mind and the spirit.

"While we honor the expertise of traditional medicine, we believe that within each of us is a natural ability to heal."

The Center's programs echo this philosophy, blending therapies that promote healing on all levels. "While we honor the expertise of traditional medicine, we believe that within each of us is a natural ability to heal," said Patricia Merritt, RN, the Center's coordinator. "We have successfully treated people from all walks of life and all levels of wellness and disease. People who suffer from chronic pain, gastrointestinal disorders, high blood pressure, headaches, anxiety, cancer, diabetes, HIV infection, sleep disturbances and life stresses have all benefited from complementary medicine."

The Center's therapies use a hands-on approach, focus on human energy and heal through balance and movement. These mind-body approaches include:

Reflexology: foot/hand acupressure designed to relax the body through the nervous system.

Energy Therapy: Therapeutic Touch and Healing Touch therapies that restore balance to the body's energy field.

Meditation/Guided Imagery: a process to quiet the mind, increasing awareness and directing the person's attention inward to create a sense of peace.

Massage: manipulation of the soft tissues of the body to relax muscles, improve circulation and relieve pain.

Stress reduction: individual and group instruction on how to decrease the effects of stress on the body, mind and spirit.

Yoga and Movement: group classes that introduce physical postures, breathing exercises and meditation practices.

The effectiveness of the therapies is confirmed by the growing recognition they are receiving in healthcare in America, Merritt said. More than one in every three Americans use them and many physicians and other healthcare professionals refer their patients to complementary therapies.

The Center is located at Saint Clare's Hospital/Dover and conducts programs at Saint Clare's Life Performance Center in Denville. It also presents a variety of programs throughout the community on wellness, nutrition, health promotion and complementary medicine therapies.

To arrange for a confidential interview, schedule an appointment or for information on upcoming community programs, call (973) 989-3607.

Clinton Presidential Records
Digital Records Marker

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This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

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WELLSPACE™

Comments on CAM Success and Policy Implications

White House Commission on Complementary and Alternative Medicine Policy
December 5th, 2000

Morton Rosenthal
Chairman & Founder
Wellspace Inc.

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Key Points

- Wellspace is attempting to consolidate and brand CAM, making it safer and more accessible.
- Wellspace is complementary, not integrated - no MDs, very limited reimbursement.
- Because of the small economic spread (gross margin) between the prices we charge the patient and the amount we pay practitioners, we require a laser-like business focus while maintaining high quality therapeutic and service standards.
- Attention to the customer/patient is critical at *all* levels of service delivery and in the entire patient experience.
- In CAM, the quality of the individual practitioner matters enormously. To attract and retain the very best practitioners we pay a lot of attention to culture as well as to economics and practice standards.
- Significant investment in systems and infrastructure is required to both support the level of consistent quality we demand, and to maintain an affordable cost structure.
- Physicians have, in general, been receptive to Wellspace, and provide some patient recommendations (as opposed to referral). Nonetheless, only 10% of our 100 new customers per week come from conventional medicine, and none of our patients want an ongoing relationship between their CAM practitioners and their MDs.
- Based on a test of free availability of our care, it appears that patients are relatively price insensitive. If a consumer knows about CAM choices, they are willing to spend the money to try it, and if it works, to use it.

Metrics and results

- Metrics
  - 10,000 square feet in Cambridge Center
  - 21 treatment rooms
  - Open 90 hours/week - 7 days/week
  - 70 practitioners
- History
  - Open for 27 months
  - Seen 10,000 patients (not including classes)
  - Had 40,000 visits (not including classes)
- Financial Results
  - Approximately $8M of total invested capital
  - Cambridge prototype center break-even after 23 months in July 2000
  - Cambridge prototype generate approximately $2M of revenue in 2000
  - Run-rate +/- 10% EBITDA contribution margin per center
  - Free-standing centers can be opened for less than $1M
  - Satellite center (in health or fitness facility) for as little as $500K
  - Several centers required for company break-even
- Modalities
  - Massage, including Feldenkrais and problem specific bodywork
  - Acupuncture and Chinese Herbs
  - Chiropractic
  - Naturopathic Medicine
  - Nutritional Counseling
  - Classes
- Referral
  - 70 to 100 new patients per week
  - 60% word of mouth
  - 20% retail - drive or walk by
  - 10% medical
  - 10% program offering

- Utilization
  - 70% overall
  - New practitioner goes from 0% to >50% immediately
- Retention
  - 60% of patients come back, and then return an average of 6 times/year
- Conditions
  - 45% stress/relaxation
  - 55% medical condition other than stress
    - Pain - back and neck
    - Headaches
    - Sleep disorders
    - Fibromyalgia
    - Fatigue
    - Allergies
    - Women's health
    - Pediatric
    - Cancer - with physician's approval
    - Many other conditions

Wellspace is complementary, not integrated

Wellspace attempts to create an idealized delivery system for healthcare. We have concluded that this necessitates a system that is neither modeled after, nor dependent on, the existing healthcare system,

- An idealized delivery system for healthcare
  - Attention to the quality of patient care at all levels and at every point.
  - Care begins when the appointment is booked.
  - An environment where practitioners are cared for and supported, and enjoy collaboration oriented clearly to the maintenance of the health of the patient.
  - Facilitate in every way possible a broad range of patients care choices, and be supportive in their decision-making process.
- There are no barriers and no existing legacies that need be adhered to that prevent this happening in the CAM space.
- Delivery systems for conventional healthcare do not work for patients, practitioners, or payers.
- We needed to avoid healthcare models and emulate retail models, such as Home Depot, where the consumer's expectations are met or exceeded for personal and knowledgeable service, top quality, and a fair price. (Not a high-end "Neiman Marcus" model, where quality and exclusivity are tied together.)
- The original notion of Wellspace was to create a parallel universe of healthcare delivery, with an expectation that the patient appeal would drive more conventional practices into our model. To date, we have been approached by dozens of allopathic practices. One Harvard teaching hospital is negotiating to put a facility (cardiac rehab) into a Wellspace center.

Business Focus Required

In order to be sustainable (for profit or not-for-profit), a CAM center must be extremely focused on operational excellence, quality service, and cost control. This is driven by the fundamental economics of the "industry".

- Wellspace is a "consolidation layer". This consolidation of individual practitioners creates value for both patients and practitioners but also adds another mouth to feed.

- Basic CAM economics
  - Successful CAM practitioners make $30K-$60K (top chiropractors and acupuncturists aside) .
  - CAM services generally are paid out-of-pocket at $50 to $100 per hour
  - CAM services are generally not leveragable (one-at-a-time).
  - It is hard to build a practice.
  - Examples
    - Acupuncturists 5 years out of school can expect under $50K/year
    - Massage - at $60/hour - 20 visits/week - $60K max if fully utilized

- Wellspace's margins are based on:
  - A small price premium to patients for convenience and amenities.
  - A small per-unit discount in pay to practitioners made up for by increased utilization and decreased costs.

- Wellspace margins are very low compared to any other service business
  - Wellspace "bills" at 1.5X what we pay practitioner (gross margin 33%)
  - Other reference points
    - MDs were at 4 to 8X pre-managed care, now at 3 to 5X
    - Consultants, lawyers, accountants are typically at 3 to 7X

- Therefore to survive as a "Consolidation Layer", the business must be run very tightly in order to survive, and maintain its quality patient and practitioner focus.
  - Heavy investment in leveragable systems and processes
  - All costs focused on quality, service, and affordability (from the front-desk personnel to the materials for the build-out)
  - Don't spend it if there is not a direct benefit to the customer, the practitioner, or the core business economics

Attention to the Customer

Patients are making a choice to come to Wellspace. They need to be treated like any customer in a highly competitive marketplace, with a single overriding principal: every touch is an opportunity to deliver care and to create loyalty.

- Patients *never* wait for an appointment! - breaks designed into the schedule leave some flexibility, no tolerance beyond that.
- Money transactions are done easily and simply - all payment types accepted with great systems support, and the check-in/intake process is quick and smooth.
- Appointments are available when the patients want them. We have an elaborate supply and demand model that creates staffing to peak demand, with long hours 7 days a week. Afternoon and evening demand is high. Weekends are busiest.
- If education is needed, we make it non-threatening, informative and sensitive. Although there are both print and online options for information (internally created), many patients who need education about their unique condition want to visit our highly knowledgeable and trained Wellspace Guides.
- Wellspace is an urban oasis - the physical environment supports the mission in appearance, smell, sound, textures, materials, etc.
- We inform patients about their health without being pushy - ongoing staff training on communicating treatment plans; difficult situations have clear processes.
- We need to rely on a service attitude of all staff members, *but* we reinforce that commitment with defined processes and ongoing relentless service training for staff and practitioners.
- We have clear customer service policies that are consistent, broadly communicated, and supported by systems.
- Our customer service efforts yield high return rates most first time visitors, and 60% of our new business comes from patient referral.

Attention to the Practitioner

The patient/practitioner relationship is what matters in CAM and therefore what drives success. To attract and keep the best practitioners, we need to focus on the quality of their experience, from an economic, practice policy, and cultural perspective.

- If the treatment experience is both efficacious and caring, then the patient will have loyalty and will return to Wellspace and make referrals.
- The range of quality in CAM practices is very broad, in part a result of the lack of standards of education and licensure. At the same time, the most gifted practitioners with the best outcomes may have been trained by apprenticeship, and have immeasurable skills.
- In CAM, the care is always very personal, so that the best practitioners will consistently deliver the best care. Therefore, Wellspace employs experienced and successful practitioner.
- These practitioners are looking for a community of professionals within their modality, as well as an opportunity to work with other practices.
- Wellspace provides a professional working environment, with some connections to allopathic medicine. (e.g. SOAP notes on all visit, no tips)
- Their practices are fully managed, so that practitioners simply do what they are good at: delivery of care. They do not have to worry 7x24.
- Compensation that is probably better and certainly more reliable, with a target that net compensation improves at Wellspace. Compensation varies by practice, but is generally 1/3rd salary and 2/3rd performance-related. The performance component is mostly based on number of visits, with extra compensation based on patient retention and practice utilization.
- Benefits include health (including CAM), disability, malpractice, 401K, and stock options. These benefits are not generally available to a CAM practitioner.
- Cultural considerations are extremely important, We support ongoing learning with subsidies and in-service training. We include practitioners in decision making. We are constantly broadly reinforcing the mission.

Systems and infrastructure

To maintain consistent quality while controlling the cost structure, it has been necessary to invest in high quality customized systems and processes. These systems can be leveraged to multiple Wellspace centers with only small incremental costs.

- Resource planning
  - The critical system that maximizes the key economic driver - utilization.
  - Design of shifts, hours, rooms to optimize the balance between high utilization and low unavailability
  - These systems drive shift design, business practices, and practitioner rules.
- Appointments and Point-Of-Sale
  - Appointments are requested by type (e.g. problem specific bodywork), time (e.g. Saturday morning), and person (next available with Dr. Chen), The system must accommodate all views.
  - Appointments are entered by a 9-person front-desk staff, and potentially by both practitioners and patients
  - Payment by cash, check, credit card, gift certificate, and multiple-session prepayment.
  - New patient intake demographic and medical record input
- Medical records
  - We built a full point-and-click vocabulary for our modalities that allows, for example, acupuncture diagnosis for TCM and Japanese traditions; treatment records by pointing and clicking acupuncture point menus.
  - In general, our system does not track directly to ICD-9, or CPT codes.
  - 100% of visits have a full SOAP note - 40,000 visits on 10,000 clients.
  - The database is highly structured with ability to add free-text.
  - Systems (and practitioners behavior) maintains EMR discipline & confidentiality
  - We have the capability to generate electronic or faxed progress notes.
  - [Note: Since we "can't" diagnose and we are not reimbursed for coded treatment, no one quite knows what to do with our "outcomes" data.]

Relationships to Physicians

Although we have excellent relationships with most local physicians and practices, we do not get traditional referrals, nor do we rely on other practices for our new patients. Our patients are generally not interested in integrative care.

- We made a decision initially to have no physicians practicing at Wellspace.
  - Billing and reimbursement added complexity that seemed too much for a start-up business trying to build a new model.
  - We perceived an issue of patient ownership, and wanted to make sure we hade equal access across all health traditions without hierarchies.
  - We perceived that having in-house physicians would be perceived as competition with other physician practices, particularly in a polarized environment like the Boston medical community.
- We get +/- 10% of referrals (7 to 10 per week) from physicians.
  - Generalized recommendation with knowledge of Wellspace quality, not a traditional referral. ("I give up, try acupuncture," or "If you don't want surgery...").
  - Sometimes success with one patient leads to specific recommendation for a practitioner.
  - Some joint programs (e.g. women's health).
- Currently Wellspace is well known and well thought of in the Boston physician community. We are developing a cardiac rehab program inside of Wellspace run by a Harvard Hospital.
- Today there is almost no patient-oriented consultation between Wellspace practitioners and MDs, and no request for feedback or progress notes. Similarly, when asked, almost no patients were interested in their physician knowing about their treatments at Wellspace.
- Our lack of "integration" is a result of lack of training of medical doctors as to the efficacy of CAM and how, concretely, to integrate patient care. In fact, most physicians are open to CAM and interested in learning more.

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Norman Brinkley is on his way.

Managed Care

Managed Care, in general, increases administrative cost and lowers fees through negotiation, lowering unit margin with the assumption of increased demand. In CAM, these economics do not work, today.

- In CAM where margins are low (1.5X vs. 4X) the unit margin may become negative under managed care
  - In an effort to provide a perceived benefit to members, price negotiations are aggressive.
  - Since managed care organizations categorically don't do *new* things well, the administrative costs are staggering.
  - The unit margin (which then contributes to covering operating costs) has been negative in Wellspace's experience,
- Wellspace experience with a 2000 member test (no prior approval, co-pay only, access to massage, acupuncture, chiropractic):
  - Only 70 out of the 2000 took advantage in 6 month period.
  - During the pilot, we lost money at the gross margin (before operating costs) line with every treatment (low fees, high admin costs)
  - Close to 60% of patients continued to come after the program ended and when fees were fully self-paid.
- Today, the price elasticity of demand is low, that is price does not particularly matter in a patient's treatment selection.
  - If patients are knowledgeable about the efficacy of CAM, they will spend discretionary out-of-pocket dollars.
  - The cost to the patient is relatively low compared to the pain.
- [Wellspace has just started to accept PIP, Medicare, and selective PPO's for chiropractic.]
- Managed care or reimbursement could work:
  - If there was more education (to and from physicians, as well as others) then more patients would come
  - If administrative systems were streamlined
  - If managed care organizations established fee structures based on savings relative to allopathic and pharmaceutical solutions, rather than attempting to negotiate a discount from self-pay retail pricing.

Policy Recommendations

Caveat - these recommendations are pragmatic, and with limited experience and knowledge of healthcare and healthcare policy. In an ideal world, and perhaps eventually, CAM will be universally understood and universally available, and all healthcare will be equally focused on both crises and wellness. As this is not currently the case:

- Reimbursement today
  - CAM today cannot survive today's form of reimbursement, as a reduction of today's fees and the increased administrative costs are not compensated by increased volumes, and would lead to bankruptcy.
  - Up to now, the best practitioners with the best outcomes have, in general, not chosen reimbursement options even when available.
- How to make reimbursement work more broadly for CAM
  - CAM must be studied more broadly in pilots that demonstrate efficacies for specific conditions and for general wellness using both medical and non-medical delivery models.
  - CAM must be better known for its efficacy through education of the consumer, and of healthcare providers who will educate consumers.
  - The systems for CAM reimbursement must be efficient, to minimize administrative burden for payers, practitioners, and patients. These systems should not be based on existing healthcare reimbursement systems.
  - Reimbursement must derive from value-based pricing, which in part is based on the efficacy and cost of CAM relative to allopathic and pharmaceutical choices.
- The delivery system for CAM will remain, to a large degree, stand-alone and patient-driven, for the next 10 years.
  - Conventional medicine practices are not well versed in how to integrate a CAM practices or integrate CAM into a patient's individual care.
  - Existing medical environments are, in general, not conducive to CAM choices.
  - Existing healthcare delivery systems have so many immediate issues, that getting long-term focus on CAM integration is extremely difficult.
  - Addressing these issues requires changes in medical training that will take at least a generation.

- The acceptance and recognition of CAM as an important form of care, should not be dependent on the integration of the delivery systems.

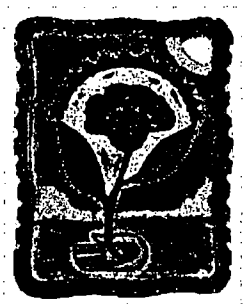
- CAM is a $20B market delivered almost totally by individual entrepreneurs and entrepreneurial organizations. Entrepreneurial organizations only survive if they are successful, which means customer satisfaction, which, in this case, means an improved perception of health.
  - Policies must support of these entrepreneurs and entrepreneurial organization.
  - Policies must not require integration for legitimization or appropriate reimbursement (some models will reimburse only if an MD is on-site).

- Academic medicine, where new allopathic procedures are studied and introduced, may not be the only place to examine CAM. There need to be better studies of how CAM is used today and with what result.

- Regulation
  - Some regulatory oversight, such as licensure and standards, provides a clear benefit the consumers.
  - Too much regulation may result in higher cost and less consumer appeal, if CAM becomes more like the medical delivery system. This must be avoided.
  - CAM practices and practitioners need to be given an equal place at the table of CAM regulation, in recognition of the radically different mind-set of many CAM practices. If medical doctors are the dominant voice in modeling the regulation of CAM, it may be cast as an ancillary service, which would be catastrophic to the industry and the consumer.

- Support for the development of curriculum that educate medical doctors as to the basis and efficacy of CAM, would go a long way to achieving the generational shift that may be required to improve patient access to diverse and appropriate choices.

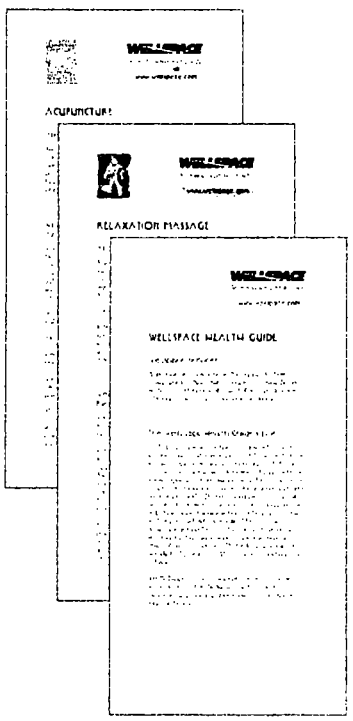
WELLSPACE®



DESCRIPTION

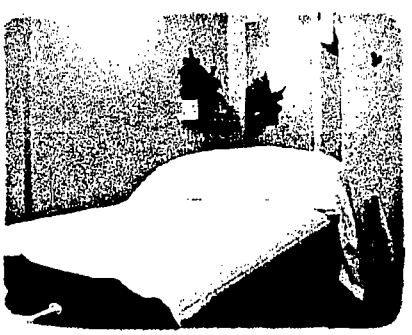
Wellspace, opened in Cambridge, Massachusetts in 1998, is the country's largest natural health center, providing 40,000 patient sessions of Complementary and Alternative Medicine to over 10,000 individuals in the past 27 months. Conceived in 1996 as a model delivery system for effective and responsible Natural Healthcare, the company now employs 70 practitioners and a support staff of 10. Practice areas include Massage, Acupuncture, Chinese and Western Herbal Therapy, Naturopathic Medicine, Chiropractic, Nutrition, Movement Education. Wellspace also offers an extensive mind/body class curriculum, as well as lectures and workshops on a wide range of health issues. Currently operating one stand-alone facility, the company plans to open a second center in a health club setting in spring 2001.

WELLSPACE®

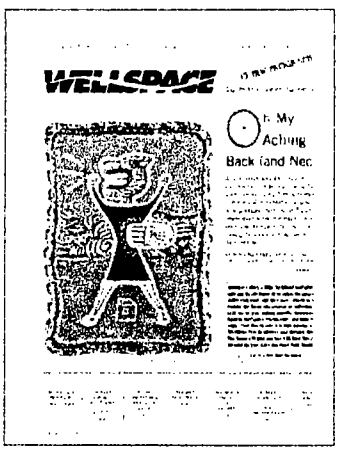


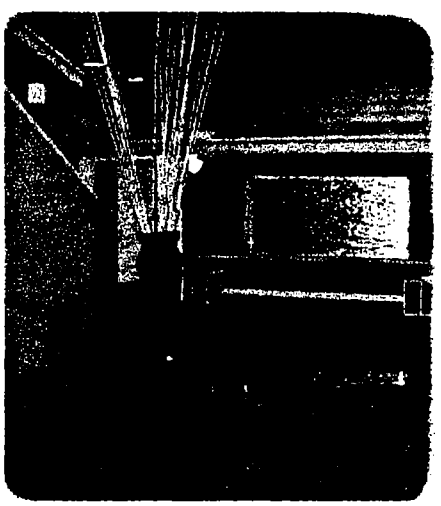
MISSION & PHILOSOPHY

Our mission is simply stated: ***To do remarkable things in healthcare****. This approach informs everything we have done over the last 4 years. Surveying a healthcare landscape in disarray in the mid 90's, Wellspace's founders sought to help mainstream CAM as an important complement to western medical traditions, and to provide easier and better access to care, in contrast to the shrinking access that the evolution of managed care had created. Sharply focused on the experience of both Practitioners and Patients, Wellspace seeks to attract top-quality individual Practitioners into a collaborative setting, provide economic stability to them, and absorb all administrative burdens; Patients are attracted to a physically appealing environment, guided choice of health options, and the highest quality care.*



WELLSPACE®





PRODUCTS AND SERVICES

Therapeutic Practices

- Acupuncture
- Chinese Herbs
- Chiropractic Healthcare
- Naturopathic Medicine
- Nutrition Counseling
- Massage *(Relaxation, Pregnancy, Sports)*
- Movement Education *(Feldenkrais® Method)*
- Therapeutic Bodywork *(Problem Specific, Myofascial Release, Reiki, Shiatsu/Oriental, CranioSacral Therapy)*
- Reflexology *(Hand & Foot)*

Programs

- Back & Neck Pain Relief *(see next page)*
- Women's Health
- Fibromyalgia Relief

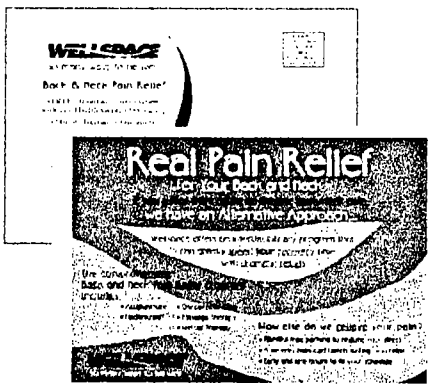
Education

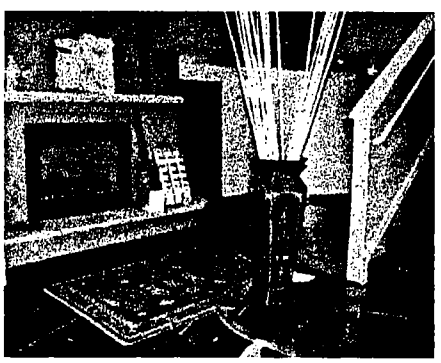
- Classes *(eg. Yoga, Pilates-based Conditioning, Meditation, T'ai Chi, Qi Gong, Weight Loss, Prenatal Exercise)*
- Lectures *(eg. "Fat Loss Strategies for Better Health," "Body Intuition and Your Health," Acupuncture Mini-clinic)*
- Workshops *(eg. Infant Massage, Feng Shui, Couples Massage)*

WELLSPACE®

BACK & NECK PAIN RELIEF PROGRAM STATUS

The program began in Spring 2000. To date 74 patients have initiated contact, with 93% subsequently enrolling, accounting for 518 scheduled sessions. 32% of those enrolled have had 1 or 2 visits only. 20% are on a maintenance program, reporting that they are "Doing well," and revisiting as necessary. 48% are in active treatment, with 36% of that group reporting that they are "Doing well."





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Divider Title: Quevedo

Submission on Hospital-based Centers

White House Commission on Complementary and Alternative Medicine Policy

December 4-5, 2000. Washington, D.C.

The Center for Integrative Medicine at O'Connor Hospital

Sylver Quevedo, MD, MPH

Initial Conception and Early Development

It all started for us in 1997. I had just left the medical faculty at Stanford and was doing nephrology and internal medicine at the O'Connor Hospital in San Jose, California. O'Connor, a 300-bed hospital, had just become part of the Catholic Healthcare West (CHW) organization, a large 50-hospital consortium with operations in California, Arizona and Nevada. A year earlier CHW had begun to develop a series of complementary medicine centers under the auspices of a new subsidiary they created called the American Centers for Health and Medicine. The flagship center was based in Phoenix, Arizona where CHW had acquired the practice of Sam Benjamin, MD. Dr. Benjamin had a large practice, which integrated complementary and conventional family medicine. He and Bernita McTernan (a Senior Vice President at CHW) championed the development of complementary medicine within the CHW organization. CHW and the American Centers group explored interest in complementary medicine among member hospitals through presentations in the San Francisco area. After attending one of these Sheila Yuter, then the Director of Business Planning for O'Connor Hospital became enthusiastic about bringing complementary medicine to O'Connor. She had a personal interest in it and saw the possibility of developing a new market where there was a good fit with consumer interest in the SF Bay area. Sheila convened a physician focus group on complementary medicine. I was part of the original group and shortly thereafter became the chief medical advisor to the hospital for the project.

Development History

- 1996 CHW Develops American Centers for Health and Medicine, Phoenix, Arizona
- 1997 O'Connor Hospital (OCH) Planning Group in Complementary and Alternative Medicine
- 1998 OCH Board approves plan for the Center for Integrative Medicine (CIM)
- 1998 CHW closes the Phoenix Center for financial reasons
- 1999 CIM opens

Figure 1

Sheila and I visited Phoenix several times during 1997 and 1998 and met with medical and administrative staff there. Dr. Benjamin had moved to New York to start another complementary medicine program at the State University of New York (SUNY) in Stonybrook. Dr. Howard Silverman, a family physician and educator had followed in the role of Medical Director. The Phoenix center was altogether impressive. It was beautifully designed with feng shui principles in mind, plenty of attention to color and interior décor, and good patient flow characteristics. It was a large facility of approximately 14,000 square feet centrally located in Phoenix but unaffiliated with a

hospital or medical complex. Physicians and associated practitioners were on salary in a staff clinic model doing exclusively ambulatory care. I was inspired by the effort in Phoenix and by the Integrative Medicine movement in general. Here was a great opportunity to reinvent medicine from a broader perspective, more humane, more encompassing in concept and practice. Our plan was to start a second site at O'Connor under the American Centers umbrella, but with attention to the unique aspects of our local situation (Figure 2).

Initial Plan for Organizing the CIM

- Analyze the strengths and weaknesses of our institution and community
- Begin a Focus Group. Include members of the medical staff, administration, and selected community partners.
- Design a program model
- Build on existing programs and practices where possible

Figure 2

Returning to California, we continued our meetings with the physician focus group. The hospital sponsored several physicians to travel to complementary medicine meetings. Each of us on the committee made presentations on the specific area that we were investigating. I was in the second year of a Divinity School program and had become interested in the intersection of medicine and spirituality. I also attended and reported on the NIH Consensus Conference on Acupuncture. Others presented on homeopathy, massage and bodywork, biofeedback, and more.

We surveyed key medical staff members regarding various complementary medicine modalities with four basic attributes in mind: safety, efficacy, acceptability to the medical staff, and availability of practitioners. This proved to be an important consensus-building exercise as it involved medical staff leadership and many physicians who were not part of the planning effort. Since a good relationship with the medical staff was a founding principle for the program we were attentive to the development of key relationships (Figure 3). We emphasized that we were building on a foundation of the "best" of scientific medicine and that we were committed to working with the medical staff. We searched for deeper elements common to all healing traditions and avoided an approach defined by specific modalities or complementary therapies. We were impressed with the "Manifesto for a New Medicine" so well stated by Jim Gordon. We worked with this paradigm to understand it, articulate it, and make it our own. It has proven to be a unifying ideology and very important to

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Develop Key Relationships

- **Medical Staff:** Identify physician-champions, use physician member of the Focus Group to cultivate support
- **Executive Body of the Medical Staff: Develop** a credentialing process for practitioners of complementary therapies that this group endorses.
- **Administration:** Use Focus Group members again. Align Center goals with institution-wide goals in a strategic planning initiative
- **Community Partners**

Figure 3

Why Integrative Medicine ?

- Build on a foundation of the "best" of scientific medicine
- Work with the hospital, existing institutions, physicians, and the larger community
- Expand the dialogue on the meaning of health and healing

Figure 4

our success. Since this was largely uncharted territory we wanted to emphasize evaluation and research. Finally, our posture was that we had no "answers" and that our intention was to expand the dialogue on the meaning of health and healing (Figure 4). We chose to call our vision Integrative Medicine using the terminology promulgated so widely by Andy Weil (Figure 5). With this vision we developed plans for a model center. This was to include (1) an overarching Center for Integrative Medicine (CIM) which provided the administration and housed the practice, programs, and community activities (2) a medical practice which was physician led and supervised, and (3) an Institute which was intended to support education and research activities.

We remained in contact with the staff of the Phoenix program. They generously provided information on their experience and challenges. We became aware that they were having difficulty generating adequate revenue to support their operation. We studied their experience and learned from it. In our planning we decided on an initial program that required low operating overhead and did not use a staff model with physician or staff salaries. We designed a small space of 3500 square feet. We borrowed what administrative support we could from existing hospital staff and started with a very small increment of new staff. Only 2 full time equivalents were to be added, one nurse and one receptionist. All the other staff members were to be private practitioners brought on with contractual agreements where the majority of their income was to be derived from direct patient care or services in the programs provided at the Center.

A Vision for Integrative Medicine

- Holistic Approach
- Emphasis on Uniqueness of the Individual
- The Importance of Relationship and Community
- A Healing Partnership with Patients
- Self-Care
- Respect for Other Healing Traditions
- Working with Groups
- The Spiritual Nature of this Work
- A Relationship to Nature

Figure 5

In discussions with the physician focus group, we reviewed three possible scenarios for center development (1) a department of the hospital, (2) a joint venture with a private investment group and (3) a practice wholly owned by the physicians who started the group. The physicians involved all had established practices and were reluctant to assume the risk of starting a new group practice with many of the uncertainties involved. As a joint venture with private investors it was not clear whether the Center could develop freely without commercial pressures and that the hospital would be satisfied with its degree of control. During1998, the Phoenix program began having serious financial difficulties and was facing a solvency crisis. Catholic Healthcare West began to doubt the financial viability of the original Centers concept and were hesitant to continue the development of their subsidiary the American Centers for Health and Medicine. At O'Connor

Hospital, however a strong focus group had already developed and was gaining support from medical staff and hospital administration. Because of this, the effort continued in spite of misgivings regarding the financial difficulties of the Phoenix program. O'Connor Hospital decided to assume the risk itself and fund the initial investment. The Center for Integrative Medicine was to be an ambulatory care center within the Hospital structure. Approximately $400,000 was allocated to fund initial start-up and operations with the expectation that the Center would be reaching self-sufficiency within approximately 18 months. The above plan was presented to the medical staff leadership and hospital board and approved in the late fall of 1998. I was appointed Medical Director and Tim Levers became Program Director. Shortly thereafter implementation efforts began. We wrote principles of practice (appendix 1) and policies and procedures governing all of the complementary medicine modalities. We developed a credentialing strategy (appendix 2) and recruited professional staff. California State Health Department licensure review was carried out early in 1999. Health Department reviewers told us that we are one of the first Integrative Medicine centers affiliated with a hospital to be reviewed and licensed in California. On May 12, 1999 the Center was opened for patient care and programs.

Initial Structure of the Center for Integrative Medicine

- A Center of the Hospital, licensed as an ambulatory care center, participating in institution-wide quality assurance activities, under Department of Medicine
- Physicians are all members of the Hospital Medical Staff
- Treating body, mind and spirit
- Team approach to individual patients, physicians act as team leaders
- Classes and group therapy to augment individual care
- A commitment to work with referring physicians
- Emphasis on evaluation and research

Figure 6

Key Assumptions and Decisions Used to Develop the Business Plan and Program.

- Physicians or doctoral level professional staff would direct all program areas.
- All physicians would be members of the hospital medical staff.
- A structured formal credentialing process that paralleled the medical staff process would be used for the practitioners of the complementary therapies. Formal quarterly reports on Center progress would be provided to the Medical Executive Committee.
- Program success was predicated on a good relationship with the hospital and its medical staff.
- Third party payers would not be major source of revenue or support for development.
- Direct patient care would not provide sufficient revenues to support all Center development. Diversification of revenue sources would be necessary. Revenues would be sought from

work with classes and groups, events, retail sales, and grant programs. Overhead should be kept at a minimum.
- Incentives for practitioner income and practitioner productivity should be aligned.
- There is sufficient interest on the part of consumers and the medical staff to support the development of integrative medicine in this community.

Key Clinical Elements

- Physician Services
- Holistic Nursing
- Acupuncture and Traditional Chinese Medicine
- Therapeutic Massage and Bodywork
- Biofeedback, Hypnotherapy, Guided Imagery and Meditation
- Nutrition
- Psychological Care and Spiritual Guidance
- Programs in: Women's Health, Spirituality and Medicine
- Education and Support Groups

Population Served and Methods of Triage and Co-management

The Center was initially designed as a consultative service with an emphasis on working with referring primary care physicians. Patients are referred by physicians and self-referred. During the first year of operations, all patients were accepted including those with marginal ability to pay. This is now being changed and a timeshare model is now being developed. Each practitioner will pay an hourly charge for use of the facility and will determine his or her own billing and collection procedures. All patients undergo initial holistic nursing assessment and for the most part are seen by an internal medicine physician for initial assessment prior to referral for complementary therapies as appropriate. Case Management is used as a principal mechanism for ongoing supervision of care. The physician acts as the team leader in case management reviews with the various practitioners and the nurse provides day to day continuity in terms of patient management. The major challenges of this clinical model have been:

1) The achievement of "integration". It requires significant commitment of time and effort to organize and integrate the care across different modalities. It is quite possible for complementary medicine to be offered in quite the same way as conventional specialty medicine with fragmentation and little or no communication between various practitioners. All providers of care must be committed to integration and collaboration or it will not occur. It is often a challenge to discuss cases because various practitioners sometimes use entirely different paradigms of care. Similarly, there is no standard case format or language consistently used to describe symptoms, signs, disorders, treatments or progress. Hence discussions are often idiosyncratic. Discussion of cases is sometimes quite a cross cultural experience. So it is a challenge for the physician acting as a team leader to translate across paradigms and try to "integrate" the care in order to achieve the desired outcomes.

2) A second challenge has been creating cohesion among a group of individual private practitioners. Since we are not operating as a staff or formal group model, there is little incentive for the individual practitioners to meet outside of patient care to discuss cases, talk

about standards of care, learn from each other's approaches and explain the language and logic of their own approaches.

Fiscal Realities

The practice was initially intended to be a fee-for-service practice. We fully expected that third party coverage would be minimal for many of the complementary therapies that we hoped to offer and that authorization, billing, and coding would be time-consuming and difficult. We intended to give patients a "super-bill" so that they could bill their own insurance. However, as part of the hospital we were obligated to operate under the existing hospital contracts and accept third party coverage and contractual rates. During the first year of operation billing was handled centrally by administrative support staff. This proved to be cumbersome since coding for diagnosis and treatment in complementary medicine was difficult. Many claims were denied. In general, third party payment for complementary therapies has been poor. Physician's services have generally been reimbursed by third party payers and so have some acupuncture services. However, massage and bodywork, biofeedback, hypnotherapy, guided imagery and much of psycho-spiritual care has been paid directly by patients or written off as a loss.

At present approximately 40% of our patients are fee for service and the remainder have third party coverage. We are now changing to an arrangement in which each practitioner pays a proportional timeshare rent for the use of the facility and defines billing and collection procedures for himself or herself directly with the patient. Practitioners will then do their own billing and collecting and decide if they will accept third party payers.

Prospects for Growth

During the first year of operation, patient utilization grew at approximately 20% per month to a stable total patient volume of approximately 300 patient encounters per month. We have not yet provided primary care for patients and have continued primarily as a consultative service. However, consistent requests by patients for primary care in our setting have led to plans for this in the coming year. This should result in additional growth. However, for individual practices to grow, third party coverage will be necessary. Substantial out of pocket expenses are incurred by the patients under the current model and this has limited the availability of care for many patients. Our educational programs and conferences have developed nicely with substantial increases in scope, content, and attendance anticipated for the coming year. We are in the process of developing a credentialing process to bring Integrative Medicine into the hospital. Our initial agreement was that credentialing for the complementary therapies would be limited to the outpatient setting. However, as the medical and nursing staff has become conversant with these therapies we have had numerous requests for acupuncture, massage therapy, Reiki, and integrative medicine consultation for inpatients. The medical staff leadership has asked the Center to design and lead this effort. This is intended to pave the way for bylaws development for a Department of Integrative Medicine in the hospital as part of the medical staff organization.

Research

Research and evaluation was emphasized during program planning. This was very important to the medical staff leadership, as they were hesitant to enter into the area of complementary medicine without this emphasis. Physician or doctoral level lead individuals were established over each of the modality areas with overall program responsibility residing with the medical director. A quarterly report to the medical executive committee at the hospital is regularly given

concerning utilization and program growth and development. All patients complete a baseline and periodic health status measure (SF-12) as part of their usual care. However, quality assurance, patient outcome assessment, and formal protocol driven research with institutional review are still very much in the design phase. One study has been approved but not yet implemented. We are committed to participation in clinical research, including multi-site studies. The medical staff, the center administration and the individual practitioners are all interested in participating in clinical research. Clinical research and health services research would enhance the credibility and stature of the Center in the eyes of medical staff, the hospital and larger community.

Philanthropy

We have not solicited or received any major grants or donations from benefactors. We are only beginning discussions concerning the development of an Institute to support the Center activities.

Appendix 1

CENTER FOR INTEGRATIVE MEDICINE
AT O'CONNOR HOSPITAL
PRINCIPLES OF PRACTICE

The members of the Center for Integrative Medicine shall endeavor to practice the following principles of holistic health care:

1. In the practice of holistic healthcare, the goal is healing the whole person, body, mind and spirit.

2. The practice of self-care and personal development is integral to holistic health care and is a continuous process. The effort to balance what one gives to self and to others is essential to achieve and maintain wholeness.

3. Professional staff shall approach health care practice with a sense of sacredness about their work. In so doing, they create and enhance the healing environment. They make it conducive to wholeness by bringing a spiritual perspective that conveys meaning and purpose in life.

4. Catholic Healthcare West core values: Dignity. Collaboration, Justice, Stewardship, and Excellence shall be practiced in the Center.

5. Recognizing the uniqueness of each individual patient, the professional staff shall endeavor to render care that is consistent with the patient's preferences, interests, culture and beliefs, family background, and hopes and dreams.

6. Professional staff will practice interventions grounded in the theory of Integrative Medicine based on research and evidence where available and with a commitment to developing new knowledge, approaches, and evidence. They will use conventional scientific approaches, while simultaneously exploring new methodologies necessary to elucidate a broader paradigm of health and healing.

7. Professional staff will encourage and allow patients to take responsibility for their own self-care, providing support, education and resources to the patient. They shall be willing to give up control of information and "knowing what is best" in order to minimize co-dependence and encourage autonomy of the patient.

8. Holistic Healthcare regards both intellectual and empirical knowledge and intuitive and empathic knowledge to be important in the care of patients.

9. Professional staff is committed to the study and acceptance of other healing traditions.

Text by Deborah Quevedo, RN

Appendix 2

Center for Integrative Medicine at O'Connor Hospital

Credentialing Plan

Philosophy - The Center for Integrative Medicine at O'Connor Hospital is an innovative effort to bring together, under one roof, a number of practitioners of Integrative Medicine. Integrative Medicine uses the broadest concept of health and healing and approaches the patient holistically, with attention to body, mind and spirit. In this effort, physicians, nurses, acupuncturists, massage and physical therapists, nutritionists and psychologists will work together in a team effort to provide holistic health care to patients. A credentialing strategy, which seeks to apply the highest possible standard for all practitioners, has been developed after thorough discussions and review of the experience in other states and in other institutions. An internal program of review and approval for qualified practitioners, which is formal, structured and periodically reviewed, is herein presented. Such a program will develop standards which will assure that all of it's practitioners are in compliance with external regulatory agencies but will simultaneously seek to further refine and develop these standards and promulgate them regionally and nationally with a concerted effort to education, research and quality improvement.

Responsibility – The Credentials Committee of the Center shall hold the principal responsibility for credentialing for Integrative Medicine. The Medical Director will chair this committee. The Administrative Director will hold an ex-official position. Representatives of the credentialing body of the medical staff will be asked to serve to serve on the committee, as well as other individuals external to the Center but holding key positions at the O'Connor Hospital. Outside individuals will be asked to serve in areas where special expertise is required.

The physicians will be credentialed through the traditional medical staff system.

Methodology - Screening of applicants will be carried out in order to determine licensing, certification, training, competence, malpractice history, and recommendations from colleagues and peers. Screening materials will then undergo verification and the applicant's general desirability will be based on screening, interviews and pre-censorship where appropriate. The Medical Director will make the recommendations to the Credentials Committee and approval or denial will follow. Credentials Committee action will be reported to the administrative officers by the Medical Director.

Within each of the complementary medicine areas, the scope of practice, the responsibility and authority of practitioners and the methods of performance evaluation and practice monitoring will have been established in the policies and procedures governing the center.

Performance Measurement - In an activity, which will be defined subsequently, the credentialing committee will also engage in performance measurement and monitoring for practitioners. The principal approach herein will be educational, but efforts will be made to conduct patient satisfaction studies, to process patient feedback, to review incident reports and practitioner comments and complaints.

Patient's Outcome Monitoring Program – A program is being developed in collaboration with the Stanford Center for Disease Prevention and the Complementary and Alternative Medicine Program at Stanford to conduct ongoing outcome studies of patients treated at the Center. Systematic collection of data on both clinical and functional outcomes will be part of the "usual care" process. More formal protocol driven clinical studies will also be conducted periodically.

Presented to Medical Executive Committee January 8, 1999.

BIOSKETCH

Sylver Quevedo, M.D., M.P.H.
Dr. Quevedo graduated with honors in biology from the University of California at Berkeley. He earned his medical degree at Harvard Medical School, while simultaneously earning a Masters of Public Health at the Harvard University School of Public Health. After training in Family and Community Medicine he worked in and developed Community Health Centers for several years. His postdoctoral training further includes Internal Medicine, studies in law and public policy at Stanford Law School and a fellowship in Nephrology and Medicine at Stanford University Medical Center where he was Robert Wood Johnson Foundation Clinical Scholar. He was subsequently Clinical Assistant Professor of Medicine at Stanford and Medical Director of the Artificial Kidney Unit at the Santa Clara Valley Medical Center.

In 1995, he joined the O'Connor Hospital Medical Staff in the practice of Nephrology and Internal Medicine. His areas of interest are quality of life and disease reversal in chronic illness, the phenomenology of healing, the intersection of spirituality and medicine and the comparative study of healing traditions. He is the founding Medical Director of the Center for Integrative Medicine at O'Connor Hospital in San Jose, California.

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Merrell

Divider Title: _____

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December 5, 2000

Presentation to the White House Commission on Complementary and Alternative Medicine Policy

1) Why and how did you decide to open your center in an academic medical center?

I would only have opened this center in an academic setting. Many proprietary groups have proposed centers for NYC. But their model was to open a center, then franchise it, go public and make money for the initial investors (in the halcyon IPO days). This is the wrong focus. Not that for-profit centers do not have a place in this newly evolving field of integrative medicine. But given the tenuous ground on which many of the centers stand, it is clear to me that in a for-profit model, if the financial going were to get tough, the first things to go would be the research and education components, with a demand for practitioners to ratchet down the time per patient, and to turn up hourly volume to nearer managed care rates (7 minutes per patient).

To be successful and bring this field into legitimacy, CAM centers must maintain the three pillars of clinical care, research and education. To do this they must be affiliated with academic medical centers. Also, I want to bring CAM into mainstream medicine, not from the outside, but with the active participation of academic medicine.

Beth Israel Medical Center (BIMC) has a tradition of innovation in medicine: their chair of family medicine is a homeopath; BIMC opened the East coast's first Planetree unit; the center had a five year program in Humanistic Care sponsored by the Nathan Cummings foundation (currently merged into the work of the Continuum Center for Health and Healing).

Two forces concurrently led to BIMC's acceptance of integrative medicine in their medical system. 1) The clinical staff had been meeting with other CAM care-givers in the new York area to see how best to be able to integrate CAM into medical centers, and 2) one of BIMC's most respected trustees, William Sarnoff, through personal experience, became convinced that CAM had to be incorporated into the medical center's offerings. At the urging of Mr. Sarnoff, backed by some of the Center's clinicians, the board of trustees and senior administration held a two-day think tank on integrative medicine in the summer of 1997. This was attended by most of the thought leaders of the medical center: trustees, administration, medical and allied health leaders, and outside consultants (myself included). The conclusion of this meeting was clear: integrative medicine is the future of medicine, patients are increasingly demanding it, patients are using it often without proper guidance, there is sufficient evidence basis to justify many modalities within integrative medicine, some medical center was going to offer it eventually, and it might as well be BIMC. They went on a search and I was hired in the summer of 1998. Backed by Mr. Sarnoff's pledge to raise $3 million, BIMC allotted $5 million to create the Continuum Center for Health and Healing (CCHH). This was envisioned initially as an outpatient unit---but the medical center agreed that inpatient CAM services would also be welcomed soon thereafter. CCHH opened in June 2000 with a staff of 30 (16 clinicians) in a 13,000 square foot environmentally-sensitive facility. The business plan forecast 2500 patients/month by year's end, with a break-even in year three.

2) How did you determine the staffing and CAM mix?

My vision for Beth Israel Medical Center's (BIMC) Continuum Center for Health and Healing (CCHH) was for a center that would combine the best of conventional western bioscientific medicine with those CAM practices and indigenous approaches to healing that have stood the test of time and/or scientific scrutiny---and preferably both.

To bring this vision into a clinical reality requires that many CAM modalities and approaches be included in a clinical center.

Most of the CAM centers opening in academic centers are focussed primarily on research and education. If they have clinical offerings for the public, these are usually mostly in the mind-body area---meditation, yoga, massage, and maybe acupuncture. Of course these practices are important; they are the cornerstones of this new field. But many areas of CAM are ready now for inclusion into the clinical setting. One of the criticisms of academia is that there is not sufficient evidence to justify the inclusion of more modalities. While this may have been true five years ago, the explosion of information and quality research in the last five years makes it clear that many modalities have sufficient evidence basis for their inclusion in medical care now.

At CCHH there is a mix that is just over 50-50 for conventional practitioners and CAM providers. All of the conventional providers (MD, DO, NP, & PAs) have integrative practices. They are not just open to the field and refer to CAM practitioners, but are trained and routinely utilize many CAM modalities in their practice. The CCHH clinical staff currently consists of:

Three family practitioners (2 double-boarded in family medicine and psychiatry): Their CAM experience includes; Native American Medicine, hypnosis, meditation, imagery and biofeedback, acupuncture, botanical and nutraceutical medicine, and (limited) homeopathy.

One internist specializing in ethnobotany and women's health

One holistic pediatrician

One gynecologist specializing in natural approaches to women's health

One Physician assistant specializing in women's health (holistic gynecology)

One psychiatrist who utilizes homeopathy in his practice.

One nurse practitioner specializing in family medicine, ayurveda and craniosacral therapy

One psychologist (PhD) specializing in mind-body approaches in mental health

One acupuncturist, very knowledgeable in Chinese herbology

One chiropractor

One massage therapist (including reflexology and craniosacral)

One nutritionist
One nurse (CNS-RN) specializing in holistic nursing; including biofeedback, imagery, reiki, therapeutic touch and aromatherapy
Research Director (PhD)

The administrative staff includes an executive director (MD) medical director (MD, MPH---one of the family physicians above), director of community education and outreach (RN, MPH, MS), and an administrative director (MBA). In addition some of the physicians above also have administrative responsibilities for part of their time, including a medical education director and clinical programs director.

3) What is the role of nursing in access to and delivery of CAM products and practices in your center?

Nursing must play a central role in the evolution of CAM Through the history of medicine, it has been the nurses who have been the guardians of humanism in medical practice. They have always been on the front line, with the patient long after the physicians have swept through their often brief hospital rounds. It is deeply disturbing that at so many medical centers, the role of nursing has been eroded in the last decade. Cutbacks in staffing have left nurses badly overburdened with chores that prevent them from having the time to care for more than the cursory needs of the patient---and being too tired to give of themselves to help their patients' healing process. This must change.

Nurses should be the focal point for change within the medical centers. It is they who largely should have the time and who historically do have the interest to nurture the patients' mind and spirit. Changes within medical centers need to start from within. While physicians need to play a leading role, it is their nursing peers who are there, ready and already trained in bringing a humanistic focus to medical care. This needs to be fostered and encouraged, and re-institutionalized for medicine to rise above managed cost care and move into a more healing focus.

An example of this at BIMC is the new pre- and post-operative surgery program. This is designed and run by nursing, with the approval of all chairs of the Surgery department. Patients who elect to do so, will be offered mind-body therapies, before (self-hypnosis and

imagery), during (reiki and therapeutic touch by one of the O.R's 14 nurses trained in these modalities) and after surgery. The outcomes looked at will be: the length of the recovery period, reductions in complication rates, severity of pain, and the patients' assessment of their quality of life in this very stressful period.

4) To what do you attribute your center's success?

There are four critical ingredients needed for academic CAM centers to be successful If any one of these is weak, the center's existence is threatened, These are:

A) a leader experienced in CAM who is respected by his/her academic peers for knowledge of, and ability to communicate the evidence basis for this field

B) a deep level of commitment from the medical center. Many centers have opened with one or two crucial people at the top backing the center. But once open, and especially if clinical services are offered, there is often a backlash from the conservative academics. Often this has been sufficient to lead to the eventual closing of the program. The institutional commitment must come from thought leaders in senior administration (CEO and COO), clinical staff (medical director and key department chairs), and trustees. Also the milieu of the center should ideally be one that fosters humanism and looks forward to CAM, not one where it is being rammed down their throats. Careful nurturing of the though leaders is essential before opening.

C) Experienced CAM providers. To insure sufficient patient volume to help insure financial success, the practitioners ideally should be recognized leaders within the local community---who are bringing their practice and patient following to the center (as we did at CCHH). Centers that import unknown providers, then open the doors and say we have CAM, have been having a hard time.

D) Funding. It is very difficult for CAM to be financially successful in clinical care. Centers that are well funded for research and education can support limited clinical programs tied to these grants. But to offer CAM services independently of grants, is a very tough road. Particularly in heavily penetrated HMO managed acre environments, it is

not possible without subsidies. While governmental (especially NCCAM) and NGO foundations are increasingly looking to fund CAM, there is not enough to go around. New centers must cultivate private donors in their community to insure financial survival---especially in the first three years of start-up in clinical care.

5) What lessons can be learned from your financially-unique situation and applied to other less well-financed centers?

Private funding sources are the white angels of this field. With increasingly fewer dollars in the health care pie to go around, these revenue sources are critical. Leaders in CAM must cultivate financially-successful individuals who are favorable to CAM and would look favorably on the opportunity to support integrative medicine's evolution in well-planned medical center initiatives.

The medical center should recognize that integrative medicine is a key to the future of medicine, and that the institution must commit to this to help insure its survival: even if nothing more than for marketing purposes, realizing that patients will want to come to centers and practitioners who have expertise in CAM.

The development office of the medical center should provide access to trustees and donors who could be approached to bring additional gifts to the center to support CAM. It is all one effort after all---while there will be turf battles to see who gets a particular donor's ear, the medical center should realize that *additional* funding for CAM can only help strengthen the institution.

Our center's success has been partially assured by a triad, the director of development, one of the board's most influential trustees (Mr. Sarnoff), and myself. We have raised at this point, after 2 years close to $10 million.

One other area necessary for financial success at the present hopefully will change soon: reimbursement policy. Currently in the managed cost system, CAM centers that depend on managed care reimbursement rates will find it nearly impossible to survive. Higher levels of fee-for-service rates are still necessary, until insurance companies are capable of reimbursing more adequately for the time-intensive nature of this field.

6) What have you done to improve access to and delivery of CAM products and services to the underinsured, uninsured, and medically underserved in your community?

A) We are fortunate at BIMC that we have 2 affiliated clinics that for a decade have been providing CAM modalities to these groups. 1) The Department of Family Medicine in partnership with the Institute for Urban Family Medicine uses CAM in its family medicine residency clinic. 2) There is a separate affiliated clinic Betances, that is largely state-funded for medicaid patients, serving a primarily Afro-American and Hispanic population with conventional medical care that incorporates CAM and indigenous healing modalities.

B) Our active research department, headed by Dr. Sam Shiflett (former director of the Kessler Institute's NIH-OAM funded research center), will provide access to patients in many clinical research programs

C) Group clinical programs, such as in diabetes will allow clinical care educational programs at a much reduced fee.

D) Our fellowship program will allow patients being seen by the fellows (all board certified PCPs) to be offered at a reduced fee.

E) We have established a helping Hands Fund for donors to provide access to the underserved. This program provides the practitioners' care for free, with the fund used only to cover center overhead for the visit. Practitioners donating time for care to this population is part of the center's philosophy.

F) Insurance company initiatives. We are working with insurance companies to fund pilot programs that will provide the data they need to decide which modalities work, and especially from their perspective, which are cost-effective. This will allow patients with no disposable income dependent on managed care to receive CAM services.

7) What policy recommendations do you have for the Commission? Please include your view on whether CAM should be accessed and delivered as a stand-alone or integrated with conventional care and why.

CAM should be integrated within the medical center. It should not be relegated to a boutique that provides limited services in a corner of the hospital—nice for marketing purposes but not central to

the medical center's mission to transform care for the twenty first century. It needs to be an organic process, with services accessible from within each department. Enlightened, informed physicians partnering with their nursing and other allied health colleagues and an administration that "gets it" will be the mechanism for CAM to be mainstreamed.

Having said that, in many centers, there will be a need for a formal department of integrative medicine. This is important to oversee the quality and integration of services throughout the medical center. This department's mission should be to encourage CAM to develop from within each department, not to be delivered in a limited way from afar. The department can help with collaboration efforts, institutional research and education efforts, and especially with credentialing standards and quality control. I was at first surprised when the chair of medicine at my institution told me that he *wanted* a department of integrative medicine: he said he wanted some other group to be assume responsibility for assessing standards and qualifications.

I am in support of a national Board of Integrative Medicine to set standards for this field. Attention should be paid to this month's American Holistic Medical Association's qualifying exam to see if it is appropriate.

Additional policy recommendations:

A) There needs to be a national Access to Medical Treatment Act that allows CAM providers to practice evidence-based modalities without risk of losing their licenses. I realize that the jurisdiction of what can be practiced falls to the states. But a federal guideline, with medicare standards will provide a template for more conservative states to follow.

B) There needs to be encouragement of CAM centers offering not only research and education, but fuller clinical services as well. There is enough evidence basis to justify CAM services in nearly all departments, and especially outpatient services of medical centers.

C) Insurance companies need to enter more actively into this arena. Right now, they should help fund pilot studies that will determine what modalities are clinically and cost-effective. Acupuncture, massage and chiropractic should be routinely covered.

D) NCCAM's work needs to continue to be strongly supported.

E) Patient education as to health care financing is important at this point in the nation's health care. We are increasingly becoming accustomed to demanding that all health care be free. This is probably not financially sustainable. Patients and insurers need to work to decide what modalities are fully covered, and which ones may need subsidy---from the government, foundations, and from the patient. Increasing utilization and access to Medial Savings accounts—that can be rolled over by all (currently not an option for employees of larger businesses) are very important to this process.

F) All states should be encouraged to license naturopathic medical practice. The standard such be graduation from one of the nation's premier naturopathic colleges (Bridgeport, Bastyr and National). Naturopaths are particularly qualified to utilize especially life-style, nutraceutical and botanical approaches to health and healing.

Additional comments:

1) Beth Israel Medical Center has set standards for credentialing CAM providers-currently chiropractic, acupuncture and massage that we feel is a good model for other institutions. These standards grew out of the Greely conference at Harvard in 1999. It is a thoughtful compromise between the state's wider legal scope of practice, and the comfort level of the medical center's more conservative clinical leadership. We are proud to be the first academic center in NY State to develop credentialing guidelines for CAM. CAM modalities provided by licensed PCPs are protected by NY State's Alternative Practice Act of 1993. Guidelines for standards of training and experience in various as-yet non-credentialed modalities (such as indigenous healing practices) practiced by the PCPs are decided on an individual basis by the medical director.

2) CCHH has just received (an anonymous) $1.5 million grant for a formal 2 year fellowship in integrative medicine, to begin in fall 2001. This (in collaboration with Andrew Weil's program) will help set standards for the practice of integrative medicine through training programs for fellows.

CCHH is also part of a working group at Albert Einstein College of Medicine to include integrative medicine in all four years of its medical students' education.

3) I would also like to add here another major reason to include CAM practitioners in medical systems. CAM practitioners not only provide modalities and approaches that can benefit the patient. CAM providers also provide an access point for many dissatisfied patients to re-enter the medical system. Over the last ten years, patients very frustrated with conventional (and especially managed care) medicine have increasingly been turning to CAM providers (chiropractic is a very good example of this) for much of their primary care. Bringing together conventional and CAM practices will allow this group of patients to receive the best integrated medical care.

Thank you for the opportunity to contribute my thoughts and experience to your extraordinarily important work. I look forward to a continuing dialogue with you.

THE CONTINUUM CENTER FOR Health & Healing

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MISSION

The vision of the Continuum Center for Health and Healing (CCHH) is to help in the transformation of American medicine to the integrative model of health care.

The mission of the Center is to deliver comprehensive health care that combines the best of conventional medicine with those complementary approaches that have proven safe and effective. Our goal is to provide health care that focuses on prevention and optimum wellness, and healing--- rather than disease amelioration. This occurs in a relationship-centered setting that focuses on the whole patient; on her/his mental, physical and spiritual life.

BACKGROUND

Beth Israel Medical Center (BIMC) is part of a five hospital merged hospital system, Continuum; comprising BIMC, St. Luke's-Roosevelt Hospitals, Long Island College Hospital, and New York Eye and Ear Infirmary. It is the Manhattan campus of the Albert Einstein College of Medicine (AECOM). Beth Israel has a long history of supporting innovative clinical programs. It sponsored the East Coast's first Planetree cardiology unit, and established an Ornish Program in Cardiology in 1994. It has had an endowed Art of Caring program for nurses, and received a Nathan Cummings grant for an ongoing Humanistic Care program in 1994. Many of the medical staff have been practicing complementary care, including Dr. Robert Schiller, Chair of Family Medicine who is a homeopath, and Dr. Steven Horowitz, Chair of Cardiology, one of the nation's most eloquent advocates of life-style changes in heart disease. The hospital, has always had a cultural ethos that welcomes patient-centered programs which enhance patient care and bring credit to the hospital.

GENESIS

BIMC and its parent medical school AECOM gave CCHH strong institutional commitment from the inception. This developed from the following:

The clinical thought leaders at Beth Israel and Dr. Woodson Merrell had formed a city wide Colloquium on Alternative Medicine in 1995. This was an attempt to bring together the city's leading complementary care-givers in order to see how their work could be brought into the hospital setting.

Concurrently with this one of Beth Israel's most respected trustees, William Sarnoff, presented a plan to the Board of Trustees. Impassioned for complementary medicine since an agonizing experience with his wife's cancer treatments, Mr. Sarnoff guaranteed that if the board of trustees agreed to set up a pilot CAM program he would in turn secure funding, largely from fellow trustees, for a minimum of $3 million dollars.

Seeing the interest from clinical leaders as well as trustees, the Continuum leadership held a two-day think tank in 1997. This was attended by leaders from the hospitals' trustees, administration (COO, CEO), physicians (including Chairs of

Medicine, Surgery, Endocrinology, Cardiology, Physiatry, and Neurosurgery), nursing (Department Chair and program leaders), and alternative care-givers (including Dr. Merrell). The conclusion was clear: Integrative Medicine is the medicine of the future; 1) the majority of patients are already using it and 2) it has sufficient evidence-basis for many of its therapies. Someone needed to set a standard for its use, and it would be Beth Israel, with the full backing of the Continuum partnership.

BIMC agreed to back a Center with $5 million in start-up funds—with the understanding that this would be raised through donations over time.

Recruitment for a Director and assurance of funding took six months, with Dr. Woodson Merrell selected in June 1998 to lead the program.

ORGANIZATION

From the outset, the Center of Health and Healing was given independent Center status. Dr. Merrell reports solely to the President/CEO for clinical issues, and to the COO for financial matters. Practitioners are credentialed in their respective specialty departments. Reporting to Dr. Merrell are his Medical Director (Dr. Ben Kligler, MD, MPH), Clinical Services and Community Outreach Director (Barbara Glickstein, RN, MS, MPH), Administrative Director (Cathy Schaffer, MBA), Research Director (Samuel Shifflet, PhD), and Medical Education Director (Roberta Lee, MD). All physician directors also provide patient care at least half-time. All staff are credentialed by the Medical Center and are hospital employees.

FUNDING

The financial backing for the Center is nearly completely private. The Medical Center did not make any financial contribution. They did make a commitment at the outset to back the Center for $5 million (largely on the basis of known trustee guarantees), but this was a guarantee against the CCHH's need to eventually raise the funds. The hospital did provide 2 other key ingredients: a) cooperation and often prolonged close participation from some of their key support departments, including facilities management, development, operations, managed care, research and grants management; b) strong backing of the development office for fund-raising. The Medical Center saw CCHH as important for its future and allowed the Center to pursue trustees and previous hospital donors for Center contributions.

To date the CCHH has raised $9 million. This has come largely from hospital trustees and donors, as well as Dr. Merrell's patients and contacts, and a few private foundations.

FACILITY

The Center is a stand-alone facility, 20 blocks from the hospital. It occupies a 13,000 full second floor of a commercial building, with wrap-around windows on 2 sides. There is a 1500 square foot space for lectures and movement classes on the first floor.

The Center was designed by one of the nation's leading experts in non-toxic, environmentally-sustainable architecture and design: Guenther-Petrarca. They worked closely with a renowned fung shui master, Alex Stark (a Yale-trained architect). The space is built almost entirely with natural and recycled non-toxic materials and fabrics.

Lighting, sound, air quality, colors, patient flow, clinical and administrative needs all factor in creating a space that focuses on the patient, and creates a feeling of a sanctuary-- - a haven from the pressures of NYC for the patient and staff. (See appendix II) It is a place to focus on the work of healing by both patients and practitioners.

CENTER FOCUS

The Center considers each of the primary areas of clinical care, research and education to be critical to the Center's work. To be a leading center, each component must be given equal weight. There is sufficient evidence, and the credentialing standards are in place to justify a broad range of clinical offerings. There is a need to offer quality education for the consumer and the professional. Research must underlie every aspect of this work as we are in the nascent phase of a new field of medicine.

CLINICAL CARE

A) Staffing

The prime for the Center's pump is a comprehensive clinical program. In New York, we are blessed with being able to select from a pool of highly talented specialists in CAM, who are eagerly awaiting the opportunity to bring their work into an academic setting. A description of the current staff members is appended. It includes all primary care specialties: three family physicians (two of them double board-certified in family medicine and psychiatry), a pediatrician, an internist. a gynecologist, a psychiatrist, a psychologist, a nurse practitioner, a physician assistant, a massage therapist, a chiropractor, an acupuncturist, a nutritionist, a nurse educator and a librarian/education resource coordinator. The clinical staff is supported by an office manager, three integrative clinical advisors (formerly medical technicians), a registered nurse, three administrative assistants, a front desk staff of 5, a billing assistant and an information technology director. An expanded volunteer support program is also currently in formation.

The staff's pre-opening training focussed largely on understanding what each modality can do, and which of our providers is trained in each of the primary therapies. There was a two-day retreat at the Omega Institute to foster team-building for all staff members before the opening.

Team building is a critical ongoing process. The ground-breaking nature of this comprehensive clinical model requires dialogue at regular meetings. Currently these include: 1) one hour weekly luncheon meeting for the practitioners to discuss practice management and clinical issues 2) two hour weekly all-staff meeting luncheon meeting: the center is closed while the staff discuss a) streamlining the practice b) team building, c)case presentations, and eventually also d) continuing education (by both the CCHH staff as well as outside experts). There are also sessions for caring for the care-givers, including midday sessions by the Center's care-givers in such mind-body therapies as yoga, meditation, tai chi, and imagery.

B) Clinical Offerings

The Center offers comprehensive services in all evidence-based areas of CAM. Each of our primary care-givers is acknowledged already to be an expert in a number of CAM modalities (see appendix for practitioners specialties and modalities utilized),

rather than just being open to alternatives and having to refer to others. And CCHH has highly skilled CAM providers for further in-depth specialty care.

Triage for new patients is done in three tiers: a) briefly with the front desk when the referral is obvious, or b) telephone discussion for 5 minutes with an RN to help the patient determine which provider would be best for their first visit. If there is still a question at this point as to how the patient can best utilize the Center's care givers, then the patient is offered the opportunity c) to book a (billed) 20-30 minute personal session with the Center's holistic nurse counselor.

Under the leadership of the Center's Clinical Programs Director, there will be group clinical sessions to allow patients to receive education on their specifc clinical issues in a more cost-effective manner. Some of the initial programs will include developmental disorders, prenatal classes, menopause/osteoporosis, stress and depression, musculoskeletal disorders and pre/post surgery preparation. In addition, this director has considerable experience and will be offering CCHH intensives, during which patients come for 2-5 day sessions (4-8 hour/day) for more comprehensive management of difficult problems.

CCHH also has a number of board certified specialists scheduled to come part-time to the center to provide consultations in complementary approaches in their area of specialty, currently including: Physiatry/Osteopathy; Ophthalmology; Neurology (especially in neurodegenerative disorders); Infectious Disease (especially chronic diseases such as Chronic Fatigue and AIDS); Cardiology and Urology.

One of the key elements to this kind of medical practice is giving adequate time for the caregiver- patient relationship to develop. Initial visits are one hour, and follow-ups are 15-30 minutes. The overall average visit time is 22 minutes.

The business plan expects CCHH to see 30,000 patient visits the first year, up to 50, 000 by year three.

EDUCATION

The Center is committed, and financed for a comprehensive educational program, both for the community and for professionals, overseen by our Medical Education Director, the Clinical Services and Community Outreach Director, and the Education Resource Coordinator

A) Community/Patient Education

There is a broad array of classes planned for the public. In addition to free orientation classes, there will be paid series on such topics as: optimum wellness, women's health, mind-body techniques (including tai qi, yoga, meditation, biofeedback, etc). The Center currently has a pre/post surgery preparedness program in conjunction with the departments of Surgery that includes reiki, therapeutic touch and self-hypnosis.

In addition to formal classes, the Education Coordinator is available for patients to teach them how to use the computer and Internet for self-education. Part of the Center's offerings will be a web-site that will provide access to the highest quality information sources. The Center has a library for patients and the staff, which includes considerable text, video and audio materials and handouts.

B) Professional Medical Education

Under the direction of Drs Merrell and Kligler and particularly our Medical Education Director Roberta Lee, a broad array of medical education initiatives are in process:

1) Medical Students
   a) for 5 years BIMC has offered a fourth year medical student rotation in CAM. Before the Center's opening this was done mostly in cooperation with community-based providers. Now some of this elective time will be done through a rotation at CCHH.
   b) AECOM has committed to introducing integrative medicine into all four years of its curriculum. Its Education Committee has approved a formal working group including Drs Merrell and Kligler under Dean of Education Albert Kuperman to guide a curriculum revision.
2) Residency training. In 1999 Dr. Kligler developed for BIMC the nation's first required residency rotation in integrative medicine---in the family medicine program. It is hoped that this can be replicated through other residencies, both at the Medical Center and at CCHH.
3) Fellowship. CCHH has just received a $1.43 million grant form a private donor to establish a 2-year fellowship in integrative medicine. The fellowship will be conducted with BIMC and AECOM initially for a three-year period. There will be 3 fellows per year. Most of their training will be at CCHH. They will be at the Center 2 days per week; one day didactic and one day clinical and experiential, with four 4-day intensives per year. The 2-day/week format allows clinicians to maintain their existing practices while becoming specialized in integrative medicine. Collaboration with the University of Arizona's fellowship programs is underway to help standardize the training of physicians in integrative medicine.
4) Intra-hospital education

Introductory CME CAM courses have already been held for the hospital staffs to familiarize them with the field before our opening, and will be ongoing. Regular grand round and noon-time conference presentations will inform and foster dialogue with all hospital medical departments (ancillary staff as well as physician departments). Reference materials are maintained by our Education Resource Coordinator to be available to all our care-givers to provide a common data base from which to prepare presentations.

4) Postgraduate CME courses: Two courses will be given in the next six months (Nutritional Therapeutics with Alan Gaby & Donald Brown, and Clinical Imagery with Jeanne Achterberg, Marti Rossman and O. Carl Simonton [a certificatioin course]). The Center has plans to offer at least two national CME course per year, in addition to local events.

RESEARCH

The CAM field is only as good as the quality of its care-givers and the evidence they have to guide them in their treatment regimins. Research is a fundamental cornerstone of any CAM program. At CCHH we have recruited Samuel Shiflett, PhD to run our research program. Dr. Shiflett was director from 1994-99 of one of the original 5

NIH OAM Centers of Excellence, at the Kessler Institute of Rehabilitation's Center for Alternative Medicine Research. His charge at CCHH is to develop a comprehensive research program that includes creating Center proposals for governmental and NGO organizations, and mentoring the care-givers to develop their own research studies utilizing their particular approaches and healing techniques.

TECHNOLOGY

CCHH was designed from the outset to be as much as possible a virtually paperless office. All records are electronic on Medicalogic's Logician software. The interfaces with hospital billing, records, and lab data are near completion. Working in this completely electronic medium has been steep learning curve for all the staff, but clearly will foster completeness of medical records, and greatly increase the data gathering capabilities for research work. Starting up a Center de novo makes it much easier for conversion to electronic medical records.

CREDENTIALING

All conventional primary care providers (MD, DO, NP, PA, and PhD) are credentialed through the department of their specialization.

Beth Israel Medical Center was the first academic hospital in New York State to develop credentialing standards for CAM providers. There are specific criteria for acupuncturists, chiropractors, and massage therapists that allow them to practice not only in the CCHH outpatient setting, but to make their services available within the hospital. The credentialing standards for chiropractic are appended as an example Physician acupuncturists are permitted to do acupuncture within their medical scope of privileges.

CAM providers are credentialed at BIMC for inpatient and outpatient work, but are not given hospital privileges. This means that they are hired by CCHH's director through Human Resources, not through the medical staff's Credentials Committee and Medical Board. It also means that when employment ends, credentials end and there are no hospital privileges remaining. This decision was made after advice from the 1999 Greeley Conference on Credentialing at Harvard. The guidelines for BIMC were drafted by a special subcommittee on alternative credentialing created by the Credentialing Committee; consisting of select Department Chairs, Dr. Merrell, a member of the Board of Trustees and directors of the offices of Human Resources and Medical Staff.

REIMBURSEMENT

Centers that are dependent on the typical 35% reimbursement rate from insurance carriers, when overhead is a minimum 50%, cannot make a financial go of it. CCHH is based on providing extended care giver-patient time, and fees are designed to be fair and reflective of the time-intensive nature and additional training required in this new type of medical care. The Center will not foster an elitist care situation that excludes all but those with disposable income. Therefore we have opened an ongoing dialogue with insurance companies to encourage participation in pilot programs. These would provide adequate reimbursement in return for information from CCHH's considerable data capabilities on clinical outcomes and cost-effectiveness particularly for specific for therapeutic modalities and high- cost diseases.

Additionally, the Center is recruiting funds for an endowed Helping Hands fund for the needy. The Center's fellowship and research studies will also allow underinsured patients to access the Center's care.

COLLABORATIONS

CAM centers cannot survive in isolation. Collaboration at all levels is imperative to move this field forward:

A) Within the hospital system: The Center is fortunate to have had excellent relations with the hospitals' administration and clinical staff before opening. These are being nurtured and expanded through active integration of the CCHH's care with that of outside clinicians (telephone, email, and consult letters), and through participation in many departments' grand rounds and noon conferences. The Center also is inviting departments to hold their rounds at least once at the Center to introduce them to our space and staff. Joint programs are being established with the enthusiastic participation of departments such as Medical and Radiation Oncology, the AIDS service, Surgical services, Rehabilitation Medicine, Cardiology, Family Medicine and Pain/Palliative Care.

C) Medical School and Fellowship affiliations: see above

D) Regional Consortium. In 1999 CCHH established a regional consortium of all 10 academic CAM centers in NY, NJ and Conn. This group meets periodically to plan collaborative efforts, particularly in research and education, and also to share clinical experiences. It will soon be expanded to include Centers throughout the Northeast.

E) National relationships. Meetings such the Harvard-Stanford Hawaii conference and a recent one at Miraval of the Consortium of Academic Medical Centers for Integrative Medicine are critically important to bring together the thought leaders (particularly of programs that are active) who can create the model for this new era of integrative health care.

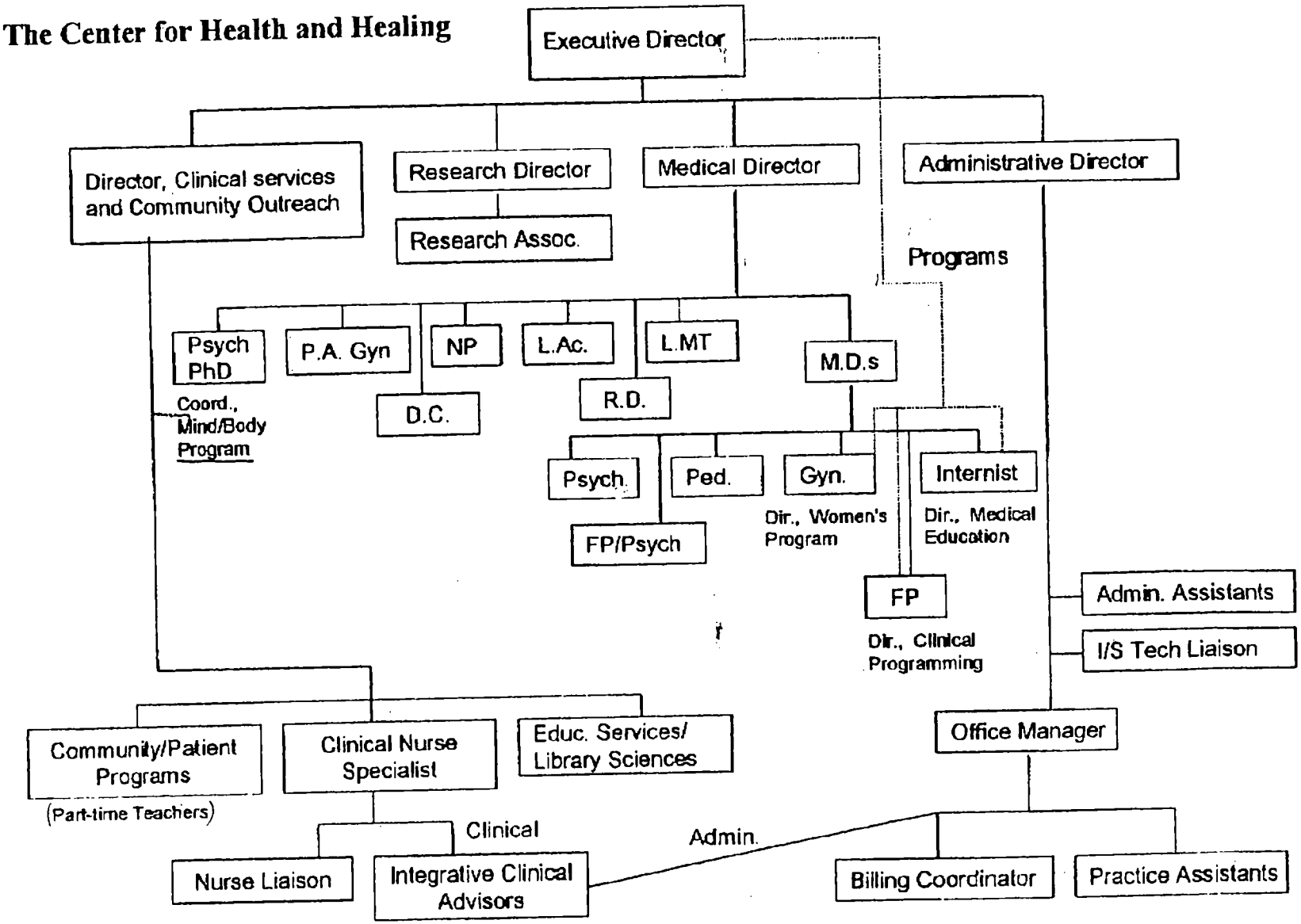
OVERALL RECIPE FOR SUCCESS

There are three critical components for a CAM Center's success. If any of these are absent, it will be very difficult for a Center to survive. These are:

1) Adequate funding. Construction, start-up and first two years' operational support necessitates a minimum (depending on locale) of $5 million.
2) Strong institutional support. The Medical Center's administrative and clinical leadership must commit to backing the Center beyond one or two enthusiasts, and this needs to penetrate to the middle levels of the staff as well.

   A subset of this would be the commitment to include all three areas of the triad of clinical, research and educational initiatives in the CAM program
3) Knowledgeable, experienced, academically-oriented CAM providers to work at the Center. Preferably these are local or nationally-known CAM providers who can bring an existing practice to the Center to ramp up adequate patient volume more quickly. They also need social skills to be able to work smoothly in cultivating relationships with the more conservative hospital staff as well as the community.

The Center for Health and Healing



THE CONTINUUM CENTER FOR Health & Healing

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The staff members of the Continuum Center for Health and Healing are:

Mary Beth Augustine, RD, CDN, is responsible for the Center's nutrition program. She is a registered dietitian and a certified nutritionist, specializing in the use of plant-based diets for the prevention and complementary treatment of chronic degenerative disease. She incorporates innovative approaches to healing through the use of constitutional diets, medicinal foods, juices, edible flowers and teas. A graduate of Marymount College, Ms. Augustine completed a clinical internship at the Medical Center at the University of California (San Francisco).

Tina Awad, LMT is the Center's massage therapist. A graduate of the Boston Conservatory (BFA) and the Swedish Institute of Massage (LMT) she has had a private practice in New York City for 11 years. Her work emphasizes energetic bodywork, as well as expertise in essential oils, meditation instruction, and reflexology (a certified practitioner of the latter).

Patricia Codrington, RN, MSH, FNP-CS, is the Center's nurse practitioner. Raised by a grandmother who used herbs and plants for food and medicine, Ms. Codrington has an affinity and indepth knowledge of the use of natural remedies. She uses cranio-sacral therapy to complement herbology and she is now concluding a two-year program of study of the Sutherland-Sills concept of cranio-sacral therapy and the energetic body. She also is trained in ayurvedic medicine and integrates this approach into her practice.

Karen Erickson, DC, BS, received her doctor of chiropractic degree with honors from New York College of Chiropractic. With 12 years of clinical chiropractic experience in private practice, she formerly was a research assistant in biochemistry at Albert Einstein College of Medicine and at the Scripps Institute of Oceanography. She is on the Board of Advisors and also a health care provider at Healing Works, a free clinic for alternative/ complementary medical care in NYC.

Barbara Glickstein, RN, MPH, MS, is Director of Clinical Services, Community Outreach and Healing. She has extensive experience in complementary medicine and humanistic health care, is a member of the Fetzer Institute's Relationship-Centered Care Network, and is active in holistic nursing and women's health care issues. She co-produces and hosts Healthstyles, a radio talk show on WBAI-Pacifica Radio. She previously was assistant director of Beth Israel's Humanistic Health Care Program, a five year project funded by the Nathan Cummings Foundation.

Marsha J. Handel, BA, MLS (Library Science), is the Center's Education and Information Resources Coordinator. For the past several years, she has been the senior medical librarian at Beth Israel. Co-author of The Alternative Medicine Resource Guide, she is an Internet education expert as well as a certified practitioner in Trager Psychophysical Integration, with 20 years of private practice in movement re-education.

The Center's Medical Director is **Benjamin Kligler, MD, MPH,** assistant professor of family medicine at the Albert Einstein College of Medicine and an attending physician at Beth Israel Medical Center. He is certified in Eriksonian hypnotherapy and Shiatsu massage, using these techniques as well as botanical medicine in his practice. Dr. Kligler graduated from Harvard University and Boston University School of Medicine. Last year, he co-directed the nation's first required residency-training rotation in integrative medicine (family medicine, Beth Israel).

Roberta Lee, MD, recently joined the team as Education Director. An internal medicine specialist, Dr. Lee was in the first graduating class of Andrew Weil's two-year Fellowship in Integrative Medicine at the University of Arizona Medical Center. She is an ethnobotanist with the New York Botanical Gardens, South Pacific project. Dr. Lee graduated from the University of California at Berkeley, and George Washington University Medical School (Washington, DC).

Suzanne Little, PhD, Coordinator of the Mind-Body Program who also is a supervising psychologist in Beth Israel's Department of Psychiatry and assistant professor of psychiatry at Albert Einstein College of Medicine. Dr. Little received advanced clinical training in family systems at NYU-Bellevue and was most recently a supervising psychologist in the Women's Health Practice at Beth Israel. She integrates psychodynamic, cognitive-behavioral and transpersonal therapeutic principles with mind/body modalities such as mindfulness, stress management, guided imagery and biofeedback in her clinical practice with children, adolescents and adults.

Lewis Mehl-Madrona, MD, PhD, is our Clinical Program Director. A graduate of Stanford University School of Medicine, he is Board-certified in family practice, psychiatry and geriatrics. Dr. Mehl-Madrona is the author of ACoyote Medicine, a book about his efforts to integrate his Native American heritage with his conventional medical training. He has a particular interest in the treatment of cancer with bio-immunotherapies, the treatment of children's neurological disorders and prevention of pregnancy and birth complications, as well as in Native American healing practices. Techniques he uses include acupuncture, body therapy, nutritional medicine, hypnosis, visualization, guided imagery, bio-immunotherapy and homeopathy. He formerly was the director of the Center for Complementary Medicine at the University of Pittsburgh.

Woodson C. Merrell, M.D. is the Center's executive director. He is an assistant clinical professor of medicine at Columbia University College of Physicians and Surgeons, and an attending physician in the department of Medicine at Beth Israel and St. Luke's-Roosevelt Medical Centers. He has maintained a private practice in integrative medicine in New York City since 1995. His practice, which serves a model for the Center's integrative care, incorporates his internal medicine training with expertise in mind-body therapies, (especially Qi gong, yoga and meditation), acupuncture, botanical therapies, nutritionals, and homeopathy. Hired by Beth Israel in August 1998 to create a leading center for academic integrative medicine, Dr. Merrell has overseen every aspect of its development. He is a graduate of Amherst College and Columbia Medical School (P &

S). He is currently Chairman of New York State's Board of Acupuncture, and a board member of New York State's Office of Professional Medical Conduct. His course in alternative/complementary medicine at Columbia was one of the nation's early comprehensive CAM educational programs for medical students. He has a special interest in indigenous healing systems, and was scientific co-chairman of the First International Congress on Tibetan Medicine, held in Wash DC in 1998.

The Center's acupuncturist/Chinese medical practitioner is **Arya Nielson, MS, MA, LaC, FNAAOM**, who is board certified in acupuncture and Chinese herbal medicine, a Fellow of the National Academy of Acupuncture and Oriental Medicine and a former Chair of the New York State Acupuncture Board. In private practice for the past 24 years, she is a senior faculty member of the Tri-State College of Acupuncture in New York City and the author of AGua Sha," a traditional technique for modern practice.

Aurora Ocampo, RN, MA, CS, is clinical nurse specialist for the Center for Health and Healing. She has many years of experience as a clinical nurse specialist in Beth Israel=s surgical nursing division. Ms. Ocampo is a trained and experience practitioner of biofeedback, therapeutic touch and Reiki. She also is certified in clinical imagery and aromatherapy.

Larry Palevsky, MD, is the pediatrician for the Center. A graduate of the NYU School of Medicine, he completed a three-year pediatric residency at Mount Sinai Hospital, followed by a one-year fellowship at Bellevue/NYU. He was an attending physician for four years in the pediatric Emergency Room at Our Lady of Mercy Medical Center and was chief of the pediatric acute care unit at Lenox Hill Hospital for three years. He recently completed a two-year tenure as the pediatrician at PS 11/Clinton School's primary care health program. Dr. Palevsky uses an integrative approach in his practice, combining theories of western and eastern medical practices. Nutrition is a major component of his work, along with the use of acupuncture and Chinese medicine, chiropractic work, osteopathy, homeopathy and natural healing modalities, such as aromatherapy, yoga and meditation, for the health and healing of all families.

Stephan Quentzel, MD, practices family medicine and psychiatry. A psychosomatic medicine specialist, he is also the chief of primary care psychiatry at Beth Israel and faculty at Albert Einstein College of Medicine. His work focuses on integrating physical, mental and social health conceptually, diagnostically and therapeutically. A graduate of MIT and the University of Illinois, where he was in the Medical Scholars Program, Dr. Quentzel is active in health policy and law.

Virginia Reath, RPA, MPH is a Physician Assistant in the Center's gynecology and women's health program. She has 20 years of practice in women's sexual and reproductive health and for the past five years, she has been developing an integrative approach in her health care practice. She is a health educator in reproductive and sexual issues for both men and women.

Administrative Director is **Catherine Schaffer, MBA.** She is a mathematics major from Brown and a Columbia MBA. Ms. Schaffer has significant experience in health care finance from her positions with JP Morgan, in health care consulting and most recently, as director of physician network development at North Shore-Long Island Jewish Health System. She also spent several years working at an indigenous clinic in rural Mexico.

Edward Shalts, MD, is a Board-certified psychiatrist and former chief resident in psychiatry at Beth Israel Medical Center. He graduated from medical school in Moscow, where he worked as a family physician for five years. He arrived in the United States in 1989, and did four years of postdoctoral research work in neuroendocrinology at Columbia University, before beginning his residency in psychiatry at Beth Israel. He also has fifteen years of experience in homeopathy, including training at a course series at Johns Hopkins University offered by the National Center for Instruction in Homeopathy and Homeotherapeutics at the New England School of Homeopathy.

The Center=s Director of Research will be **Samuel Shiflett, PhD**, who was formerly the director of the Research Center for Alternative and Complementary Therapies in rehabilitation at Kessler Medical Rehabilitation Research and Education Corporation and the New Jersey Medical School. He received his BA in psychology from the University of California (Los Angeles), his MA and PhD in psychology from the University of Illinois (Urbana). His activities in alternative/complementary medicine began in the early 1980s when he became interested in yoga and meditation. Dr. Shiflett's current research interests include the effects of acupuncture and movement therapies on functional development in neurological disorders including stroke, brain injury and MS. In addition to a grant from the National Institutes for Health, he recently was awarded a three-year grant from the National Institute on Disability and Rehabilitation Research. He has written over 40 articles and book chapters and is on the editorial board of AClinical Acupuncture and Oriental Medicine.

Allan Warshowsky, MD, is Director of the Women's Program at the Center. A Board-certified Obstetrician/gynecologist for 21 years, his practice consists of therapies that range from the conventional to the holistic, including nutritional therapy, vitamin and herbal treatments, visualization and imagery, and Chinese herbs. He has had excellent results treating the discomforts of menopause with alternative methods. Dr. Warshowsky is a graduate of Queens College and Downstate Medical Center. Currently, he is assistant clinical professor of ob/gyn at the Albert Einstein College of Medicine.

Part-time consultants who will be bringing their knowledge of conventional and complementary medical approaches to the Center for Health and Healing include:

Steven F. Horowitz, MD, chief of the Killip Division of Cardiology at Beth Israel and professor of medicine and nuclear medicine at the Albert Einstein College of Medicine is nationally renowned for his work on promoting life style changes to prevent and help treat cardiovascular disease.

Jay Lombard, MD, chief of neurology at Westchester Square Medical Center, assistant professor of neurology at Cornell University Medical College and attending physician at Albert Einstein. He specializes in complementary approaches to neurodegenerative diseases (MS, ALS, Alzheimer's, Parkinsonism)

Lillie Rosenthal, MD, an osteopathic practitioner and rehabilitation medicine specialist is an attending physiatrist at the Miller Center for Performing Artists and at St. Luke=s-Roosevelt Hospital Center. She will be providing physiatry consultations and osteopathic work

Deborah Blenk, MD, is an attending ophthalmologist at New York Eye and Ear Infirmary who will bring her knowledge of nutritional and herbal adjuncts to ophthalmic problems.

Irene Grant, MD, assistant chief of Montefiore's AIDS Unit, and assistant clinical professor of medicine at Albert Einstein College of Medicine is a specialist in HIV and chronic fatigue syndrome. She will provide consultations at the Center for difficult chronic infectious diseases.

Susan Kaplan, MD, attending urologist at St. Luke's-Roosevelt Hospital utilizes acupuncture and herbal therapies where appropriate in her urology practice.

Sopnana Koldaev, MD, former director of the Center for Tibetan Medicine, Elista, Republic of Kalykia (formerly USSR), trained in both Dharmsala, India and Lhasa Tibet in Tibetan Medicine, will be holding educational classes at CCHH on Tibetan Medicine.

Anjanette DeCarlo, BS, MS (geology) and PhD candidate in environmental sciences, will supervise in-home environmental testing and offer educational programs and consultations on creating a non-toxic home and work environment.

Additional instructors will be offering classes in yoga, tai chi/qi gong, meditation, Alexander technique and conscious exercise

BETH ISRAEL MEDICAL CENTER
Administrative Policy and Procedure Manual
Policy No.
Effective:

PURPOSE: To establish the procedures and guidelines for providing chiropractic services at BIMC.

POLICY: This policy is designed to provide a guideline for the definition, scope of practice, credentialing, verification and continued competency of chiropractors practicing in Beth Israel outpatient programs.

Provision of chiropractic services at Beth Israel

Chiropractic services will be provided as part of a multidisciplinary outpatient program by licensed chiropractors who are either employees of the hospital or have a service contract with the hospital. They will work under the supervision of a designated physician employee of the hospital.

Definition and Scope of Practice of Chiropractic at Beth Israel

Per New York State Education Law, section 6551, the practice of chiropractic is defined as detecting and correcting by manual or mechanical means structural imbalance, distortion, or subluxations in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is related to distortion, misalignment or subluxation of or in the vertebral column.

At Beth Israel Medical Center, a chiropractor will treat the spine and extremities for neuro-musculoskeletal disorders only, and not engage in the primary treatment of visceral illness.

At Beth Israel a chiropractor may request spinal x-rays only. X-rays will be requested to rule out medical or structural pathologies, but not for the purpose of finding a misalignment (except in the case of a Medicare patient where a radiographic diagnosis of misalignment is required by law). CT scans, MRI's and other imaging studies will be ordered only by a physician. All imaging studies must be interpreted by a radiologist. The interpretations of all imaging studies will be shared with the patient's primary-care physician.

At Beth Israel a chiropractor will treat only patients who are under the care of a physician. The patient's primary-care physician will evaluate any new or significant symptoms and will be made aware that the patient is being treated for a specific condition or conditions by the chiropractor. If the patient does not have a primary care provider

then (s)he will be required to obtain one or be assigned to a primary provider in the program in which the chiropractor is practicing. The chiropractor will send a letter to the primary-care physician of each patient being treated, informing the physician that the patient is receiving chiropractic treatments at the outpatient program and requesting medical information or acknowledgment of the notification. If the primary provider does not respond by the time the patient has completed 3 treatments, or if the patient refuses to have the primary provider informed of the treatments, then the case must be reviewed by the medical director of the program (or designee) before the fourth treatment. In the case of any significant new or unexplained symptoms, the chiropractor will consult with or recommend evaluation by the patient's primary-care physician or the program's medical director (or designee).

The chiropractor will supply adequate narrative reports, treatment plans and progress notes to other involved health-care personnel and be available to discuss any case with other team members.

The practice of chiropractic will be limited to out-patient programs, not the inpatient units at the hospital, except where a special request has been made by an attending physician, and written approval has been given by the clinical department chairman.

Credentialing of Chiropractors

Chiropractics will be employees of Beth Israel Medical Center. They will not be credentialed for an appointment to the medical staff or granted clinical privileges.

PROCEDURE:

The program director will identify and interview chiropractic candidates. The candidate must provide the program director with evidence of training, competence and licensure. The candidate must provide the following to the program director:

1. Valid NYS Chiropractic license.
2. Evidence of education - accredited by the Council on Chiropractic Education or NYS Education Department.
3. Required: Pass the National Board Examinations, Parts I-IV administered by the National Board of Chiropractic Examiners (NBCE).
4. Provide evidence of at least three consecutive years of clinical experience since licensure.
5. Three letters of recommendation from chiropractic practitioner peers.
6. Three letters of recommendation from physicians with whom the chiropractor has co-managed patients.
7. Evidence to support clinical competence, as requested, for approval of scope of practice by program director.

The program director will determine and approve the scope of practice with the chiropractor. The scope of practice must be signed by the candidate and the program director or physician designee.

The administrator or program director will communicate with the Human Resources department when a candidate for a position has been identified.

The potential employee and/or program administrator must provide the following documents to Human Resources:

1. Complete an application for employment .
2. Provide a copy of current NYS Chiropractic License.
3. Copy of Current C.V.
4. Copies of certificates – completed training programs, diplomas, board of examiners, etc.
5. Letters of reference/list of references for verification.
6. Scope of practice – signed by program director or designee.

Human Resources Process

- Verify NYS license: On-line verification via the NYS Dept. of Education-Office of the Professions.
- National Practitioner Data Bank query
- Reference check
- Arrange for Employee Health Service appointment
- OPMC query
- CIN-BAD verification-checks for advertising violations
- Provide New Employee Orientation.
- Notify Security for ID badge, etc.

Documents/Records

The program director/ administrator is to maintain a file for each provider, which meets JCAHO standards. Files must be secure, with access limited only to authorized personnel.

The departmental file must contain, at a minimum, the documents outlined by Human Resources- Personnel Records Newsletter (December 1999).
These files should also include:

- Initial employment documents: C.V., Reference letters, evidence of training and competence.
- Copy of current NYS license
- Copy of most current Scope of Practice – reviewed annually during Performance Appraisal.
- Aggregate data for evaluation/competence assessment
- Quality improvement data
- Other documents or correspondence, as appropriate
- CME credit documentation, as determined by program director and/or appropriate licensing board
- Annual Performance Appraisal

Clinton Presidential Records
Digital Records Marker

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Dillard

Divider Title: _____

The White House Commission on Complementary and Alternative Medicine Policy, December 5, 2000
Questions for James N. Dillard, M.D.

Question 1: Why and how did your MCO decide to offer CAM products and services?

During the year 1995, our founding CEO, Steve Wiggins, explored the possibility of including some CAM services at Oxford Health Plans. He and his wife Catherine were personally receptive toward complementary medicine approaches for health, as they both were users of alternative and complementary therapies, such as naturopathy, massage, etc. Other members of Oxford's senior management also were personal users of CAM services.

Oxford has always been known as an innovative health insurance plan, and Mr. Wiggins felt that the inclusion of CAM services in some form would add to the company's overall position as a forward-thinking competitor in this industry. Let me be clear, however, that increased market share was not his only motivation. Oxford's senior management believed that a complementary and integrative approach to health care would be of the greatest benefit to the overall health of its members. This strong belief at the senior level made building the Oxford CAM program possible.

Innovative programs always require a high-level champion who will inspire the board and senior management beyond "business as usual." Mr. Wiggins hired Dr. Hassan Rifaat, who had previous experience with building a not-for-profit CAM research foundation. Hassan explored the possibility of creating CAM services at Oxford, and consulted with CAM experts in the tri-state area. He subsequently brought on board several other CAM professionals to help build the program. I began consulting with Oxford through my connections at Columbia University in 1995 and became the first medical director for the program in September of 1996. We built the networks in 1996 and went live with the program on January 1, 1997.

During the period of time from late 1996 until early 1998, the company grew from 1.4 million members to more than 2.1 million members. The alternative medicine program was a prominent part of the company's identity, marketing and publicity during that period of time. Many of my own patients have told me, through the years, that they decided to become Oxford members because of its CAM program.

Question 2: How did your MCO determine which CAM products and practices to cover/offer?

A marketing survey was performed in early 1996. It showed that one-third of Oxford members were already using some form of complementary and alternative medicine for their health care. The number we obtained was almost exactly the same number that was reported by Eisenberg et al. in the New England Journal of Medicine in 1993.

The survey also showed that almost three-quarters of large-group benefits administrators were interested in offering health plans with CAM services available to their employees. Even more surprisingly, they indicated that they would be willing to pay a slight increase in premiums for these services.

CAM utilization is highly regional. Therefore, to choose which types of services we would offer, we simply took the top six provider types reported in the survey. These services were chiropractic, acupuncture, naturopathy (where legal), massage therapy, yoga instruction, and nutritional counseling. In addition, we developed a lifestyle-heart program in conjunction with nine regional hospitals and medical centers. The Oxford CAM model is a three-tiered program of standard reimbursed benefits, an added services rider, and contracted provider networks, now known as affinity plans.

Question 3: How did your MCO decide for which conditions, where, how, and by whom these CAM products and practices should be provided?

The Oxford program was built around provider types, not practices or specific therapies. Each provider type had its own unique set of therapies and practices as determined by state law scope of practice and/or local practice standards. Expert advisory boards in each discipline helped us set credentialing standards, practice standards, utilization management mechanisms, quality assurance policies, disciplinary procedures, and overall program design. The boards were comprised of prominent practitioners, deans of local professional training programs, and members of local state licensing boards.

Certain disciplines were limited, by contract, to certain modes of practice. Wherever possible, we tried to reference any research literature available on the topic in question. For example, our chiropractic network was required, in their contracts, to provide a primary neuromusculoskeletal diagnosis. Certain clinical practices, such as Network chiropractic and manipulation under anesthesia, were disallowed at a credentialing, utilization management, and quality assurance level. Massage therapists were recruited based upon their ability to deliver a set of services that were typical for local standards of care and not too far from the mainstream.

Practitioners who based their work primarily around techniques that were slightly more esoteric were more of a challenge during the network-building process, but we felt that the benefit they added was important. To include them, formal and informal standards were established in open discussion with our expert advisory boards. For example, we attempted to have all of the major disciplines of yoga instruction included in our network of yoga teachers, while still assuring certain minimal levels of teacher training instruction and experience.

In addition, we had entered into an extensive research relationship with Dr. David Eisenberg's group at Harvard. This work was intended to study our program, utilization, satisfaction, and cost over a multi-year period. We had hoped that this research would help to guide business practices, clinical policy, and program development. Unfortunately, due to the severe financial downturn that Oxford experienced in late 1997, this contract was canceled in early 1998, to the great dismay of all involved.

On that note, let me make it clear that the presence of the alternative medicine program at Oxford had nothing to do with its financial difficulties. Indeed, it has always been the perception on the part of our executive staff that our alternative medicine program is 1) one of the most user-friendly and inexpensive pieces of the company and 2) one of its strongest selling points.

Question 4: How much does it cost your members to access these CAM products and how were these rates established?

The standard benefits for chiropractic in all states and naturopathy in Connecticut are part of all Oxford insurance products, and do not represent additional cost to the members. The services are reimbursed in a manner similar to the payment for services of other specialists in our network, using customary co-pays and coinsurance for out-of-network care. We do not feel that adding the services significantly increased our cost of doing business.

The alternative medicine rider was sold to approximately 60 mid-sized to large employee groups, and represented an increase in cost of perhaps three to four percent on an annualized basis. To my knowledge, any cost to the company of delivering the contracted networks was not passed on to the consumer.

Members who utilize our affinity network do so at a standard discounted rate that has been negotiated with the participating providers.

Question 5: What is the role of CAM in self-care in your MCO?

From the beginning, complementary and alternative approaches to health problems have been integrated into our disease management programs. In addition, CAM integration was piloted with our Oxford On-call program (24-hour phone access to nurses). Our membership magazine has regular features on CAM approaches to health problems and Oxford provides

CAM speakers to employer groups who request them for employee forums. Currently, Oxford is building content links for our website with CAM self-care information.

Question 6: Has your MCO collected any cost-effectiveness or patient satisfaction data? If so, what are the results?

Oxford's financial difficulties and the resulting lack of resources have made it impossible to perform a comprehensive analysis of the program for the past three years. As Oxford has recently accomplished an unprecedented financial turnaround, our executive staff is committed to this analysis in the future.

However, we do have recent membership questionnaire results, which address issues of utilization, satisfaction, and acceptance/referrals for CAM services by the member's primary care physician. Those survey results are included in your data package.

Last year, we were able to enter into a collaborative agreement with the Center for Integrative Medicine at Griffin Hospital, a Yale University affiliate, in Derby, Connecticut. In collaboration with the center director, Dr. David Katz, we hope to generate some utilization and cost data.

Question 7: Have any of your members had difficulty with access to or payment for CAM products or services? If so, please specify the difficulty and how it was resolved or should be resolved.

Oxford Health Plans has always been primarily a PCP gatekeepered network, with a very popular point-of-service product option. Chiropractors in all regions and naturopaths in Connecticut are part of the standard benefits and, as such, are treated as any other medical specialty, requiring PCP referral. There have been complaints from members who have had difficulty with obtaining referrals from their PCPs to see a chiropractor. To be fair, however, difficulty with obtaining referrals to

medical specialists has been an occasional complaint with gatekeepered plans in general.

Before the program went live, we sent out referral guidelines for our CAM practitioners to all of our approximately 14 thousand primary care physicians. When individual complaints have come in regarding the difficulty of obtaining a referral, we simply suggest that the member request the referral from the primary-care physician one more time. If the physician does not comply, the member can change his PCP with a simple telephone call. It is been hard to assess the success of this strategy.

Granting direct access to CAM provider types supported by standard benefits would seem to be a solution to this problem; however, it would require the redesign of the entire Oxford product line. It would not be fair to our medical specialists to give a chiropractor a privilege another medical specialist does not have.

There has also been the challenge of having a three-tiered program and public understanding of that program. Although member and marketing materials have been very carefully written to explain the differences between insured benefits, the alternative medicine rider, and the affinity program, there have always been a certain number of members who are shocked to discover that we do not pay for their massage therapy or yoga classes. Though there have been cases across the nation of affinity plans being used deceptively, we have always made a clear effort to explain what is reimbursed and what is not. Examples of our marketing materials have been included in the data package. There is always the potential for misunderstanding here, as it is common for most people not to fully read insurance contracts or marketing materials.

Question 8: Based on your experience, what policy recommendations do you have for the commission? Please include your view on whether CAM should be accessed and delivered as a stand-alone or integrated with conventional care and why.

My recommendations are several fold. First, I would encourage the Commission to support integration of CAM services into conventional medical delivery only where there is an adequate evidence base. It will be up to this Commission and others to attempt to determine where the line for "adequate" will be drawn. I believe that appropriate chiropractic delivery for neuromusculoskeletal problems has this adequate base. It is also possible that acupuncture, particularly for pain and nausea, may be justifiable. Recent research on the use of medical massage for specifically diagnosed conditions may also make the cut. In some cases, well-manufactured herbal remedies may represent an advantage over conventional medications, such as the use of Gingko Biloba for intermittent claudication. I would hope that, as our understanding of what works and what does not work in CAM therapies develops, policy support for clinical delivery will be adjusted accordingly.

This does not mean that I would support the notion of mandated CAM benefits for all health plans. We do not have the extensive cost/benefit analyses needed to justify such mandates, and sweeping mandates would only place an added burden on those who must pay for health care. Certainly individual states will enact insurance equality laws, but it is my hope that these would be tempered by the scientific evidence base available, and not simply driven through a legislature by political bullying.

Second, there is a tremendous amount of money to be made in this industry, both from products and services. It is essential that we assiduously identify those products and services that do not work, and subsequently concentrate our delivery efforts on those things that seem to have an evidence base. We do not have the resources to do otherwise. The creation of adequate and fair-minded mechanisms to eliminate useless and dangerous products and services would seem advisable.

Third, I would also strongly recommend that the Commission support appropriate integration between the conventional medical delivery systems and CAM service delivery whenever possible. Improved communication between provider types and support for understanding the limitations of any clinical approach is critical. We all must be able to recognize our failures to reach treatment goals and be able to embrace a formal or

informal interdisciplinary team approach for the benefit of our patients. To that end, most practitioners and centers utilizing and promoting interdisciplinary teams use the term "integrative" to describe their practices, rather than "alternative" or "complementary."

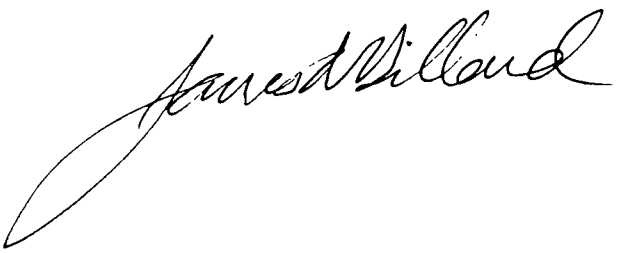
Fourth, a health plan has basically two choices when it comes to embracing alternative therapies in its insurance products -- build it or buy it. I would argue in favor of building, as this allows for the possibility of greater integration with the "conventional" side of the company. I believe that it has been of great benefit to the conventional medical directors and case managers at Oxford to have the availability of in-house expertise, both for policy and on a case-by-case basis. A stand-alone company could possibly deliver this, but I believe that it is more difficult.

Building a CAM program inside a health plan allows for integration of disease management, case management, conventional vs. complementary utilization, and more finely tuned quality management. It gives a more personal feel to the networks and programs. It creates a foundation for regional specificity and local regulatory compliance. If we believe that appropriate integration of CAM services is where we want to go, then building these programs in-house and regionally is the way to get there.

Fifth, we must work locally and nationally to bridge the gap between the conventional and the alternative medical worlds. The inability for conventional physicians to understand CAM practices and advise patients appropriately, as well as resistance on the part of CAM practitioners to working with conventional physicians, leaves the patients confused, frustrated, and afraid to discuss their real feelings. Since they often feel that they cannot really talk with their conventional doctors or their CAM practitioners without hearing ignorance and bias, they are driven to self-medication and reliance upon the information quagmire of the Internet. We must try to correct this problem.

Last, I would like to make a plea for the CAM practitioner. Many of these individuals are tremendously hard-working, dedicated professionals, who wish only to be able to practice their skills for the benefit of their patients. They are not simply a resource to be crammed into a narrow medical

model, or to be exploited by commercial delivery systems. Many of them would dearly love to work in greater concert with their medical colleagues, but not at the price of exploitation and the loss of professional respect. Administrators with diverse backgrounds and practitioners with formal training in dual or multiple disciplines, such as some of the members of this Commission, will be needed to affect greater cooperation by acting as skilled mediators and translators. This change must begin in both the conventional and CAM practitioner training programs, but anything that this Commission can do to foster that cooperation can only be of benefit to the patients.



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Divider Title: Bielinski

White House Commission on
Complementary and Alternative Medicine Policy
December 4-5, 2000
Washington DC

Lori L. Bielinski, LMP, Sr. Health Policy Analyst
Washington State Office of the Insurance Commissioner

From your perspective in the Washington State Office of the Insurance Commissioner:

1. *Should there be access to CAM products and practices? If so, to which products and practices and for which conditions should there be access and where, how, and by whom should these products and practices be delivered?*

I believe that there should be access to CAM services, at the minimum. CAM products present a different issue since there is no mechanism in place that allows a consumer to feel safe about a particular product, or other providers to be aware of potential drug interaction. Even when drugs are used by conventional medical providers, the consumer/patient has some method of learning the possible side effects of a product through research by the FDA and research and development of the pharmaceutical manufacturer, and not just reliant upon the prescribing practitioner.

CAM services and treatments offer a decreased threat of public safety since the services (at least in Washington State) are regulated by the Washington State Department of Health, and require a license or certification to practice. Professions that are not licensed or certified, and that do not have a designated scope of practice, are not included in the "every category of provider" law (RCW 48.43.045). Professions that are not regulated must present their "case" to the insurer directly to obtain reimbursement for services they provide that treat conditions that are covered in a benefits package.

Regulation of a profession has assured the public that the practice is safe, and that the education of the profession has been subjected to the accreditation process deeming it appropriate training for the practice of the identified health profession.

The regulated practitioner has proven through examination a minimum level of competency that they will not harm the public, and if they do, there is some mechanism for a consumer to complain other then, and in addition to, professional liability claims.

I believe that health professions covered by an insurance company's medical benefits should be regulated. The professions should have standardized education and examinations to assure that the practice is not going to cause injury to the public.

Addressing conditions that should have access to CAM services is much more difficult and depends on the benefits package. If the condition is covered in the patient benefit package, then the patient has a right to choose the provider for their care, as well as the method they want used for treatment.

Which provider type to treat the condition, whether CAM or conventional, should depend on the training the practitioner has received. Some conditions that can be easily treated by natural medicine providers (such as strains and sprains by acupuncture, massage and chiropractic; and headaches by acupuncture, massage, chiropractic, naturopathic medicine etc) may be able to be treated in a more timely manner, with decreased side-effects, and for less cost. If massage therapy can be a covered treatment by a physical therapist and a medical doctor, then why shouldn't a massage therapist be allowed to treat the condition also? By allowing the other specialized providers to treat the conditions already covered in the patient's

health plan, the patient has more control of their overall care, and is taking a more responsible role in the outcome.

2. *What should be done to make the CAM products and practices culturally and linguistically appropriate for CAM users?*

I'm not sure that this question relates much to my background however, I believe that the CAM users of these services and products have either turned to this for lack of better treatment in a conventional medical model.

Patients of CAM services and products need to be encouraged to discuss their CAM treatment options with their primary, or conventional, providers. CAM users need to feel safe that if they share with their conventional providers that they are utilizing other treatment options that they wont be treated differently, but instead should be encouraged for being responsible for their care and learning how to manage their conditions more effectively.

Insurers can participate in the education of CAM users by being clear in the benefits handbooks by describing what it is that is actually covered in a CAM benefit, how a benefit works and exactly what the procedures are to achieve access. If medical necessity is required, state that definition as well as the benefit limits.

Independent networks, offering provider panels, specifically CAM, must assume a zero understanding of managed care by their providers as well as the affected members/subscribers. They have a degree of responsibility to educate the providers that will be *the product* that the network is offering to an insurer. If they do not invest in the education of these providers then they have done no service to the contracted insurer or the members/subscribers that they serve.

Provider contracts can't be expected to educate the panelists. These are legal documents that protect the parties that enter into these agreements. Health care providers are not lawyers and are not able to get the legal advise in appropriate time frames to respond to some of the network/insurer demands. They can be intimidating documents and somewhere buried in a legal contract are the rules that a provider is obligated to follow. Provider meetings and forums are a much more engaging and positive process that will establish a true working relationship with the entities that are entering into a contract with each other. This method will break down barriers and develop true working relationships with networks, providers and insurers.

Consequently, I think there are problems in attempting to integrate medicine with natural health care providers, and conventional health care providers when the insurers are using outside networks to create these panels. There are CAM networks, and there are allopathic networks. There are primary care givers, and the "others" (usually contracted specialists) that have no reason to work together or communicate unless they happen to share an occasional patient. Managed care means co-managing a persons health care. This usually means that there is some coordination of benefits, or is at the minimum supposed to mean that. If this is the case, I might suggest a recommendation to networks and insurers to integrate their panels. Why do CAM provider networks not credential with allopathic providers. Why do PCP organizations not credential and include other provider that are eligible for primary care status, such as Naturopathic Physicians?

If we are truly discussing integrated care, we need to integrate the systems that provide the care, or coordinate the benefits. Establishing different rules for practitioner's of one philosophy versus another philosophy only divides the practices further.

Let's use the example of an affinity plan, for instance. Do you know of any medical doctor that would sign a contract with a network to provide a discounted rate to their already paying cash patients?

Primary Care status for eligible providers requires a level of responsibility. Regardless of your type of practice, or your philosophy of care, you, as the PCP, have an obligation to me, the patient, to understand

the process, and to know when I should be referred to another category of provider. If you aren't aware of the training or practice of other providers, you are not serving me.

Work with associations to educate providers about insurance law's and regulations. Develop working relationships with the leadership in the associations to understand the reactions of a profession when a new contract is developed, or a new relationship with an insurer and a network is formed. Don't lose sight of who is with the patient.

3. *Describe any data you have collected on clinical effectiveness, cost-effectiveness, patient satisfaction, or quality and describe what the data show.*

The Office of the Insurance Commissioner does not have an opportunity to see actual claims experience data of the insurers. If we were to collect this data it could be subject to the Public Information Act. This would make proprietary data available to their competitors, and the public, which could jeopardize their business. Instead, we initiated collaborative working relationships between all parties affected by the landmark law implemented in 1996.

The submitted report documents the establishment and work of the Clinician Workgroup on the Integration of Complementary and Alternative Medicine (CWIC). This three-year process initiated by the Office of the Insurance Commissioner represents a constructive partnership between the public and private sector as well as health insurance carriers and providers. Participants included complementary and alternative medical health care providers, conventional medical providers employed in health insurance companies, primary care providers working in primary care organizations, educators of complementary and alternative medical students, and representatives of state regulatory agencies. One of CWIC's charges was to identify the many issues related to insurance coverage for services that may be considered "complementary and alternative" to "conventional" medical services. One of the most powerful outcomes from CWIC was the positive working relationships developed between the various participant communities. Some of the terms used in this report are specifically defined within the text, in footnotes, and/or appendices to clarify their usage. It is recognized that some terms may have other meanings that should not be extrapolated beyond the context intended here.

The Office of the Insurance Commissioner's health policy staff and outside facilitators met with provider groups to identify those categories that would be most affected by this law. A series of informal discussions with health care practitioners helped identify those considered CAM, licensed by the Department of Health, and caring for patients with health conditions covered by the Washington State Basic Health Plan. Simultaneously, facilitators conducted face-to-face and telephone interviews with potential participants to further refine issues of interest and concern.

A representative group of payer medical directors and CAM providers was established using criteria that insured balance and emphasized provider experience. External independent facilitation was arranged and funded privately by the group participants themselves. In-kind OIC staff resources were provided, but the majority of direct costs for this effort were borne by the carriers and providers themselves.

There are currently several different coverage models for CAM services in use in Washington State. No preferred or "right" ways of including these benefits are being recommended by CWIC or OIC. Each approach has advantages and limitations for various constituencies.

- *Dollar Cap*: Applies maximum dollar expenditure per coverage year for a set range of CAM services.
- *Condition Based*: This CAM coverage model bases benefits on allowances related to specific clinical diagnoses or conditions. The covered benefit may require specific clinical regimens to have been followed prior to referral for CAM services.
- *Gatekeeper Method*: Characteristic of managed care coverage. Use of CAM requires direct referral from PCP gatekeeper, and benefits follow a medical necessity model. Some carriers include naturopathic physicians as PCPs.

- *Open Access Model*: Built on integration and coordination without a gatekeeper. This design allows a member to access network providers of all categories without the requirement of a PCP referral.
- *Self-referral and Preventive Care*: This model is usually structured as a rider to a core benefits package and usually follows a medical necessity model for coverage decisions. This could include patient access to a set number, or amount, of services without PCP referral, but require referral for additional coverage.
- *Discount Networks*: Some carriers have negotiated with CAM providers to provide discounts to their members, but do not provide reimbursement for the members' expenses for the services. This approach attempts to enhance access to CAM providers but does not reimburse for any of the services.

4. *What should be done to improve access to and delivery of CAM for the under-insured, uninsured, poor, and medically underserved?*

The OIC regulates insurance companies so we have a limited role in improving access to the underserved communities other then through the methods of spreading risk, limiting premium rate increases, and assisting in legislation that supports access to health insurance and removes barriers. We do participate in the coalition efforts such as Building Bridges Between provider Communities and the current King County Integrated Medicine 2010 coalition, as well as supporting efforts of the King County Community Health Clinic, known fondly as the Kent Natural medicine Clinic.

The OIC works closely with Washington State representatives from Medicare and Medicaid to encourage development of their programs allowing access to regulated providers. One significant step to increased access was the coverage of Licensed Midwives by Medicaid, allowing low income pregnant women access to home delivery or birth center delivery, which is a significant cost savings. And since Medicaid in currently pays for approximately 45% of all of the births in Washington State, cutting a hospital delivery cost, or the phamacological management if pain during labor, was substantial.

Where there is no regulatory oversight for some professions, supervisory roles can be established to assist in access to non-regulated providers that can offer less costly interventions. This may not be popular for these non-regulated professions, but as education of safety measures and accreditation requirements such as NCQA and JHACO are learned by these professions, they will understand that with insurance benefits and coverage comes a set of rules, also.

I would like to suggest strong support for health services research. Money that will explore the questions that still exist in Washington State today, even though there is a law on access. Money that will support research in utilization patterns, data on add-on versus replacement costs, and how the major stakeholders are currently including therapies and calling them insurance benefits.

5. *Based on your experience, what policy recommendations do you have for the Commission? Please include your view on whether CAM should be accessed and delivered as a stand-alone or integrated with conventional care and why.*

I suggest that policy be established that allows insurance carriers flexibility on establishing their coverage method, as long as it is not an illusory benefit (only covered on paper), and allows them some way to stand out in the marketplace on this issue. That the method use criteria and standards in how the limits will be established for the care provided by ALL categories of health care providers, not just CAM.

I suggest that policy be developed that focuses on "one-medicine" concept instead of a continued fragmented health care system that continues to draw separation between CAM and conventional providers. Networks that actually credential all types of providers and encourages the discussion and co-management of patient conditions, one that requires the communication of the providers directly rather then through an entity that passes through prior authorization notices or letters of denial.

I recommend that insurance carriers not be allowed to cover CAM services only as a separately priced benefit (rider, or carve-out). True integration of care is the best way to protect the public from harm by any

profession, and allows a coordinator of the patient's health care to know what is happening with all aspects of their health care.

I recommend that policy be developed that encourages appropriate payment for services rendered. Equal pay for the massage therapy service, regardless of who is providing it (as long as it is in their scope of practice). Discounted networks should not be considered health care benefits. Provider compensation should arrive in a timely manner, and should not cost the provider more to collect the owed fee then it cost them to provide the service.

Even after all of the legal challenges in Washington State to the "every category of provider law" it has been a law that has brought provider communities together, insurer's and providers together, and it has respected the efforts of managed care, even when managed care began to crumble. It is a law that has undergone great thought and consideration of systems that were trying to offer less costly alternatives in an environment where costs are out of control.

EVERY CATEGORY OF PROVIDER COMPARISON

		BENEFITS, LIMITATIONS AND EXCLUSIONS				
CARRIERS	General Provisions/Rate Changes	ACUPUNCTURE	NATUROPATHIC	NUTRITIONAL COUNSELING	MASSAGE THERAPY	CHIROPRACTIC
First Choice Health Plan Fee for Service and Managed Care	**Rates increase $2.00 PMPM for Small and large groups**	Referral Needed: **Yes** Limitations: **Treatment of pain and for other therapeutic purposes. $10 copay.** Exclusions: **No limits on number of visits or dollar amount.**	Referral Needed: **Yes** Limitations: **No limitations in contract.** Exclusions: **Aroma therapy botanical, herbal and over-the-counter meds, hair analysis, vitamins and food supplements and prescription drugs except B12 injections**	Referral Needed: **Yes** Limitations: **No limitations in contract.** Exclusions: **None**	Referral Needed: **Yes** Limitations: **For medically necessary services with a $10 copay.** Exclusions: **None**	Referral Needed: **Yes** Limitations: **Benefits are provided for 10 visits per year in base plans; or a buy up rider of 20 visits with copay; or a buy-up rider with no maximum visits or dollar amounts.** Exclusions: **None**
Group Health Cooperative	**Rates haven't been filed yet. The definition of a participating provider is one that has signed an agreement who are licensed or certified to practice in accordance with Title 18 RCW.**	Referral Needed: **Yes** Limitations: **No limitations in contract.** Exclusions: **None**	Referral Needed: **Yes** Limitations: **No limitations in contract.** Exclusions: **None**	Referral Needed: **Yes** Limitations: **No limitations in contract.** Exclusions: **None**	Referral Needed: **Yes** Limitations: **No limitations in contract.** Exclusions: **Services for obesity.**	Referral Needed: **Yes** Limitations: **No limitations in contract.** Exclusions: **None**
Kaiser Foundation Health Plan of the NW	**Carrier offered "self-referred" riders with additional costs. Referrals to alternative or complementary care providers are granted through PCP's and issued in accordance with community standards governing medical necessity and cost effectiveness.**	Referral Needed: **Yes** Limitations: **No limitations in contract.** Exclusions: **None**	Referral Needed: **Yes** Limitations: **No limitations in contract.** Exclusions: **None**	Referral Needed: **Yes** Limitations: **No limitations in contract.** Exclusions: **None**	Referral Needed: **Yes** Limitations: **No limitations in contract.** Exclusions: **None**	Referral Needed: **Yes** Limitations: **No limitations in contract.** Exclusions: **None**