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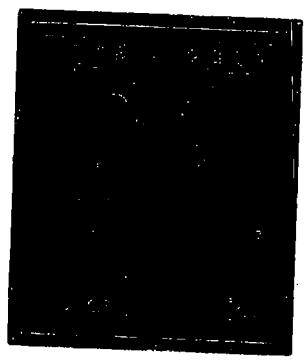
WHITE HOUSE COMMISSION ON COMPLEMENTARY AND ALTERNATIVE MEDICINE POLICY

TOWN HALL MEETING

March 16, 2001

VOLUME 1

Hubert H. Humphrey Institute
Cowles Auditorium
Minneapolis, Minnesota



[This transcript contains inaudible portions and speakers are not always identifiable as herein indicated.]

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P R O C E E D I N G S

OPENING REMARKS AND INTRODUCTIONS

MICHELE M. CHANG, CMT, MPH

EXECUTIVE SECRETARY, WHITE HOUSE COMMISSION ON ALTERNATIVE MEDICINE POLICY

MS. CHANG: Good morning.

We would like to go ahead and begin so if you could all take your seats.

The first row in front of the table here is reserved for speakers so I would ask you to sit in any other place that is comfortable for you this morning.

All right.

Good morning, everyone.

My name is Michele Chang. I am Executive Secretary of the White House Commission on Complementary and Alternative Medicine Policy and I welcome you here today.

Thank you for participating in our fourth Town Hall. We began on the West Coast with San Francisco and Seattle some time ago and most recently we went to the East Coast with New York City so it is really fitting that we are here today in the heart of our nation now.

We are delighted by the agenda that we

have before us today and not only are we gratified by the number of people who have come to speak but also by the diversity of issues and perspectives that you have offered to cover for us today.

We would like to recognize and acknowledge the hard work and the dedication and the openness of the planning committee that so kindly helped us to organize this event. This was headed by Mary Jo Kreitzer up there at the top and was comprised of many others.

We also want to acknowledge the community of consumers, practitioners, educators and others for giving us such an exciting agenda.

Let me very quickly offer a few guidelines for all the speakers and the audience today.

All the speakers will have three minutes to make their oral presentations. I will give you a one-minute warning and when you hear the beep go off then you know that your time is finished. And I would ask you to please be mindful of the others still waiting to speak and stop when your time is finished.

I will not use the stun gun -- but, no, I am just kidding.

Commissioners will be invited to ask questions once all the speakers of a panel have finished making their oral statements. We have asked them to be brief in their questions so we would ask you to be brief in your answers so that it allows everyone else on the panel a chance to participate as well.

We have asked all the speakers to provide us with a written version of their oral statement and they have, in fact, complied.

If you still need to submit your's or anything else, any questions, please see Doris Kingsbury -- she is outside. She is from our staff -- and any of the other wonderful volunteers that are helping her today.

We also welcome the observers of today's proceedings and ask that the audience be respectful to all the speakers coming forward today.

We consider our Town Halls to be public forums for open dialogue and invite all perspectives to be voiced so that we may all have the opportunity to learn from one another.

We regret that we were unable to schedule all of the nearly 100 registrants that came to us for today's agenda. Please do not hesitate to send us your written comments, whether you speak today and have more thoughts or did not get a chance to address the commission today, and you can drop them off with Doris or you can send them to us through our website.

The transcript of today's proceedings and all of our meetings, in fact, are always available on our website usually 10 to 15 days after a meeting has closed.

So just a quick thing on the agenda, we will have a couple of breaks today. The first one this morning will occur around 10:55 if we are on schedule and a lunch break for one hour, 12:30 to 1:30 p.m.

Since this is the only time that the commissioners have a chance to make their break for bathrooms and food, we would ask you to let them go to do what they need to do and catch them after the meeting if you can.

Let me now introduce our chair of our Commission, Dr. James Gordon, who will moderate

today's proceedings.

Thank you.

THE HONORABLE JAMES S. GORDON, MD

CHAIR, WHITE HOUSE COMMISSION ON COMPLEMENTARY AND ALTERNATIVE MEDICINE POLICY

COMMISSIONER GORDON: I wanted to both welcome you to this meeting and especially to thank you all for the welcome to Minnesota, to the Twin Cities. It is wonderful for us to be here and it is one of the places that I knew we had to come to as a commission because there is so much experience here with so many different aspects of complementary and alternative medicine that it was sort of a "must" stop place for us. And so we really are very much looking forward to the hearing today.

Before we go any further, one of the things that we do at the beginning of our hearings is we take a moment of silence just to sit with ourselves and sit with one another and collect ourselves and be present. So I ask you all just to join me in a moment.

(Pause.)

Okay. Thank you very much.

I would like to introduce the other

commissioners who are here. We have a -- the total commission includes 20 people and they are -- as you can see, there are five of us here today and all of them were extremely eager to come here.

And let me begin with Linnea Larson.

Do you want to say good morning?

COMMISSIONER LINNEA LARSON

COMMISSIONER LARSON: Yes, I am very privileged to be here and it is not my home state but I certainly have a lot of relatives here, and I want to thank you for your commitment and the time and effort that you have put into bringing this forward.

Thanks.

COMMISSIONER GORDON: Next is Joe Pizzorno.

COMMISSIONER JOE PIZZORNO

COMMISSIONER PIZZORNO: I am delighted to be here today and I think we are all gathered here because we have a common purpose, and that is that we believe in improving and working together to improve the health and well-being of the human community. I think we all have -- each of us have a lot to offer. And I think --

I have been following for quite some time the experiment that is this state and am very, very interested in seeing what we can work on together to solve some really tough problems we have as a society with all the ill-health that we are experiencing.

COMMISSIONER GORDON: Thank you, Joe.

Wayne Jonas?

COMMISSIONER WAYNE JONAS

COMMISSIONER JONAS: Yes. It is a great pleasure to be here.

I have been all over the country and looked at a variety of different activities but I have never been to the heart and I was struck by Michele's comment that this was the heart of the country.

I am reading a book now by Gayle Godwin called Heart that summarizes the images of the heart throughout cultures and all of the world.

And I hope as we go forward and we see testimony from a variety of stakeholders that we will remember that the primary stakeholder is the public and patients, and if we can balance our hearts and our heads as we do that then, hopefully, they will benefit the most.

COMMISSIONER GORDON: And next is George DeVries.

COMMISSIONER GEORGE DeVRIES

COMMISSIONER DeVRIES: Well, good morning.

It is a pleasure to be here. We thank you for joining us today, of your commitment of time and preparation to be here, and we look forward to learning from you and for you helping us as we move forward in our work.

COMMISSIONER GORDON: Thank you, all.

I just wanted to add that I have been coming to Minnesota regularly for about 15 years. I think Mary Jo reminded me yesterday. It has been about 15 years and coming here -- and even before that actually I was working with runaway and homeless kids here in this area, and in the last 15 years I have seen an extraordinary growth and variety of programs, and a tremendous excitement.

The program today -- what we see in the program today is a flowering of so much, so much effort and so much commitment, and of so many different practices from all over the world that it is a -- it is a very fertile heartland and it

is good to see those flowers blooming.

And we are really -- I really just want to add to what the other commissioners have said -- is that your testimony based on your experience and your perspectives is going to be helping to shape the recommendations that we make to President Bush and to the Congress for legislation and for administrative change. And your experience, if you will, the natural experiments that you have all been engaging in over the years, that that experience, that data of all kinds, is going to help us with the recommendations we make for our interim report, which will be in -- this July. As well as for the recommendations and the kind of blueprint for the direction that we hope that CAM will help to guide all of health care in -- that we will make in March of 2002.

So this is very important to us and having read over the agenda and some of the materials pretty carefully, it is an extraordinary richness and diversity here that I think is going to have a major impact on what we do.

So each of you is going to have a brief

time to speak and we -- brevity is the soul of wit but -- we would like to hear you longer but what we have tried to do, which we feel is really most important of all in a way, is to have more time for the dialogue, for us to ask you questions.

And one of the things we would like you all to focus on, both the people who are here on the first panel and throughout the day, is what direction should we be going in. What are the biggest challenges? What are the biggest obstacles? What is your vision and how do you think we can get there?

And we will be -- as Michele said, everything that you tell us will be available not just to the five of us here but to all the commissioners. We will be sharing it with them and will also be available to the public. And we want you to continue this process -- I will reiterate this, I am sure, towards the end of the day -- with us.

We want you -- if you go home and you think of something or something unfolds, and I know here in Minnesota as the new legislation takes place -- and I have already spoken with

Diane Miller about this -- we want to understand what this means. How it is working, what the difficulties are, what the challenges are, what the possibilities are. So we want progress reports from you. We want to hear what is going on and we want you to give us progress reports about how we are doing as well.

So thank you very much.

We will begin now with some remarks from Gayle Hallin, who is the Assistant Commissioner of the Minnesota Department of Health.

* * * * *

WELCOMING REMARKS

GAYLE HALLIN, MPH, BS

ASSISTANT COMMISSIONER, MINNESOTA DEPARTMENT OF HEALTH

MS. HALLIN: Thank you.

It is my pleasure to extend an official Minnesota welcome to the White House Commission on Complementary Alternative Medical Practice and Policy.

And in thinking of what makes this a good state to come to, I was thinking of several things.

First, we have a governor, who is always alternative and sometimes complimentary. We have a state that is a big "M" state. We are the spawning ground and the home of the Mayo Clinic, Managed Care, Medical Alley, the University of Minnesota and the "many" here who have contributed, as you have referenced, to some of the beginnings of complementary and alternative medical practice.

We also are in the Hubert H. Humphrey auditorium. This is also the state of a very strong social ethic so in addition to the focus on medicine and medical care and business, the

strong social ethic here has driven us to look at not just what are we buying in health care but what are we getting in health.

And in this particular administration with Governor Ventura and our Commissioner Jan Malcolm, we have taken a major effort in re-looking at buying health and moving towards a future where we are getting more health for our money and not just spending money on health care.

We know in Minnesota that if you look at rankings of our health status in Minnesota we are almost always on the top as the healthiest state but, when we look at the health of our state beyond the averages, Minnesota has one of the widest disparities in health status in any country -- of any state in this country.

We also are a state that is experiencing, like many others, a work force shortage and that is at the heart of some of what we are looking at in health care as well.

I believe this Town Meeting and the report of the Commission on Complementary and Alternative Medicine is very important in shedding light on such things such as the public

cost and the public benefits of the standards, the licensure, the regulation of this particular field.

Tom Hiendlmayr from the Department of Health will be describing the conditions surrounding the new Minnesota legislation affecting this area as one of the panel discussions.

Second, I think the work of this panel has potential to contribute to our need to bring more holistic and culturally effective health services to our increasingly diverse population and also potentially drawing more people of diverse cultures and ethnic backgrounds into our health field to assure that we are more successful.

Third, the value of the research and the practice, which demonstrates the contribution of this field of practice in the health area, I think has huge potential for looking at how we can get a bigger return on our investment that we spend on health care dollars. In looking at what we get in the way of health and moving towards that as our prime focus and indicator, not just the focus on health care and health

care services.

So thank you to the panel. Thank you for making this one of your sites.

And thank you for those who are here to testify for your pioneering efforts and for the work you will do to help us understand how we can make this a more important and significant and integrated component of our health system.

Thank you and best wishes for a great day.

COMMISSIONER GORDON: Thank you very much, Gayle.

* * * * *

COMMISSIONER GORDON: Okay. We will now begin with the first panel.

Frank Cerra, good to see you.

ACCESS, FINANCING AND REIMBURSEMENT

FRANK CERRA, MD

SENIOR VICE PRESIDENT, ACADEMIC HEALTH CENTER

UNIVERSITY OF MINNESOTA

DR. CERRA: Good morning.

Mr. Chair, members of the commission, the Academic Health Center has made a major commitment to complementary and alternative medicine.

The driver for that commitment came from our health professional students, the faculty of all the health professional schools and the communities that we serve. They all wanted to know what works, what does not, what are the side effect profiles, and how does this approach compare to the allopathic.

The integrated approach to prevention, wellness and therapeutics is now part of the health professional education and training programs, particularly in medicine, nursing and pharmacy. The approach is interdisciplinary and evidence-based.

The research program is also well on its way. It has received competitive peer-reviewed funding from public and private sponsors. The research is basic, translational and outcomes based.

The focus on outcomes and education also prompted the need for a referral based clinic. This was established. It is functioning well but a financial subsidy is still required.

What we have learned is that the expectation of the people who seek healing there is that their health insurance should cover this service.

Indeed, the university in a recent survey of the health benefits of its 17,000 employees had complementary and alternative medicine on the survey.

Most employees stated very clearly they wanted access to these services through their insurance coverage.

I think there are several policy questions that arise from our experience:

(1) There should be demonstration projects focused on defining the value of complementary and alternative medicine; projects

that use defined metrics and have public reporting requirements.

(2) There should be more public funding focused on basic, translational and outcomes research in complementary and alternative medicine; expanding the extramural programs in the National Institutes of Health in this area would be an excellent approach.

(3) There needs to be accountability in the provision of complementary and alternative medicine services.

This accountability could take the form of accreditation, of educational institutions, regulation of the delivery of services and/or licensing or certification of providers.

CAM holds great potential for promoting health and improving health status, particularly when integrated with the allopathic approach.

We need to find where that value is and promote it in the education programs and delivery systems that have responsibility for health status.

Thank you for the opportunity to comment.

COMMISSIONER GORDON: Thank you very much.

Chris Foley?

CHRIS FOLEY, MD

DIRECTOR OF INTEGRATIVE HEALTH;

HEALTH EAST CARE SYSTEM, WOODWINDS CLINIC

DR. FOLEY: Thank you, Mr. Chairman.

I deeply appreciate the opportunity to address the issues before us. Please assume for a moment that the underpinnings of the complementary and alternative medicine movement are not about diverse, unconventional medical modalities but rather that they are grounded in forces such as the deregulation of information, and a cry for freedom and autonomy.

Also assume, if you will, that the transactions of health care goods and services have been crafted into a carefully-designed set of rules, procedure codes, and relative values that are highly specific to the deployment of allopathic medicine. This effectively codifies a "currency" peculiar to our health care system without which any vendor or buyer cannot participate.

This "currency" is further advantaged by its "pretax" leverage, protections granted to it's larger trusts, and the rather restrictive

filters through which it must pass in order for it be usable by those who originally earned it.

There are no pretenses about the need to protect insurance funds are necessary but does a separate currency need to be created for the management of a headache, menopause or high blood pressure? If it does, should not all modalities be allowed to deal in the same currency?

Leveling this playing field can be done by, first, facilitating the development of individualized insurance vehicles such as medical savings accounts, flexible benefit design, and multiple option plans. Tax law needs to be coherent between the states and the federal codes so as to allow these options with a minimum of confusion and maximal consumer awareness. The consumer must enjoy a part of the "pretax dollar leverage" that up until recently has been controlled by the insurance company.

Secondly, the procedure and diagnostic codes and current relative value scale used to determine payment must be re-worked to be based on time rather than diagnosis and procedure. We

must remove negative incentives that now exist for a physician, chiropractor or any health care professional to spend time a patient. We all know that putting an instrument into someone is rewarded more than listening. It is particularly difficult when one cannot find a descriptive diagnostic code that fits an ill-defined condition that has no specific x-ray or blood test to confirm it. For all of the sacred mantras we hear about the "doctor-patient relationship", it seems that the current coding system has done more to destroy it than almost anything else.

So it is, therefore, recommended that this commission:

(1) Seed the development of a "common currency" for the consumer such that they will enjoy the same pre-tax advantages and choices when seeking alternative care as they do in the allopathic world; and

(2) Move to redefine the procedure and diagnostic coding systems through which health care professionals are paid to reflect time, training and experience, rather than specific allopathic procedures or diagnoses.

Thank you.

COMMISSIONER GORDON: Great. Thank you very much.

Thank you, both, for the brevity and the wit.

Roger Chizek?

ROGER CHIZEK

MEDTRONIC

MR. CHIZEK: First of all, I appreciate the opportunity to be here today and tell you a little bit about what Medtronic is doing in support of complementary therapies.

In 1999 we undertook a lengthy review of our employee benefit programs and determined that they were not nearly integrated enough for our employees to receive the greatest benefit from the resources we provide. Out of this review came "Total Well-Being." Total Well-Being was introduced at the same time that Medtronic announced Vision 2010, our strategic vision for the next ten years.

Vision 2010 has focused the company on providing lifelong solutions for people with chronic disease.

One major premise of this vision is that

to enable people to heal, we have to recognize the whole person, mind, body, heart and spirit, and to provide solutions that treat the whole person, not just the physical being.

Total Well-Being allows us to meet these needs in a variety of ways. It is the health and wellness initiative that lies at the heart of our Total Well-Being that I will briefly describe here today.

On January 1st of this year we introduced a new health plan for our options that is based upon the principle that consumers know best what their health care needs are. This plan provides them the opportunity to be active and informed consumers of health care rather than passive receivers.

Unique in the plan design is an amount that each employee receives that can be used as the individual and their health care provider feel is appropriate for their health care needs, including complementary care that is not typically covered under a more traditional health plan.

Administered through Definity Health, other defining features of the plan are easy

access to credible, relevant health care information, choice of deductibles, direct access to centers of excellence, 100 percent coverage for preventive care, personal health advocate and, as I indicated, coverage for complementary therapy and others. To summarize, it puts the employee in charge of their own health care with the plan providing multiple resources for achieving good health.

Other wellness activities include fitness centers, low fat diets in company cafeterias, nutritional counseling, regular company exercise programs, free flu shots, on-site screenings, health risk management tools, stress-reduction tips, smoking cessation programs, on-site massage, yoga classes and many others.

How does all of what I described relate to the topic under discussion today? Well, first of all, in keeping with the whole person concept of total well-being, the employee programs are designed to meet the needs of the employee through a variety of resources, including complementary care.

In addition, the Definity website

includes a natural pharmacist, provider of evidence-based natural health content that is developed and reviewed by a team of physicians and pharmacologists, and provides consumers and health care professionals with balanced, accurate and up-to-date information.

Evidence suggests there is a growing demand for complementary and alternative medicine.

According to some reports, as many 627 million visits to practitioners of alternative medicine are utilized each year and individuals spend $27 billion of their own money to pay for alternative therapies.

The National Institute --

[Three-minute bell.]

MR. CHIZEK: Can I finish my conclusions?

COMMISSIONER GORDON: Just a couple of the sentences, yes.

MR. CHIZEK: Okay. Policy recommendations:

Any public policy in this area needs to fully acknowledge and encourage the fact that health care is undergoing a change. Some would

say a revolution. That change can only take place if public policy is not restrictive as to prevent innovation in how conventional, alternative and complementary health care is delivered and paid for.

Thank you.

COMMISSIONER GORDON: Thank you very much.

James Woodburn?

JAMES WOODBURN, MD, MS

MEDICAL DIRECTOR

BLUE CROSS/BLUE SHIELD OF MINNESOTA

DR. WOODBURN: Thank you. It is a pleasure and an honor to be here.

Blue Cross and Blue Shield of Minnesota has been providing affordable and accessible health plan products for over 65 years in the state of Minnesota. As we strive to make a healthy difference in our members' lives, we balance the often conflicting goals of affordability versus access to health care services. It is with this challenging balancing act that I present to the commission today one health plan's perspective on complementary and alternative medicine.

The opportunities for our health plan members for integrated care benefits would be greater access and affordability to treatments that are currently unavailable through traditional coverage benefit designs. The benefits of CAM will be addressed by many speakers during the course of the White House Commission meetings. If research bears out the cost-effectiveness and clinical quality improvement benefits, health plans will begin moving in the direction of providing expanded coverage. It is with sincere hope on the part of Blue Cross/Blue Shield of Minnesota that evidence will soon be available to document the cost-benefit and the quality of life improvements that CAM may offer.

The current barriers to expanded health plan coverage for CAM modalities can be summarized by the following three observations:

(1) There is or appears to be limited purchaser demand for benefit designs that pay for integrative care benefits to the same extent that medical care is currently covered.

(2) There appears to be insufficient rigorously defined and evidence-based reports in

published peer-reviewed literature that documents the cost-effectiveness for CAM modalities that would lead to a net cost-benefit in medical treatment improvement beyond those of current therapies.

(3) There is uncertainty of the professional and governmental or regulatory oversight for assuring high quality practitioners of CAM modalities such as through licensure or certification that would then be used to build a network of CAM providers for our members.

I would like to reiterate that Blue Cross continues to work hard to balance the affordability of care with benefit designs that our purchasers and members demand. We do this day in and day out and rely on the results of scientifically sound medical judgments and practice.

I would like to conclude my remarks by announcing that Blue Cross/Blue Shield of Minnesota will soon be implementing a partnership with American Specialty Health Networks to provide complementary and alternative care services at discounted, out of

pocket delivery. This will allow our two million members to receive discounts on services such as acupuncture, massage, herbal supplements, as well as traditional health care memberships. We believe that this continues our journey to provide the types of care at the best possible prices that will allow our health plan products to be competitive in the Minnesota market.

Thank you.

COMMISSIONER GORDON: Thank you very much.

Patricia Culliton?

PATRICIA CULLITON, MA LAc,
DIRECTOR: ALTERNATIVE MEDICINE CLINIC,
HENNEPIN COUNTY MEDICAL CENTER

MS. CULLITON: Good morning. Thank you for this great opportunity.

Last December in Washington, D.C., while I was presenting data on the cost effectiveness of acupuncture to this panel, I made a comment during the question and answer period about the discrepancy of cost versus reimbursement with some third party carriers, particularly those that use federal dollars. Today I want to

expand a little bit on that.

You may remember that I mentioned the medical assistant's reimbursement rate of $17 for an acupuncture visit and my concern of establishing an appropriate Medicare reimbursement rate. I alluded to my fear that there might be a $12 reimbursement rate for $50 worth of paperwork costs. That was an embellishment but the intent of my statement was genuine and at that meeting, Dr. Gordon, you asked me to submit more information on this topic so I have developed a list of costs associated with providing an acupuncture treatment in a large multi-specialty clinic system, which I have included in your packet there.

COMMISSIONER GORDON: Great.

MS. CULLITON: Based on rather conservative estimates of rent and salaries, the cost of an acupuncture visit in this type of setting is between $30 and $50. Additionally, there are no other billable charges such as procedures or office visits to add to the cost charged to an insurance provider. The acupuncture treatment itself is the only item

billed.

As a side note, locally Medicare reimbursement for chiropractic is $29. However, chiropractors generally see two to six times more patients per hour than does an acupuncturist. The cost of acupuncture in a private practice would be less than those that I have just listed but one would expect an increase in their cost with the handling of insurance forms and the inevitable nonclinical time spent with consumers when they are complaining about their bills.

Many groups, including both consumers and providers are lobbying for Medicare coverage of acupuncture. Unless we proceed with caution and a clear understanding of the cost, I have concern that the reimbursement level could be so inadequate that providers would then refuse to offer the service. This would cause reduction of accessibility and would be, of course, antithetical to the reason for Medicare coverage. Clearly I feel great care must be taken before including acupuncture in federal reimbursement policy at an inadequate rate. We do not want to increase the barriers to

treatment for the elderly.

Finally, I just want to take a minute to elaborate on another issue that I had also mentioned earlier and I ask that you consider the use of acupuncture in public health settings and the potential of student loan forgiveness for those acupuncturists who would work in those public health programs. Of course, the use of acupuncture for the treatment of substance abuse is well known and I feel there is great potential in neighborhoods of poverty, including Native American reservations for providing cost-effective addictions health care.

Another potential area of service that have data support in clinical efficacy of acupuncture are chronic pain, angina and incontinence. Acupuncturists working off their student loans in publicly funded nursing homes and inpatient treatments are likely to have a great impact on human suffering as well as potentially decreased health care costs.

Thank you for this opportunity.

COMMISSIONER GORDON: Thank you and thank you for fulfilling my request. I appreciate it. I appreciate the very specific

breakdown here. It is very helpful.

Next is Lynn Lammer.

LYNN LAMMER, BA, JD

HOMEOPATHIC CONSULTANTS, INC.

MS. LAMMER: Good morning, Mr. Chair and members of the commission. I am a classical homeopath and president of Homeopathic Consultants, Inc. Prior to that I was an attorney and I have been involved with the development of the Minnesota model. I am addressing excess delivery and reimbursement and just what I see as some of the most salient points under those areas.

The concern on access is that access to care and practitioners is limited nationally by current state laws. Individuals cannot frequently access complementary and alternative health care modalities and/or practitioners of their choosing. CAM practitioners fear criminal prosecution for practicing medicine without a license. The recommendations to address this concern are as follows:

Freedom of access legislation, similar to Minnesota Statute 146A, The Complementary and Alternative Health Care Freedom of Access Act,

should be enacted in every state. This legislation should provide a regulatory framework for a broad range of healing practitioners without requiring licensure and should provide an exemption from medical statutes for those practitioners where such statutes make it illegal to practice without a license.

Legal reforms need to be introduced into every state that would allow licensed health care practitioners to practice outside the prevailing standard of care if there is informed consent and the practice utilized is not more harmful than the prevailing practice.

Government should not use its police power to restrict people from practicing their health care trades and professionals where harm and fraud are not an issue.

The Minnesota "model" offers citizens the right to make their own choices from a broad variety of health and healing options and balances the government's responsibility to protect the public.

The concern on delivery of such services is that health care services currently do not

utilize a collaborative approach. Practices outside of allopathic medicine are viewed as complementary, alternative or practices that should be "integrated" into conventional allopathic care.

The recommendations to address this concern are as follows: The first requirement is to legalize the delivery of non-allopathic health care practices and second is to realize, and this is very important, that no single modality has all the tools or answers. Each practice has strengths, limitations and needs to be utilized in a collaborative process to ensure optimal care.

On reimbursement the concern is people should be able to choose a type of health care and practice they prefer. We have existing models that can be reworked creatively to address and contain costs. Allopathic care to date has not been able to do that and we have seen an upward spiral despite attempts to contain costs. Current reimbursement plans such as pre-tax medical savings accounts, medical contribution plans, and voucher programs that do not restrict access to different types of care

can be reworked under current existing plans.

The use of natural therapies in health promotion and disease prevention have been shown to be very cost-effective in a number of areas and, when implemented, have helped to lower health care costs. Non-allopathic therapies should also be reimbursed through Medicaid and Medicare.

DISCUSSION

COMMISSIONER GORDON: Thank you. Right on time.

Okay. We now have time for questions.

Frank, do you want to come back to the table.

And we will begin at this end with Linnea. Anything right now?

Joe, do you have one?

I have several. I will ask one and then we will move on and give other people a chance and then we will come back.

I wondered in formulating the plan at Medtronic -- first of all, I would love to see the plan and sort of all the sort of -- everything connected with it, including particularly the financial considerations. But

I wonder if you could tell us a little bit about how you came to do what you did and how you computed it economically as well?

MR. CHIZEK: When we started to look at the plan what we were looking for is something that was completely different than the -- I will use the word "traditional plans" that we have locally in Minnesota. Most people recognize the traditional ones, the Health Partners and Amedica Plan, which are pretty traditional. We wanted to do what we could to remove the gatekeeper concept in plans. We took a strong belief that health care needs to be directed by the patient and no longer by managed care companies and by their physicians. And to that extent we tried to remove barriers and also provided an amount within the plan that people could use as they see fit to purchase medical services, including some complementary care alternative therapies as long as they were generally accepted types of things to be doing.

We -- on a cost basis we modeled it be cost neutral with our other plans. There are always economic concerns and --

COMMISSIONER GORDON: Cost neutral

meaning?

MR. CHIZEK: Cost neutral meaning that the new plan that we put in would be -- would not -- neither increase nor decrease our cost with our other plans on a composite basis.

COMMISSIONER GORDON: I see.

And how -- did you do -- do you have a kind of coverage for catastrophic illness and then a separate open dispensation of money?

MR. CHIZEK: Yes, it really includes three components. In summary -- or four components really. Preventive care is all covered at 100 percent. We strongly encourage people to do preventive care. The personal care account, which is this amount that an employee receives, is the amount that is charged first for any medical services. The full cost of medical services. After that is used then the individual has some out of pocket cost. After the out of pocket cost is reached then the plan pays 100 percent. So it is a tiered approach again with individuals selecting deductibles from a low, media, high level of deductible. So again they get to pick the risk level that they want to participate in but the plan will still

protect them from catastrophic situations.

COMMISSIONER GORDON: Great, that is terrific.

Does Medtronic spend more on health care than comparable corporations or not?

MR. CHIZEK: From what I see in surveys we actually spend less money on a per employee basis.

COMMISSIONER GORDON: Is that right?

MR. CHIZEK: Yes.

COMMISSIONER GORDON: So we would very much like to see whatever you can provide us because we are -- one of the things that we are doing clearly is looking for models that we can recommend.

MR. CHIZEK: Okay. I can get that -- I can get a description of that to you.

COMMISSIONER GORDON: Thank you very much.

Wayne, any questions?

COMMISSIONER JONAS: Is this on? No? I have a couple of questions.

Dr. Cerra, you suggested demonstration projects and I am wondering if the preference from your perspective in terms of establishing

benefit and/or harm in some of these areas is in the area of effectiveness rather than efficacy, that is clinic-based types of outcomes research? That was the impression I got from your statement, is that correct?

DR. CERRA: That is correct.

COMMISSIONER JONAS: Okay. Then that leads me to the next question. Is that the kind of evidence, Dr. Woodburn, that is used to establish whether benefits will be provided or covered by Blue Cross/Blue Shield?

DR. WOODBURN: Yes. Those are -- that is among the type of research and results that we look for when we determine our coverage benefit design.

COMMISSIONER JONAS: Is it possible to establish -- what I am trying to get at is that there is a discrepancy as described by ARC and a number of others between efficacy, which is controlled research, controlled trial research, and effectiveness, which is more, I think, what you are referring to, what happens out in practice and people have a disagreement over often what kind of evidence is sufficient for different types of practices and I am just

wondering, you know, is this an issue that needs to be addressed in some way as to what type of evidence is required for these areas before benefits are provided?

DR. WOODBURN: I think that is definitely at the core of current benefit design structure in the typical health plan. The level of evidence that is required for most medical policies to pay for services is a very high bar requiring multiple peer-reviewed, randomized, controlled clinical trials over many years in many clinical settings and I think that is too high of a bar but that is the bar that we have set to try to assure quality of care to our members.

So I think some reconciliation between the providers and the community and health plans to put that bar at a different place where we can use effectiveness information rather than efficacy information is really the dialogue we need to have within our community.

COMMISSIONER JONAS: I was struck by Dr. Foley's recommendation that we now pay for listening and the time to listen, and again thinking about what current standards we use to

make decisions about payment now as to how we would even go about evaluating that. Any thoughts about how to do that?

DR. WOODBURN: I also agree with Dr. Foley. I think the lingua franca, the currency, the exchange of CPT codes and RB/RBS values, that is how we exchange money between our purchasers and our providers, and that is a very defined concrete set, set by the AMA and their CPT coding committee. And I think we definitely need to get to a place quickly to find a different way to reimburse for the care that improves the health and quality of lives of our members. .

COMMISSIONER JONAS: I would think it would be extremely difficult to figure out how to pay for time and listening but it is certainly maybe one that should be explored. I would love to hear some specific ways in which that might be codified or tax benefits provided.

COMMISSIONER GORDON: Are there other -- I think that is really important and I am wondering if there are other -- if there experiments that you know of or that any of the panelists know of along that line of trying to

do -- trying to code and provide according to time spent and not just according to procedures?

DR. WOODBURN: Dr. Gordon, when the RB/RBS was originally designed the American Society of Internal Medicine was very involved with that and I was the President of the Minnesota Chapter at that time, and time as a unit of exchange was seriously looked at but in many cases it discouraged the performance of certain types of procedures and, therefore, it was weighted out of that discussion but it is re-emerging now as a principle by which we may measure the time or the exchange between a provider and a patient.

Now during that period of time there may be weighted scales of time based on experience. You know, a surgeon's time may be more valuable than an internist's time but nonetheless it is actually -- it may be very easy to do that and that is reemerging now in the discussions of recodifying that type of exchange in currency but right now it is basically discouraged. I think we have seen the distillation of time out of the relationship.

COMMISSIONER GORDON: When you say it is

re-emerging, is it -- are there experiments underway or about to be underway?

DR. WOODBURN: You know, I -- it has just been discussed in the American College of Physicians and the American Society of Internal Medicine level, at the policy level now it is being discussed as suggestions for reinventing the RB/RBS system.

COMMISSIONER GORDON: Right. Okay. Thank you.

George?

Any? Yes, Joe?

COMMISSIONER PIZZORNO: This is for Mr. Chizek if I am saying your name right. I have three questions. First off, I did not see any written testimony from you. Is there -- did we get written testimony --

MR. CHIZEK: Yes.

COMMISSIONER PIZZORNO: Did I just miss it?

MR. CHIZEK: Yes, I do.

COMMISSIONER PIZZORNO: Okay. I will dig it up.

Second is one of the issues for preventive care versus intervention care in the

past -- in looking at CPT coding has been that preventive care is reimbursed at a lower level even though it is the same amount of time that is being spent. I was wondering if you have addressed that.

MR. CHIZEK: Well, preventive care in most plans, like I said, is paid at 100 percent of cost.

COMMISSIONER PIZZORNO: But I am saying the practitioner themselves is paid less per unit of time for providing preventive care as compared to interventionist care so I wonder if that has been handled in your system in any way.

MR. CHIZEK: I cannot speak to that directly.

COMMISSIONER PIZZORNO: Okay. Okay. Thank you.

COMMISSIONER GORDON: I had another -- did you have a question? Go ahead, Linnea.

COMMISSIONER LARSON: One more question to you, Mr. Chizek. How many employees do you have?

MR. CHIZEK: We have in the U.S. about 15,000 employees.

COMMISSIONER LARSON: And is there an

average age?

MR. CHIZEK: The average age company-wide is approximately 39 to 40.

COMMISSIONER LARSON: Okay. Thank you.

COMMISSIONER GORDON: Chris, I wondered -- you said something here that I did not -- I do not quite understand and maybe you could spell it out having to do with -- I think it is pre-tax leverage. Is that what it is?

DR. FOLEY: Yes. Well, right now essentially the consumer is told how their pretax dollars are going to be spent after they have been collected and invested and managed and administered. I think that what Medtronics has done and begun to do is to assume that the consumer perhaps is capable of deciding how those pretax dollars are going to be spent. That is a different currency than someone who has to spend after tax dollars.

Families who invest $500 a month in health insurance premiums and then would seek to obtain complementary care in an area that they deem effective for them may find it very ill-advised to go back into their pockets again after they have already spent their health care

premium and actually may spend very little of that premium dollar on allopathic medicine, and this is a problem. Like I say, there are two completely different currencies and standards, and this is a major barrier to integrative health.

COMMISSIONER GORDON: And what would your suggestion be on how to do an --

DR. FOLEY: Actually I am privileged to be sitting next to one of the models, I think, that is beginning to answer that and that is that greater options that place greater autonomy in the pocketbooks of consumers need to be explored and this is a great way to do it as a sentinel effort on the part of this commission. This could be a model for the rest of the health care system. In the information age we can no longer say that the consumer is not intelligent enough to spend their own health care dollars.

(Applause.)

COMMISSIONER GORDON: I wonder if other panelists have thoughts on this issue, any of you, your experience?

Yes, Frank?

DR. CERRA: We have been looking at this

Definity Health Care Model as a benefit for the university as we decide what we are going to do with our 17,000 employees and the one thing that has come out of the employee groups and the administrative groups that have been working on this --

(End Tape 1, Side A.)

DR. CERRA: -- use of the dollars. And there is some concern about the responsibility of the employer for making sure there is sufficient information and education on health available to their employees and it is not that there is any concern about people's ability to learn. I do not think that is the issue but right now if you go out on the web you are flooded with data.

Making data into information is another task and there are all kinds of websites with all kinds of health claims, much of which has very little in the way of evidence-based and somehow that needs to be balanced against an informed consumer and the right of a consumer to spend their dollars on whatever they wish to spend it on.

COMMISSIONER GORDON: Thank you.

Either of the other two of you?

MS. LAMMER: I found in my practice that the consumers that come in as clients seeking alternative care, among the most educated of those people are the ones that have the pretax medical accounts. They spend a great deal of time and are very informed by the time they walk through my door and they utilize fewer services because they have been so involved with their own care.

COMMISSIONER GORDON: Thank you. Any other comments?

I have one question for you, Pat. As you -- now that you have laid out how much it actually costs for acupuncture treatment, what is your next plan? What are you -- I mean, aside -- we appreciate it and it will help us but how are you going to use this? How are you going to approach insurance plans and others?

MS. CULLITON: Well, with a lot of prayer actually. I think it was actually shocking when we discovered -- to discover how much an actual individual treatment costs within an academic setting and so I would like to have more conversations with insurance companies.

For the most part, many of them have reimbursement rates that are around that level so it is not that much of a problem. My concern, as I stated, was we know we have friends in Washington right now lobbying for HCFA to look at reimbursement of acupuncture and my concern is that when it comes to federal dollars that the reimbursement rate might actually -- as I said, might actually just be too low and, therefore, have a negative effect on access. So that is the big thing.

COMMISSIONER GORDON: Negative effect in what sense?

MS. CULLITON: Well, I know physicians that do not take people -- you know, patients with Medicare because they just do not want to deal with the paperwork.

They do not want to deal with the limited costs and I think if an acupuncturist finds out that they are going to lose $20-$30 every time they see a Medicare patient they will just say, "We do not want to see them."

COMMISSIONER GORDON: Okay.

Thank you.

Any final questions?

Okay. Thank you.

Thank you all very much.

(Applause.)

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INTEGRATION OF CAM INTO CARE DELIVERY SYSTEM

MS. CHANG: Will the next panel please come forward? That would include Sharon Norling and Julie Schmidt, Tim Culbert, Carolyn Torkelson and Kathy Schurdevin. Thank you.

COMMISSIONER GORDON: Okay. We will begin with Sharon Norling. Good morning.

SHARON NORLING, MD

MEDICAL DIRECTOR: MIND BODY SPIRIT CLINIC

FAIRVIEW HEALTH SYSTEMS

DR. NORLING: Good morning.

Chairman and commissioners, I am honored to be here.

I am the Medical Director of the Mind Body Spirit Clinic and that is the partnership between the Academic Health Center and Fairview Health System. In that role as Medical Director I have had many opportunities and many challenges but what I am passionate about and what people and individuals are passionate about is that we need to be able to offer CAM therapies to people with cancer, pain, acute and chronic illness.

Health plans have begun to offer limited benefits. However, for reimbursement, as we

heard earlier, they require that the services are safe and effective and that the providers are credentialed, certified and licensed, and they want medical supervision. Now how does a physician comply with the standard of care within the medical profession while referring to a CAM provider, while discussing these therapies and what about the physician that is practicing integrative medicine?

If we are to partner with the patient and the health care professional, we must have the highest standards. The Federation of Medical or State Medical Boards actually has maintained that "unconventional practices" should be regulated by applying the prevailing standard of practice. My concerns are that without regulation or an unregulated model that we may reduce reimbursement and access. And, secondly, that this may impact our ability to provide integrative medicine.

My recommendations are that we have defined standards of care and scope of practice and that we certify, license and credential both the physician and the nonphysician who are providing CAM therapies.

And, third, that there is a mandate that health plans or health insurers as well as federal programs reimburse at an appropriate level for these services that are safe and effective.

Then we can offer the best of both worlds and that is really the transformation of health care. Thank you.

COMMISSIONER GORDON: Thank you.

Julie Schmidt?

JULIE SCHMIDT, CEO

WOODWINDS HEALTH CAMPUS

MS. SCHMIDT: Yes. Members of the White House Commission on Complementary and Alternative Medicine, thanks for this opportunity to speak briefly at this Minnesota Town Hall meeting. I am the CEO of Woodwinds Health Campus in Woodbury, Minnesota.

I have provided you with a more lengthy testimony and background information on the Woodwinds Health Campus. The Woodwinds story is one that I think you will find to be a wonderful opportunity of what health care can be in the future. I hope that we will have the opportunity to give you a tour of the facility

on a future occasion.

In the interests of honoring your schedule, I will make but a few brief points but most importantly I am here to demonstrate the opportunity and responsibility that I feel as a leader to support these efforts.

Complementary and alternative medicine is growing in popularity because of consumer demand, as you know. It is a trend we saw emerging five years ago during the design phase of our hospital project. Members of our design team, community residents and staff members chosen for their innovative thinking, conducted community forums and surveys with hundreds of area residents.

One of the overwhelming messages was that consumers did not like the fact that traditional Western medicine and complementary medicine were so distant from one another and they wanted them integrated in their future vision of health care.

Because our goal is to design a health care delivery model that would better meet the needs of our community, our design team created a set of guiding principles, one of which was

"Foster Choice" by providing a spectrum of care with integration of select complementary approaches to health and well-being. Bringing this principle to life required collaboration among several parties and I can't underline that enough, "collaboration."

Healthy Care System, Children's Hospitals and Clinics, and Woodwinds partnered with Northwestern Health Sciences University and the University of Minnesota Center for Spirituality and Healing to address the community request to offer an integrative approach to care.

The result is a proactive effort to link traditional and complementary medicine on the campus on several fronts. The Natural Care Center at Woodwinds, which is a joint venture of Woodwinds and Northwestern Health Sciences University, offers chiropractic, acupuncture, massage therapy, naturopathy and a certified master herbalist.

It took two years of relationship building to make this care center a reality. It is all about people and understanding. A key to successful integration is the role of our

medical director, Dr. Foley, who you have heard from, as well as our integrative health services leader, who is a holistic nurse. Her responsibilities include staff physician and community education, coordination of services from the Natural Care Center to the inpatient and outpatient areas of the hospital, and identification of research opportunities.

Accomplishing true integration as opposed to peaceful coexistence will be along journey but we have made an important progress in just a few months.

Again thank you for giving me time to speak to you today. We look forward to working with you who advocate continued pursuit of providing health care consumers a wide variety of appropriate approaches to healing.

COMMISSIONER GORDON: Thank you.

Tim Culbert?

TIM CULBERT, MD

INTEGRATIVE THERAPIES:

CHILDREN'S HOSPITALS AND CLINICS

DR. CULBERT: I appreciate the opportunity to lend a pediatric perspective to today's conversation. Children's Hospitals has

been fortunate to have strong administrative leadership and philanthropic support that allowed for the creation of a one of a kind system-wide integrative medicine program at Children's two years.

The Integrative Medicine Program currently includes eight health care professionals involved in a variety of clinical, educational and research activities around CAM. Program focus has been on children with chronic illness and disability who, as a group, are among the highest CAM utilizers. Our own internal survey data indicate that 52 percent of patients in pulmonology, neurology, primary care and sickle cell clinics report currently using some form of CAM for their children.

Support has been widespread. We have gotten a number of referrals from our colleagues and there have been no attitudinal problems by and large amongst the staff. Feedback would also suggest that people appreciate the fact that we have a CAM service that is affiliated with a well-known respected health care name in the community.

Coding and billing challenges, however,

remain big obstacles. I will give you a personal example. I am a pediatrician but also board certified in both biofeedback and medical hypnosis. In ten years of practice I have not found an effective way to build those therapies despite the fact that they are amongst the best demonstrated in terms of evidence-based therapies in pediatric health care.

In addition, because incident-to-billing is not allowed in the State of Minnesota by and large, we have been forced to create a fee-for-service situation for CAM services by and large, which immediately and to a large extent tends to excludes those in the lower socioeconomic status, which we think is very unfair. We have been lucky to have philanthropic support to date but have not been able to manage that problem yet.

Credentialing and privileging is also a big issue, I believe, in pediatrics that has not been addressed. We must rely in pediatrics on parents being sensible consumers and advocates on behalf of their children. In my opinion we must establish national specialty certification requirements for all CAM practices that are

specific to children and adolescents. Children are not just little adults.

Research and education efforts in pediatric CAM also need more in the way of national funding. Pediatricians' biomedical expertise does not adequately prepare them to consult on CAM. There is only one national level pediatric conference on CAM in the United States. Only one compared to hundreds in the adult arena.

We also need to see education in the reverse direction, I believe, that CAM practitioners that work with kids would likely benefit from some basic pediatric training themselves to understand how to handle acute illness and when to refer to a conventional pediatrician.

My closing comments would be that it would appear that the utilization of CAM services in pediatrics is as prevalent as it is in adults yet pediatric specific CAM activities in terms of training, education and clinical practice are lagging behind the adult field. We need more funding around safety issues that are paramount in pediatrics and this could be

supported through clear, consistent licensure and training standards as well as national level educational efforts again that are specific to pediatrics.

Our program has already enjoyed great enthusiasm and support within our system and within the community, however its long-term sustainability remains a shared challenge.

COMMISSIONER GORDON: Thank you.

Carolyn Torkelson?

CAROLYN TORKELSON, MD

BUSH FELLOWSHIP PROGRAM OF STUDY

DR. TORKELSON: Thank you for this opportunity.

I am a conventionally trained family practice physician who practices holistic care. I am here today as a clinician. One that is prepared to deliver CAM services and integrated care but I am faced with the reality that there are few clinical settings in which to practice.

If we believe our current health care system needs to offer integrative medicine then the application of CAM needs to be available. Currently CAM services are too fractionated and access is difficult. We need to provide

clinical settings where the consumer has easy access to our skills, knowledge and guidance.

My proposal is to create a model of clinical application, which I call a "Charter Clinic." It would much like a charter school phenomenon where the center would be dedicated to providing the consumer with care that is not obtainable in the general health care setting.

The reason for that would be is that we need some kind of demonstration clinic. The clinic would provide integrative care with holistically trained MD-DOs and CAM providers. It would be in a designated location with care provided in a safe and trusted environment.

Now in addition to the clinical application it would also serve other purposes as far as a training ground for residents and physicians. It could also be a resource base for education and classes and a referral base for CAM providers outside of the charter clinic concept.

In order for the charter clinic concept, though, to be developed, we need financial and political support and that is where I think the White House Commission can be helpful. In order

for a CAM charter clinic to survive, I think, initially it would have to be fee-for-service, especially given the current reimbursement plan because we have such poor reimbursement for primary care time.

It could also, though, be helped by private sector or major institutional collaboration that would be investing funds, space, personnel, or marketing.

We need -- but more than anything, we need government support, to dedicate funds, to direct policy and mandate policy so this kind of charter clinic could happen and support CAM through improved reimbursement.

In summary, what I want the White House Commission -- the commissioners to hear is that:

(1) Consumers are demanding safe and accessible integrative care.

(2) We do have CAM providers and I think this was best demonstrated by 300 medical doctors taking the holistic boards this last December.

(3) We need a clinical setting for Cam providers to practice the art and the science of medicine.

(4) And I think charter clinic concept is a model that would demonstrate success and build on the future of integration.

Thank you.

COMMISSIONER GORDON: Thank you.

Kathy Schurdevin?

KATHY SCHURDEVIN, PRESIDENT
MINNESOTA NATURAL HEALTH LEGAL REFORM PROJECT

MS. SCHURDEVIN: Mr. Chair and members of the Commission, the main issue we are facing is how to integrate complementary and alternative therapies to provide the citizens fully with the care they need. Ideally, in the best interest of the clients, integrative care should be predicated on "clinical parity." A number of so-called integrative partnerships have been tried but these have fallen short of expectations due to the intense interest of the parties involved on maximizing revenues.

A structured delivery system, consistent of "clinical parity" void of competing financial interests and free of the dominance of the traditional JCAHO delivery model needs to be developed. Under this "integrity model" an up front multi-disciplinary patient assessment

would drive patient care.

I do not feel that integration is the best option but believe that collaboration would be a much stronger model to pursue. This would require good collaborative networking between the medical doctor and hospital systems and the alternative healings throughout the community; an intricate system that supports the client both during and after hospital care.

The citizens want options and time available to them that has been eliminated from current mainstream medicine. They want their alternative healers brought into the hospital setting without interference on a consultation basis upon request of the attending physician, the client or the client's family.

Interventions must be designed to help the client progress towards personally valued health goals with comprehensive focus on multiple areas of function, such as mental, emotional, spiritual, social, work-related, and taking a long-term perspective toward improving the course of their health.

An emerging body of evidence demonstrates that community interventions can

improve the long-term outcome of wellness and illness. If clinicians are to be effective in serving their clients, they must be knowledgeable about nonpharmacologic interventions designed to decrease symptom severity or distress, avoid hospitalization, improve psychosocial functioning and improve satisfaction with life.

Examples of such interventions include:

Collaborative alternative and allopathic treatment with direct provision of services provided, rather than brokered services;

Assertive community treatment models of case management. This management involves clear traditional medicine and alternative therapy treatment goals and treatment options;

Family involvement and intervention in care. This has been found to reduce hospitalization and decrease relapse rates;

Illness and wellness self-management training. This provides a shift from passive recipient of treatment to active involvement in the management of his or her wellness and illness, with education about illness and alternative and allopathic treatment options,

teaching how to recognize and respond to early warning signs of illness or relapse and teaching coping strategies to deal with stress or persistent symptoms;

And supportive employment incentives, such as paid wellness days off and use of sick time accumulated revenues for alternative wellness and illness care.

I respectfully request that the Commission consider this for policy recommendations.

As a parting thought: "A single choice can build destinies or destroy them."

Thank you.

DISCUSSION

COMMISSIONER GORDON: Thank you very much. Thank you.

Wayne, do you want to begin?

COMMISSIONER JONAS: Yes. Dr. Culbert, can you describe what services do you provide in your integrative clinic for children? Are there some specific ones that children especially need and/or use that you have available or do not have available?

DR. CULBERT: Sure. I think that we

have tried to take a look at services that are (1) safe and (2) evidence-based, and we do offer a range including biofeedback, hypnosis, massage therapy, which has reasonably good evidence in a variety of childhood conditions, healing touch, aroma therapy, which as you probably know is pretty well documented in the European literature but not so much the United States literature, acupuncture and those are -- and spiritual guidance and so those are the modalities we are going with right now.

COMMISSIONER JONAS: Are there herbs and homeopathy available or used?

DR. CULBERT: In the community, not in the hospital right now. There are two of us on staff that are physicians that are gradually moving into adding herbals and botanicals as part of our consultation.

COMMISSIONER JONAS: We heard in the last panel that there is a discrepancy perhaps about what type of evidence is required for provision and what I heard you say is that at least a couple of areas, biofeedback and hypnosis, there is considerable evidence it perhaps meets even the highest standards that is

required and yet it is still not reimbursed. I wonder if you could comment on that. Do we have a -- do we have kind of a hodge podge application of evidence to reimbursement?

DR. CULBERT: Well, I will give the specific example of pediatric headache and migraine. It is very clear from 15 years of literature that biofeedback and other forms of relaxation are superior to things like propranolol, for example, and despite that being well-documented it is still difficult through many insurers to get biofeedback if it is coded as a CPT code reimbursed or reimbursed adequately.

COMMISSIONER JONAS: My impression is that in the area of healing touch or therapeutic touch in children there is little to any evidence.

DR. CULBERT: That is correct.

COMMISSIONER JONAS: And yet that is something you provide available, is there a reason for that?

DR. CULBERT: I think that is looking more at emerging trends and the fact that one other way that we weight some of these things is

to consider whether they have any inherent toxicity or are unsafe and, you know, there is some evidence, it is more anecdotal in case study, that healing touch can provide subjective, at least comfort and feelings of well-being in kids so that is more why we would offer it there thinking that it is fairly unobtrusive or noninvasive but certainly there is not real good evidence.

COMMISSIONER JONAS: For those types of things. Thank you. That is fascinating.

COMMISSIONER GORDON: I wanted to follow up on Wayne's question. Have you -- have you put down on paper some of sort of the thoughts and the considerations that have come up in trying to get reimbursement for some of these therapies and the particular example you were -- the two of you were discussing of biofeedback and hypnosis for, you know, pediatric migraine or pediatric headaches generally, have you made a position paper and have you dealt with insurers about that?

DR. CULBERT: Yes. We actually have. In a certain number of cases what I have actually done is written a letter and attached

to that letter several studies and clipped it to the letter and when I have done that specifically and asked for, let's say, ten sessions, I have actually had it authorized on a few occasions. So that has been a good strategy and it has been successful.

COMMISSIONER GORDON: I am wondering if you could share that -- the whole of that experience with us, that is the literature and the specific tactic that you used with insurance companies and the outcome.

DR. CULBERT: Sure.

COMMISSIONER GORDON: Because this is -- I think this question that you two are discussing is really important because -- and this is -- you know, not so much for your benefit because I know you are aware of it but for everyone else's. One of the issues is, well, we need evidence-based care and we did hear that last time. And what about where there is evidence?

DR. CULBERT: And it is not being recognized?

COMMISSIONER GORDON: Yes. So that would be very helpful for us. And, also, this -

- I am asking Dr. Culbert specifically but if others of you have this kind of information that you would like to share with us, it would be very, very useful for us.

Questions, Joe and Linnea?

COMMISSIONER PIZZORNO: I do. Actually this is for Julie Schmidt. You mentioned the specific term "certified master herbalist." By what process was that designation determined?

MS. SCHMIDT: You know, I am not sure. I -- from the clinical perspective I am not sure. I rely on our clinical folks to make those determinations so I cannot answer that question. I am sorry.

COMMISSIONER GORDON: Okay. We will be having testimony from herbalists later on today and we can begin to -- maybe one of them will even be able to answer this specific question.

MS. SCHMIDT: Right. Thank you.

COMMISSIONER LARSON: This is for Dr. Culbert. You mentioned here you have some data on your patient mix and the reimbursement, 22 percent Medicaid, 64 percent insurance, commercial, et cetera. Now that is for inpatient and outpatient?

DR. CULBERT: That is correct. That is total inpatient.

COMMISSIONER LARSON: Okay. And then you, also, mentioned you do not get very much reimbursement for those who cannot afford. Is the same kind of population -- is it a similar breakdown in terms of is the 22 percent who you would say cannot afford to pay of your -- and 70 percent can afford to pay?

DR. CULBERT: You know, I do not have statistics on that but that sounds about the range that I would be considering, you know, 20 to 25 percent have a significant problem with payment, especially with these fee-for-service items where we have been lucky to have philanthropy to pay for a number of them but we have not been successful at all in figuring out other -- either sliding scale mechanisms or fee-for-service ways to do it.

COMMISSIONER LARSON: So you really are relying on philanthropy?

DR. CULBERT: Currently but, of course, that cannot continue.

COMMISSIONER LARSON: So you are going to have to cut those services to the under

served?

DR. CULBERT: Yes. Or discontinue them completely really depending on how it goes.

COMMISSIONER GORDON: I have a question, a general question. Kathy Schurdevin's testimony made me think of it in particular.

Are there models that are currently functioning that you can tell us about or, Carolyn Torkelson, that you can tell us about that fit this charter clinic that -- because that is one of the things that would be very helpful is if there are either informally or formally if this kind of services are being delivered?

MS. SCHURDEVIN: There are models that have been used in the mental health community that do not particularly pertain to CAM but they are using the model of using the community as an outreach and working from that model and they have been very helpful and they are very clear. I have given you some references in the material that I have enclosed and they very clearly state what has worked and what has not worked if you want to look at those where --

COMMISSIONER GORDON: Okay. And you

have given us that material?

MS. SCHURDEVIN: Yes.

COMMISSIONER GORDON: Okay. Good.

And do you have a sense of why the mental health community has not integrated CAM?

MS. SCHURDEVIN: I -- well, my impression is that they are very heavily at this point controlled by the drug companies and to even take the time to look at it, they do not have time. They are being bombarded daily with new medications and they are having a hard time even keeping up with that and there is a lot of real heavy prejudice at this point for allopathic medicine.

There are a few doctors that I have known that are willing to look at it but a lot of times the docs that are in charge over them are very anti-alternatives and there is a lot of fear in the community.

COMMISSIONER GORDON: Are you looking to create such a model here?

MS. SCHURDEVIN: I would love to see that.

COMMISSIONER GORDON: Because, I mean, I think -- I am a psychiatrist by training and

have obviously or perhaps not obviously, I have done a lot of this kind of work with people with so-called psychiatric diagnoses, and I agree with you that it is not happening, that there is a split between what is going on in the CAM world and what is going on in psychiatry and, in fact, that split is often greater than with other medical specialties or other conditions.

So, you know, I would just encourage you to do whatever you can even if it is rudimentary in providing this kind of model and documenting it.

MS. SCHURDEVIN: Okay. I am working at present in the mental health community with the Hennepin County and I am in the inpatient setting and it is not happening.

COMMISSIONER GORDON: Yes.

MS. SCHURDEVIN: There are some community things offered but as far as alternatives there is a very negative, negative response and I have not been able to get past that at all, and I have been working but it is very difficult.

COMMISSIONER GORDON: You two wanted to respond to the question and then Wayne has

another question. Go ahead.

DR. TORKELSON: I have been -- had the opportunity over the last eight months to be on a Bush Fellowship and have actually looked at integrative clinical sites throughout the country and have seen various models that have been applied, all with varying success, and I can certainly submit that information because I think there are components and factors that make for more successful clinics. There is no question about that. Certainly states like Washington where you already have state mandates to cover things like naturopathy, those are some of the things that make it ideal places to get integrative medicine moving forward.

When you are dealing in a state like Minnesota where naturopaths are not even licensed or there is not any direction from state to mandate, if we had, for example, a mandate from, you know, the state to develop charter clinics, this would be a way that you could start to implement different models.

COMMISSIONER GORDON: What would be very helpful is as you look -- have looked at those centers if you could give us some of your

thoughts about why one -- which ones succeed and why, what the conditions are for making it possible, that I think will be very helpful.

DR. TORKELSON: I can do that.

COMMISSIONER GORDON: Sharon?

DR. NORLING: Yes. I just wanted to say at the Mind Body Spirit Clinic at the Academic Health Center, we really do have an excellent integrated model and provide several services of CAM therapy and work in an integrated model with allopathic or conventional physicians in the same site with integrative team conferencing. We also conduct research there and have research now that is being started in GYN oncology looking at usual care of the patients and then usual care plus complementary alternative medicine therapies and the outcomes, the clinical outcomes and lab data, as well as quality of life. We also educate medical students and residents throughout that clinic.

COMMISSIONER GORDON: If you can give us some of the details of that, and also the details of the cost, because one of the issues, as I am sure you know, is that -- and Carolyn, I think, pointed it out -- is that many of the

clinics have gone under in the last couple of years and so whatever you can do to provide guidance about how to survive and thrive would be very helpful.

DR. NORLING: All right.

COMMISSIONER GORDON: Wayne?

COMMISSIONER JONAS: Yes. I agree. You have addressed several of the things I wanted to talk about, too.

I mean, our charge really is to figure out are there ways -- are there viable and appropriate ways in which complementary and alternative medicine practices can be brought into our current health care system and often as we go through these meetings it appears that there may be some things that we do not want to bring in or cannot be brought into the current health care system without some fundamental changes.

In the last panel as well as this one in your reference to the mental health field also struck me as almost a reverse process that the mental health field actually started off paying for time and listening, the very thing we talked about, and now seems to be regressing in that.

And I am thinking there are some core reasons for that that if we do not address are going to happen in this area in the exact same way and it would be helpful to hear some things about that, those core areas.

COMMISSIONER GORDON: Right. Thank you, Wayne.

Other?

I have one other question for you, Tim. Why do you think since America professes to love its children so much, why do you think pediatrics is neglected?

DR. CULBERT: That is a good question. I think there is a couple of things. You know, historically kids are, of course, not big consumer health care advocates. They do not have the money in their pocket. That has been one of the issues.

But I am somewhat perplexed by why nationally, although there is a ton of interest in pediatrics -- you know, a recent survey showed that 50 percent of pediatricians surveyed said they would be willing to refer for CAM and they would refer for things like biofeedback and massage but if you look at training it has just

not been available so I am somewhat perplexed.

I think that pediatricians are relatively holistic by nature but I have not seen the amount of enthusiasm or research there. That is part of it. And so I do not really know.

I think there is not as much leadership in the pediatric community and you can only really identify maybe half dozen people in pediatric CAM per se that are well-known nationally relative to the adult community where there are, you know, literally hundreds.

COMMISSIONER GORDON: What do you do, though, at pediatric meetings? Are there programs on CAM?

DR. CULBERT: Yes, there are beginning to be.

The American Academy of Pediatrics just established a task force on complementary and alternative therapies. I am on that task force and part of what I am doing is designing the CMV opportunities for the next two years for the AAP.

So one thing we are doing this summer in New York is we are going to give a huge talk to a 1,000 pediatrics, a basic intro to what is CAM

and how to talk to your patients about it. It is not, you know, a laundry list of how to do all these things but it is just an introduction of how to begin to understand it.

COMMISSIONER GORDON: All right. Again, with the survey data, you mentioned a 1994 survey.

DR. CULBERT: Yes.

COMMISSIONER GORDON: I did not see the reference.

DR. CULBERT: Lexicon, yes.

COMMISSIONER GORDON: If you could send us any of the data on the surveys and also some of the issues you are raising about the lack of attention in pediatrics.

DR. CULBERT: Sure.

COMMISSIONER GORDON: The interest but the lack of attention in a sense. That would be great.

Sharon?

DR. NORLING: Yes. One important thing I forgot to mention is that the psychiatrist and psychologist at our clinic do practice CAM therapies with clinical hypnosis, recommending herbal therapies, meditation and so they do have

one of the few integrative practices and are very, very busy.

COMMISSIONER GORDON: Thank you.

Okay. Thank you all very much.

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DIETARY SUPPLEMENTS

MS. CHANG: Matt Wood, Jodi Chaffin, Rick Kingston, John Mastel, R. William Soller.

Thank you.

COMMISSIONER GORDON: Matt Wood, good morning.

MATT WOOD

COFOUNDER: MINNESOTA NATURAL HEALTH COALITION

MR. WOOD: Thank you for the opportunity to speak before you today. I am a member of the American Herbalist Guild and the Minnesota Natural Health Coalition. I have been a practicing herbalist for 20 years and have seen thousands of clients and earn my income solely from this calling.

COMMISSIONER GORDON: Matt, speak a little louder and into the mic. Okay.

MR. WOOD: I believe herbalism is one of the more difficult issues the commission will face. Both safety and freedom of access issues are involved so I offer the following suggestions:

First, safety issues can be met by establishing an official herbal pharmacopeia, like that for allopathy and homeopathy. Plants,

genera and families with toxic compounds should be noted and controlled. A broad base of traditional non-toxic herbs, similar to those currently on the GRAS list of the FDA, can be established, which will be in the public domain and available for professional and folk usage. Suspected side effects of drug interactions can also be noted.

Appropriate manufacturing methods for standardized extracts would be included as well as simple standards for traditional preparations. Herbal products should be described in both scientific and traditional terms. For the latter, I would avoid terms implying specific uses like diuretic, adaptogen, alternative in favor of a few wide, general categories based on obvious physical characteristics like bitter, astringent, stimulant, mucilage, et cetera. These are, in fact, scientifically valid.

Second, I believe that there should be a two-tiered system of regulation for practitioners:

Tier 1. Medical and naturopathic physicians who desire licensure should be

allowed to have it but it should be based on their use of medical procedures, not alternative therapies. These should remain in the public domain.

Tier 2. CAM practitioners such as herbalists and homeopaths, who do not practice medical diagnosis or treatment, should be allowed to practice under guidelines similar to those we have developed here in Minnesota. However, if groups within these movements desire licensure in the future, they should be allowed to have it based on their education in and use of medical procedures. Thus there would be room for evolution within a profession.

A third tier may have to be instituted for folk healers who do not keep records and practice completely without regulation. They should not be subjoined from practice but should be held accountable for injury.

Payment. I am going to change what I wrote there. I support the Medtronics model. The poors' access to CAM is protected by the protection of folk healers. This I know from working in an inner-city herb store for eight years.

Most importantly, these guidelines should be established by people within the professions themselves working in conjunction with the government, not by outside experts with no practical experience in the field.

Thank you.

COMMISSIONER GORDON: Thank you.

Jodi Chaffin?

JODI CHAFFIN, PharmD

CHAIR: HERBAL TASK FORCE OF MINNESOTA PHARMACEUTICAL ASSOCIATION, HEALTH PARTNERS

MS. CHAFFIN: Thank you for this opportunity to express the needs of Minnesota pharmacists and the needs of physicians and nurses of Health Partners.

People, who are choosing to self-medicate with dietary supplements, are calling upon us for information in order to avoid adverse reactions and/or interactions with these products. We are called upon because dietary supplements lack appropriate labeling for self-medicating. The labels do not provide the information that would enable a person to avoid adverse reactions and/or interactions. In many cases, the information itself is not available.

For example: Ginkgo biloba. Do the case reports of bleeding episodes imply a trend? Does ginkgo biloba really interact with warfarin?

Kava. Do the recent liver toxicity reports reflect a reaction that will be expected to show up in 0.01 of people using or in 10 percent?

St. John's Wort. The recently documented interactions between St. John's Wort and pharmaceuticals make us question our current sources for information, including traditional use in Germany.

We need reliable data. Numerous authoritative references today have direct contradictions about adverse reactions and interactions. We do not have the data people need to safely self-medicate.

With no pre-marketing review for dietary supplements, we need a post-marketing program to increase the detection of adverse reactions and interactions.

We need a program that will:

(1) Be publicized to health care providers, hospitals, pharmacies, clinics and