White House Commission on Complementary and Alternative Medicine Policy

6701 Rockledge Drive, Suite 1010, MS-7707, Bethesda, Maryland 20817 tel: 301-435-7592 fax: 301-480-1691
E-mail: whccamp@mail.nih.gov Website: www.whccamp.hhs.gov

May 3, 2001

Dear Commissioners:

Enclosed are two separate packets of materials for your advance review. Packet 1 includes a preliminary agenda of the May 14-16 meeting. Also included is a short document intended to provide you with critical background and context for the Coverage and Reimbursement presentations of our meeting. While copies of this document will be included in your briefing books, we strongly advise you to read this document in advance of the meeting.

Packet 2 summarizes the December 4-5, 2000 meeting on Access and Delivery. Please review this material in preparation for Breakout Session: Access and Delivery, scheduled on Day One of our upcoming meeting on Monday, May 14 from 4:15 – 5:15 p.m.

Please note that this session is a brief departure from the planned agenda for May, i.e., Reimbursement (Day 1-2) and Coordination of Research (Day 2-3), so that Commissioners can quickly revisit Access and Delivery issues and develop draft recommendations necessary for the next step -- the interim and final reports--which are the topics of our July 2-3, 2000 meeting.

The **objective** of the Day One Breakout Session is to **develop draft recommendations**, based on the attached materials, **relating to the Access and Delivery** of Complementary and Alternative Medicine approaches and interventions.

Packet 2 includes:

(1) Staff analysis of the major themes from the December 4-5, 2000 meeting. There are two categories to consider: (1) Access (primarily Barriers to Access), and (2) Delivery. Dr. Joe Kaczmarczyk, the staff lead for the December 4-5 meeting, has outlined a number of "umbrella" themes under these two broad categories for your review. We strongly encourage you to read this document carefully in advance of the meeting.

(2) Stratified listing of recommendations received from the December 4-5 meeting. This list of recommendations has been loosely organized under the umbrella themes proposed in Dr. Joe's analysis to provide you a "launching pad" for thought and discussion. These recommendations are taken directly from the meeting transcript and have not yet been fully edited. Therefore, there may be some degree of redundancy and ambiguity to many of the items as currently listed. We strongly encourage you to study this document carefully in advance of the meeting.

(3) Background reading: a 26-page meeting summary prepared by Jim Swyers in lieu of the meeting transcript. Dr. Joe's analysis is based on this report; it is provided to you as background reading only.

YOUR TASK:

You are requested to review Items 1 & 2 of these materials in advance of the meeting, and be prepared to develop draft recommendations during the one-hour Breakout Session that address the major themes identified from the December 4-5 meeting. The attached list of recommendations will provide you with a starting place, but you are encouraged to return to your own meeting notes and briefing books to develop a more focused and actionable list of draft recommendations on the Access and Delivery of CAM services.

We currently are continuing to review and stratify the numerous lists of additional recommendations received during all the Commission and Town Hall meetings. The expanded list, also loosely organized under the proposed themes discussed in the attached analysis, will be provided to you at the May meeting.

Breakout Group 1: Access Barriers
Suggested Chair: Julia Scott
Suggested Members:
George Bernier, David Bresler, Effie Chow, George DeVries, Wayne Jonas, Linnea Larson, Dean Ornish, Conchita Paz, Joe Pizzorno

Breakout Group 2: Delivery
Suggested Chair: Tom Chappell
Suggested Members:
Joe Fins, Bill Fair, Veronica Gutierrez, Sr. Charlotte Kerr, Tieraona Low Dog, Buford Rolin, Ming Tian, Donald Warren

Thank you for participating in this process. Should you have any questions, or would like to discuss the Access and Delivery Breakout Session further, please contact Dr. Joe Kaczmarczyk at 301-435-6197. Please also note the two additional Breakout Sessions scheduled in the preliminary agenda, during which draft recommendations will be formulated for both the Reimbursement and the Coordination of Research Issues.

Sincerely,

Steve Groft

Stephen C. Groft, Pharm.D.
Executive Director

Advance Briefing Packet #1

- Preliminary Agenda
- Critical background reading on Coverage and Reimbursement

WHITE HOUSE COMMISSION ON COMPLEMENTARY AND ALTERNATIVE MEDICINE POLICY

Meeting Site: Academy for Educational Development
1825 Connecticut Avenue, NW, Room 800, Washington, DC

May 14-16, 2001

PRELIMINARY AGENDA*

****Final Agenda will be posted by May 10, 2001***

DAY ONE: Monday, May 14, 2001

7:30 a.m. **Registration Opens**

Meeting Topic I.
Complementary and Alternative Medicine: UNDERSTANDING COVERAGE AND REIMBURSEMENT

8:15 a.m. Opening Remarks and Introductions
- **Stephen C. Groft, PharmD**, Executive Director, White House Commission on Complementary and Alternative Medicine Policy
- **James S. Gordon, MD**, Chair

8:30 a.m. **Panel I: Overview of Health Care Financing in the US**

(1) Michael O'Grady, Project Hope

- *Discussion*

9:25 a.m. **Panel II: Federal Purchasers**

(2) John Whyte, MD, Health Care Financing Administration

(3) Abby Block, US Office of Personnel Management

- *Discussion*

10:45 a.m. – 11:00 a.m. **BREAK**

11:00 a.m. **Panel III: State and National Perspectives**

(4) Joy S. Wilson Johnson, National Conference of State Legislators

(5) Marilyn Francis, American Association of Health Plans
(6) Alan Korn, MD, Blue Cross Blue Shield Association

- *Discussion*

12:00 p.m. – 1:00 p.m. **LUNCH BREAK**

1: 00 p.m. **Panel IV: Employer Perspectives**

(7) Tom Sawyer, William M. Mercer
(8) Mary Jane England, Washington Business Group on Health
(9) TBA

- *Discussion*

2:10 p.m. **Panel V: Health Plan Perspectives**

(10) Rick Gallion, Blue Cross Blue Shield of South Carolina
(11) John Kelly, MD, Aetna/U.S. Healthcare
(12) John Weeks, *The Integrator*

- *Discussion*

3:10 p.m. – 3:25 p.m. **BREAK**

3:25 p.m. **Panel VI: Special Populations: Minorities, Uninsured, Underinsured**

(13) Nathan Stinson, MD, PhD, Office for Minority Health, DHHS
(14) TBA

- *Discussion*

4:15 p.m. **Breakout Groups: Access and Delivery***
**(review of December 4-5, 2000 meeting discussion)*

5:15 p.m. **Group Reports and Discussion**

6:00 p.m. **Adjourn**

DAY TWO (Topic I Continued): Tuesday, May 15, 2001

7:15 a.m. **Registration Opens**

Meeting Topic I.
CAM: UNDERSTANDING COVERAGE AND REIMBURSEMENT continued

8:00 a.m. **Opening Remarks**

- **Stephen C. Groft, PharmD**, Executive Director
- **James S. Gordon, MD**, Chair

8:05 a.m. **Panel VII: Issues and Ideas**

(15) Melinna Gianninni, Alternative Link, Inc.
(16) Linda Bedell-Logan, Solutions in Integrative Medicine
(17) Wayne Sickles, Massage Therapist

- *Discussion*

(18) Max Heirich, Professor Emeritus, University of Michigan

- *Discussion*

9:25 a.m. **Break/Breakout – Small Group Discussion (CAM Reimbursement)**

10:50 a.m. **Group Reports and Discussion**

11:30 a.m. – 12:30 p.m. **Lunch Break/Adjourn Meeting Topic I.**

DAY TWO: Tuesday, May 15, 2001

Meeting Topic II.
Complementary and Alternative Medicine: RESEARCH CHALLENGES

12:30 p.m. **Opening Remarks**

12:40 p.m. **Panel I: Overview of CAM Research Challenges**

(19) David Eisenberg, MD, Harvard University

- *Discussion*

1:25 p.m. **Panel II: Foundation Support for CAM Research**

(20) M. Bridget Duffy, MD, Medtronic Foundation
(21) Dorianne C. Miller, MD Robert Wood Johnson Foundation

(22) Susan Braun, Susan G. Komen Breast Cancer Foundation
(23) Ronald Chez, MD Samueli Institute for Information Biology

- *Discussion*

2:35 p.m. – 2:50 p.m. **BREAK**

2:50 p.m. **Panel III: Approaches to Evaluating Research Literature**

(24) Donald A. Lindberg, MD, National Library of Medicine
(25) Douglas B. Kamerow, MD, MPH, Agency for Healthcare Research and Quality
(26) Brian Berman, MD, University of Maryland

- *Discussion*

4:10 p.m. **Panel IV: Concerns about CAM and CAM Research**

(27) William M. London, EdD, MPH, National Council Against Healthcare Fraud
(28) Simeon Margolis, MD, PhD, Johns Hopkins University
(29) Arthur P. Grollman, MD, State University of New York at Stonybrook

- *Discussion*

5:30 p.m. **Adjourn**

DAY THREE (Topic II Continued): Wednesday, May 16, 2001

7:15 a.m. **Registration Opens**

Meeting Topic II.
CAM: RESEARCH CHALLENGES continued

8:00 a.m. **Panel V: Research Methodology**

(30) John A. Chabot, MD, Columbia University
(31) Marcia Angell, MD, Editor-in-Chief Emeritus, New England Journal of Medicine
(32) Jennifer Jacobs, MD, MPH, American Institute of Homeopathy
(33) B. Alex White, DDS, DrPH, Kaiser Permanente Center for Health Research
(34) Bruce Rabin, MD, PhD, University of Pittsburgh

- *Discussion*

9:25 a.m. **Panel VI: Training of Conventional and CAM Investigators**

(35) Nancy Pearson, PhD, National Center for Complementary and Alternative Medicine
(36) Neal West, PhD, National Center for Complementary and Alternative Medicine
(37) Robert H. Blanks, PhD, University of California at Irvine
(38) Russell Phillips, MD, Harvard University
(39) Richard Hammerschlag, PhD, Oregon College of Oriental Medicine

- *Discussion*

10:35 a.m. – 10:50 a.m. **BREAK**

10:50 a.m. **Panel VII: Publication of Peer-Reviewed CAM Research Results**

(40) Edward W. Campion, MD, New England Journal of Medicine
(41) Jackie C. Wootton, MEd, Journal of Alternative and Complementary Medicine
(42) Phil B. Fontanarosa, MD, Journal of the American Medical Association
(43) David Riley, MD, Alternative Therapies in Health and Medicine
(44) Christine Laine, MD, MPH, Annals of Internal Medicine
(45) Arnold Relman, MD, Editor-in-Chief Emeritus, New England Journal of Medicine

- *Discussion*

12:30 p.m. – 1:30 p.m. **LUNCH BREAK**

1:30 p.m. **Breakout – Small Group Discussion (CAM Research Challenges)**

2:50 p.m. **Group Reports and Discussion/Adjourn Meeting Topic II.**

4:00 p.m. **BREAK**

4:15 p.m. **Public Comment Session – 3-Minute Oral Statements***
**this list will be revised and posted on the website no later than May 10*

(46) Audrey Di Maria, Art Therapy Credential Board
(47) Katherine Jane Gorton, American Dietetic Association

(48) Su Liang Ku, FITCM
(49) Matt Ward Russell, National Integrative Medicine Council
(50) Carolyn Jones Sabatini, Pharmavite Corporation

- *Discussion*

(51) James Sensenig, American Association of Naturopathic Physicians
(52) Nancy Kristine Haller, Feldenkrais Guild of North America
(53) Diane Davis Cole, University of Virginia Cancer Center

- *Discussion*

5:00 p.m. **Adjourn**

Introduction to
Understanding Coverage and Reimbursement
For the White House Commission on Complementary
And Alternative Medicine

The struggle for access to quality health care at an affordable price has been unfolding for most of the last century, but not according to any type of mediated plan or national strategy. William Sage, a noted physician-lawyer-health policy researcher, has written "Modern health insurance is an odd endeavor." Jon Gabel, another noted health policy expert, calls health care in the U.S. an "accidental system." The factors that have helped shape the current complex system are too numerous to list, but include the competing interests of States, the Federal government, organized medicine, employers, unions, insurance companies, and companies in the business of health, such as pharmaceutical companies.

Health insurance as we know it today began evolving in the 1930's and 1940's. Until then, insurance companies had avoided entering into covering health risks because of potentially high costs, and "adverse selection."[1] The high cost of hospital care and the financial uncertainty of the Depression gave rise to the first attempts at group coverage for hospital care. These were known as hospital service plans. At first, hospitals took the lead at offering this protection and then the non-profit Blue Cross plans emerged. The initial success of the Blue Cross (hospital) insurance plan attracted commercial for-profit insurers into the market. Increasing competition and attempts by State medical associations (California, Michigan, New York, Pennsylvania) to offer prepayment plans or insurance for physician services - which Blue Cross was specifically prohibited from offering - led to the formation of Blue Shield. This bifurcated model of covered hospital benefit and a separate covered physician/medical benefit has had far reaching effects, and helps to underscore the western medical approach to health care in the U.S.

World War II had its effects on the evolution of health insurance too. In order to help employers respond to the labor shortage and wage controls during the war, the Internal Revenue Service ruled in 1943 that health care benefits were tax deductible (for the employer) - and tax-exempt for the employee. This contributed to the growth in Blue Cross Blue Shield plans from a pre-war membership of 1.4 million to 31 million members in 1949, with commercial insurers covering 28 million lives by the same year. The tax incentives, along with the interest of labor unions in health benefits, helped seal the employer-based nature of the U.S. health system.

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[1]Adverse selection - a recognized tendency for sick or injured persons to seek a particular health plan or provider more than the public at-large because of an attractive feature. If adverse selection occurs, there is usually higher utilization and medical costs than estimated during budget development. This results in higher prices and/or financial instability.

Starting in the 1950's, commercial insurance companies were able to move ahead of the Blues plans in large part because of their ability to "experience rate." Blue Cross Blue/Shield plans were required to charge all their members the same amount, based on a "community rate" methodology for setting the price of a health benefit plan. That is, Blue Cross Blue Shield plans could not differentiate what members had to pay by factors such as age, sex, employer size, or experience of an employer group. Commercial insurers, on the other hand, had the flexibility to establish a premium price based on the experience of a group, usually the employer group. This, over time, focused the attention of employers on the rising cost of health care, as health benefits for employees began to significantly affect the price of their products or costs of their services. The impact of health care benefits on the ability of employers to compete locally, regionally, nationally, and globally has been well-documented in the popular press.

Federal Role

The federal government's role in health insurance evolved more intermittently, with the most significant event being the enactment of Medicare in 1965. During the early Kennedy-Johnson years, the effort to provide federally-sponsored health insurance for the elderly labored in debate, with notable opposition from physicians and the American Medical Association. A historic legislative event occurred with "the great compromise." Agreement was reached only when the Blue Cross Blue Shield model was adopted for Medicare: Medicare Part A for hospital insurance and Medicare Part B for physician (and suppliers) insurance coverage. Further, while federally-funded, the insurance program would be based operationally in the private sector. Rather than establishing government-run hospitals and clinics, seniors would utilize the hospitals and physician practices already operating in the private sector, and the millions of claims would be handled by the experienced health insurance industry.

Another significant role for the federal government came about in 1974 with passage of the Employee Retirement and Income Security Act. This law placed self-insured employer health plans under federal regulation – a federal preemption of State laws. Insignificant in 1974, the number of persons in such self-insured plans has grown to over half of all insured workers. Thus, by another "accident," many U.S. workers are in health plans with few consumer protections. ERISA does not offer protections because, unlike Medicare or state insurance laws, the law does not contain any standards of performance for self-insured employer plans. In the recent era of managed care, there also have been court cases dealing with the right of members of ERISA-covered plans to seek legal remedies regarding claims and medical decisions.

In 1964, as part of President Johnson's War on Poverty, the Office of Economic Opportunity (OEO) was formed to eradicate poverty and improve the social and economic situation of the nation. The OEO believed that addressing the health

problems of the poor would help to alleviate their economic burden on society, and began funding neighborhood health centers. These health centers helped to eliminate barriers to health care for the poor and underserved and had a strong emphasis on community participation and control. They provided a wide range of medical and non-medical services, regardless of ability to pay. The success of these neighborhood health centers resulted in expansion of the program, now known as the Community and Migrant Health Center Program (C/MHC). The C/MHCs now consist of over 700 health centers with nearly 3,000 clinics and 6,500 primary care clinicians who serve almost 10 million of the nation's poor and underserved. The C/MHCs remain as the nation's premier "safety net" program for people who would otherwise lack access to health care.

State Role

The most relevant discussion here is the current regulatory role of States. In economic terms, States play a role in supply and demand. The State role in recognizing, licensing, and defining parameters (such as scope of practice) for practitioners, hospitals, nursing homes, and other providers of health care is an important influence supply for the private sector health system, and Medicare. Then there is the Medicaid program, where the State may influence the amount of demand for health care services by expanding eligibility to Medicaid coverage. States also influence demand by creating "State-mandated" benefits, whereby all health insurers doing business in the State are required to offer certain benefits. 2

In our U.S. system, other than ERISA-exempt plans, States have the right to regulate and set standards for health insurers and HMOs. These standards typically address financial solvency (the States' first priority), transition of coverage in the event of a failure, approval of premium rates, disclosure of information to consumers, performance accountability, and certain prohibitions.

From this general framework of how we arrived at where we are, there are specific topics that are helpful to discuss.

Identifying the Components of Reimbursement Policy

Generally, those who work in health care reimbursement break the area into 3 broad component parts:

- Eligibility—who is qualified to receive or be reimbursed for health benefits

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2 State-mandated benefit -- all health insurers and HMOs in a State must add the mandated benefit into all their plan offerings (except Medicare products), and to increase premiums to reflect the plan's added cost of covering the benefit. Usually the only flexibility insurers and HMOs have is in pricing: the premium increase and member cost-sharing amount.

- Coverage—what services, products, or devices qualify for payment by responsible (liable) party

- Payment—the methodology for establishing how much is paid, and to whom, when eligible individuals obtain covered services.

Eligibility usually is established by the purchaser of health insurance. For example, the Federal government, through Title XVIII of the Social Security Act, governs who is eligible for Medicare: the elderly, the disabled, and individuals with End Stage Renal Disease (ESRD). The Federal government set the eligibility floor for Medicaid, the program for the poor that it shares with States, but States generally have expanded the federal definition of poverty to include those above the floor – and to capture many of the uninsured and medically indigent. Employers usually cover their full-time employees, their spouses, and children.

Coverage generally follows the earlier discussion of types of benefits -- inpatient hospital services and physician services, as well as services established for Medicare including nursing home stays, home health care, outpatient services, various diagnostic testing methods, durable medical equipment . To control utilization, and ultimately costs, insurers or the purchaser (e.g. employers, Medicare program) will place limits on the coverage. For example, the blood benefit may be limited to 3 pints of whole blood or plasma; the dental benefit is limited to a dollar cap; the nursing home benefit may be limited to 100 days and only to stays that meet a definition of "skilled" care. Some benefits may be excluded, such as cosmetic surgery. Most recently, we have seen some movement toward letting employees determine what benefits they obtain from an employer, rather than the employer designing a "one size fits all" set of benefits, including health benefits. This new approach is called defined contribution.

Payment is an area undergoing change also. Most of the history of health insurance in the U.S. involved fee-for-service indemnity plans: a service was provided, a claim was sent to the insurer, the claim was paid. (See the discussion of medical necessity, below.) Because this payment methodology contributed significantly to high inflation in health care costs (sometimes more than 3 times the general rate of inflation), the stage was set in the 1970's and 1980's for managed care and prepaid capitation.[3] The growth in HMOs spurred the development of preferred provider organizations (PPOs), which were loosely administered networks of physicians, hospitals, and other providers which were paid a discounted fee for each service. Other payment methodologies that evolved during the last 25 years are fee schedules, diagnosis relate groups (DRGs) for hospitals, relative value

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[3] Capitation – A payment amount set in advance and based on average member costs: a health plan usually is paid a set amount per member per month for the period of the contract.

scales, and graduated payments with a cap (e.g. 80% is paid on the first $1000 of covered services, then 50% is paid on the next $1000, then the cap is reached).

Medical Necessity

Insurers, including Medicare, only pay for "medically necessary" health care services. Medical necessity is usually not defined, or only broadly, and the power to determine what is medically necessary is important. Under fee-based health plans, the determination is made by the treating physician, with some oversight by the insurer. In managed care, treating physicians retain considerable patient decision making, but high cost services and inpatient hospital stays are usually subject to preauthorization by the HMO. Medicare has spent immeasurable time and effort to develop guidelines for determining what is covered and when the service is medically necessary, some centrally by federal staff and some through its fiscal intermediaries and carriers.

Cost-sharing

An insured individual is usually expected to share in some manner with the cost of health care. The intent is to place a temperate control on the demand for and utilization of health care services. There are 4 types of cost-sharing arrangements:

- Copayments – a fixed charge, usually $2 to $20, for a unit of service
- Coinsurance – a charge for a service that is a proportion of the total charge established for the service, such as a 20% coinsurance
- Deductible -- the initial fee for a service(s) are paid by the insured up to a threshold, such as the first $500 of a health care bill
- A combination, such as the use of both a coinsurance and a deductible.

Studies in the 1970s demonstrated that copayments did indeed help control utilization, and the incremental increases in cost-sharing resulted in further reductions in utilization. However, further studies showed that the health care utilization of the poor and poor children were more affected than the non-poor by copayments.

The "Woodwork" Effect

Efforts by the federal government, States (with Medicaid), employers and insurers to add benefits have often led to what is called the "woodwork effect." That is, the cost and utilization estimates that are made for a new benefit often are proved too low because persons who want to and do use the benefit "come out of the woodwork." Actuaries and health researchers are limited in making their estimates

by available information regarding the frequency of a condition or incidence of disease, claims, and cost estimates. Even with reasonable techniques to overestimate, the experience of huge, unanticipated costs in future years has made the responsible parties reticent toward expanding benefits into new areas.

Conclusion

This brief paper is intended to provide an overview of the history and some of the key principles in the area of coverage and reimbursement. This information should serve as a foundation as the Commission discusses policy options for coverage and reimbursement of complementary and alternative medicine.

News Releases

Passing Health Plan Cost Increases to Employees Not An Option for Firms Struggling with Labor Shortages

Contact: Stephanie L. Poe
stephanie.poe@us.wmmercer.com

With a 7.3% increase in health benefit cost in 1999 and 7.5% predicted for 2000, employers try "softer" cost management approaches, a new survey finds.

New York – 14 December 1999 – The cost of employer-sponsored health plans jumped 7.3% in 1999 – nearly three times the rate of general inflation – and no relief is in sight, reports a new survey released today by William M. Mercer, Incorporated. Average cost per active employee rose from $3,817 in 1998 to $4,097 in 1999, on the heels of last year's 6.2% increase, which ended a five-year break from health benefit inflation. Now employers face a third tough year, budgeting for an overall 7.5% cost increase in 2000.

Cost rose in all types of medical plans in 1999, with HMOs performing not much better than unmanaged traditional indemnity plans (per-employee cost rose 5.4% and 6.5%, respectively). One factor behind these increases was a jump in cost for prescription drugs of 15.2%, according to Mercer's 14th annual *National Survey of Employer-sponsored Health Plans*, a nationally representative survey of over 3,100 employers.

Small employers, who have less purchasing power with plan vendors, were hit the hardest. Among employers with fewer than 500 employees, costs rose 9.0% to reach $3,804. Employers with fewer than 50 employees reported a whopping 13.8% increase. Among large employers (500+ employees), costs rose 7.0% to reach $4,320, not including the cost of retiree medical coverage.

Last year's enrollment 'blips' solidify into trends

Throughout most of the 1990s, benefit cost management generally consisted of moving employees into lower-cost managed care plans. But migration out of traditional indemnity plans has nearly bottomed out, dropping to 11% from 13% last year. Enrollment in the classic closed-panel HMO was flat at 30%, while enrollment in the open-ended HMO, or point-of-service (POS) plan, fell from 18% to 16%. Enrollment in preferred provider organizations (PPOs), the least restrictive form of managed care, rose for a fifth straight year in 1999, from 40% to 43%. (See "As HMO Enrollment Hits Plateau, Managed Care Shifts Direction,"" for an in-depth discussion of these trends.)

With 9 out of 10 employees already in a managed care plan, employers must find other ways to put the brakes on rising cost.

For now, employers seek to manage cost rather than shift it to employees

In 1999, employers were sparing in their use of the tried-and-true cost management tactic of shifting cost to employees through higher contributions and less generous plan design. Increases in employee

contributions lagged well behind increases in plan cost. The fact that employers added PPOs in 1999, which in most markets still cost more than HMOs, indicates a willingness to pay more for employee satisfaction.

In addition, when asked about plans for 2000, only about a fourth of employers say they will increase either employee contributions or cost sharing. "In this tight labor market, many employers are reluctant to upset workers with bad news about their medical benefits," says Blaine Bos, a consultant in Mercer's Chicago office and one of the study's authors. "They'd rather target cost management efforts at trouble spots like prescription drugs, or look for win-win ways to control cost."

Large employers focus on drug plans, disease management

Large employers, with more resources and more dollars at stake, have been the first to act. Many are targeting prescription drugs, which in 1999 accounted for nearly 15% of total medical plan cost. Among employers with 500 or more employees, 32% made changes to the drug benefit design, adding or increasing financial incentives to use generic drugs or drugs listed on the plan's formulary.

In addition, 10% of all large employers, and 20% of those with 5,000 or more employees, have decided to limit or exclude coverage for certain new prescription drugs, tests, or medical treatments. "For example, an employer may be willing to allow coverage for drugs designed to treat arthritis but prescribed for other pain management, but not coverage for hair loss treatment," says Mr. Bos.

Employers are also looking for solutions from the "softer" side of managed care – programs that save money by improving employee health. The use of chronic disease management programs jumped sharply in 1999, with 58% of employers' largest health plans including one or more such programs, up from 49% last year. In addition, a growing number are adding coverage for alternative medicine. For example, chiropractic care is now covered in 78% of employers' largest plans, up from 61% in 1998, and acupuncture is covered in 21%, up from 17%.

Employers giveth to active employees, taketh away from retirees

Despite rising costs, large employers were more likely to enhance active-employee benefit packages than to cut them. Employers added vision plans (now offered by 46%, up from 42%), long-term care insurance (16%, up from 12%), and health care spending accounts (60%, up from 56%). In addition, 15% of large employers say they recently added non-traditional benefits or programs relating to health and life-style – such as a health club subsidy – specifically in order to improve their organization's ability to attract and retain employees.

At the same time, retiree coverage continues to erode. For the sixth straight year, the percentage of large employers providing coverage to Medicare-eligible retirees fell in 1999, from 30% to 28%, while those providing coverage to retirees not yet eligible for Medicare edged down from 36% to 35%. In addition, employers requiring pre-Medicare-eligible retirees to pay the full cost of coverage jumped from 36% to 42% in 1999 (40% require Medicare-eligible retirees to pay the full cost). Some retiree plan sponsors – about 20% – do not provide coverage for prescription drugs.

The cost of covering a pre-Medicare-eligible retiree averaged $5,470 in

1999, up 4.5%, while the cost of covering a Medicare-eligible retiree averaged $2,160, up 3.2%.

Other findings

- **Technology makes gains:** The use of Internet/intranet technologies in employee benefit administration is starting to take hold, led by large employers. One-third of employers with 500 or more employees, and two-thirds of those with 20,000 or more employees, currently use Internet/intranet applications in providing benefits. The most prevalent use is for disseminating information, but about one-fourth of the largest employers use it to handle annual open enrollment.

- **Litigation concerns mount:** The percentage of large employers who say they are concerned about health plan participant litigation jumped from 48% to 70% in 1999. Virtually all of the largest employers (92% of those with 20,000 or more employees) say they are concerned – and with good reason. While only 4% of all large employers have been named in a legal action related to medical care provided through one of the health plans with which they contract, fully 20% of the largest employers have, and usually in more than one case. Employers are taking action to protect themselves; half have conducted a review of compliance with laws and regulations applicable to health plans, up from 40% in 1998, and 36% have delegated claims fiduciary duty to health plan vendors, up from 29%. The largest employers have used their clout to seek protections in contracts with health plan vendors (40% of those with 20,000 or more employees, up from 32% in 1998).

- **Dental benefits gain:** Employers added dental benefits in 1999, perhaps to assist in efforts to attract and retain employees. Comprehensive dental benefits are now offered by 54% of all employers, up from 49% last year. Among these employers, the use of dental care PPOs rose sharply, from 30% to 37%. The cost of dental coverage rose 5.3% to reach $467 per employee. There was no change in either the median deductible ($50) or the maximum benefit ($1,000).

- **Health benefit cost varies widely by region.** Comparing the four census regions, the overall average cost per active employee reached $4,671 in the Northeast, $4,136 in the Midwest, $3,935 in the West, and $3,716 in the South.

About the survey

The *Mercer/Foster Higgins National Survey of Employer-sponsored Health Plans* is the largest and most comprehensive annual survey of its kind, with 3,166 respondents in 1999. The survey is conducted in accordance with rigorous statistical standards. Mercer used a national probability sample of public and private employers and weighted the results to reflect the demographics of all employers in the US with 10 or more employees that offer health coverage. Therefore, the survey results represent about 600,000 employers and over 90 million full- and part-time employees.

Copies of the ***National Survey of Employer-Sponsored Health Plans 1999*** will be available February 7 for $500 each. To order, contact:

Tara Lewis

William M. Mercer, Incorporated
1166 Avenue of the Americas, 28th Floor
New York, NY 10036
212 345 2451

William M. Mercer, Incorporated, one of the nation's leading consulting organizations, assists employers in the areas of human resource strategy and implementation. Headquartered in New York and with offices in more than 40 US cities, the firm is the US operating company of William M. Mercer Companies LLC, a worldwide consulting organization serving clients from offices in 34 countries.

BACK

Advance Briefing Packet #2

(Access and Delivery)

- Proposed Themes
- List of Recommendations (December 4-5)
- Meeting Summary (background reading)

Summary and Analysis of Themes and Recommendations from December 4-5, 2000 WHCCAMP Meeting on Access and Delivery

This is an initial summary and analysis of not only the themes, but also the recommendations made during testimony at the December 4-5, 2000 meeting of the White House Commission on Complementary and Alternative Medicine Policy (WHCCAMP) on Access to and Delivery of Complementary and Alternative Medicine (CAM). The intended purpose of this summary and analysis is to facilitate formulation of draft policy recommendation by Commissioners during the discussion group breakout session on Monday, May 14, 2001. Although additional themes and recommendations can be gleaned from town hall and other full Commission meetings testimony, the focus of this summary and analysis is limited to the testimony of the December 4-5, 2000 meeting. Additional themes and suggested recommendations from other sources can be added subsequently to this summary and analysis.

The following Access themes, which can be classified generally as "Barriers," are evident in the December 4-5, 2000 meeting testimony:

- Conventional medicine and physician resistance to CAM
- Reimbursement, coverage, and cost issues
- Balance of consumer choice and public safety (self-care)
- Needs of special populations
- Cultural and linguistic challenges (including Traditional Healing)

Conventional medicine and practicing physicians' resistance to and lack of acceptance of CAM is cited in testimony as the basis for non-disclosure of CAM utilization and as a barrier to access to CAM services. While the current reimbursement system is influenced by an evidenced-based approach, CAM generally lacks the type and amount of western scientific evidence on safety, indications, clinical effectiveness, and cost effectiveness sought by the current reimbursement system. Moreover, data on systems of care, multiple modalities, combination therapies, various delivery systems, and diverse populations are not available. The balance of consumer choice and public safety is evident in utilization of CAM as part of self-care, particularly in women's health, and is dependent on information which can be difficult to obtain, contradictory, and of questionable accuracy. Access to CAM by special populations such as HIV/AIDS, elderly, pediatrics, and cancer patients is characterized by more numerous and significant barriers than the general population. Cultural and linguistic barriers to access to CAM are associated with recent immigrants, native peoples, and an increasingly diverse US population especially in the context of Traditional healing.

Likewise, the following Delivery themes are found in the December 4-5, 2000 meeting testimony:

- Integration of CAM vs. CAM separatism
- Fragmentation of CAM
- Models of service delivery
- Service delivery of CAM to uninsured and underinsured

Although there is interest in integrating CAM and conventional or western medicine to from what is frequently termed "integrative medicine," there also is strong interest in maintaining CAM as a separate system of care, because of an articulated concern about the potential for CAM to be co-opted or usurped completely by the dominant medical system. However, the CAM community is fragmented and does not possess unifying infrastructure or global consensus. Despite numerous attempts and failures, the best models of CAM service delivery have not been identified yet. All of the problems of CAM service delivery are magnified by the challenges of service delivery to the growing numbers of uninsured and underinsured. If CAM services and products improve health status, health disparities in uninsured and underinsured populations without CAM services and products may worsen.

The recommendations extracted from the December 4-5, 2000 meeting transcript by James P. Swyers, MA have been grouped according to the above Access and Delivery themes and are summarized on the following pages. While recommendations admittedly can fit in multiple categories, recommendations were placed into only the category in which there appeared to be the best fit, albeit subjective.

Recommendations Related to Conventional Medicine and Physician Resistance to CAM

- Direct education resources to training medical students and physicians in the effectiveness and cost benefits of CAM approaches as opposed to delivering the modalities themselves. **(Patricia Culliton, LAc)**

- Train all health professionals, not just medical doctors, but CAM professionals as well, in how to interrelate to each other. **(Patricia Culliton, LAc)**

- Improve teaching of nutritional information in medical schools. If implemented, the cost of care will undoubtedly come down by billions of dollars. **(Alan Gaby, M.D., nutritionist)**

- Encourage schools of medicine, complementary and mainstream, to foster relationship-centered care. **(Robert Duggan, TAI)**

- Establishment an emergency, "crash" education program on CAM for: 1) the approximately one-half million practicing physicians, 2) academic research scientists, and 3) the general attentive public. **(Rustrum Roy, University of Arizona Program for Integrative Medicine)**

- Promote initiatives to integrate nutrition into the core curricula at American medical schools.**(Neal Barnard, President the Physician's Commission for Responsible Medicine)**

- Promote programs to educate medical students and physicians about the use and effectiveness of all CAM modalities, especially medical acupuncture, and teach them that CAM is not a threat to their practice. **(Marshall Sager, President-elect of the American Academy of Medical Acupuncture)**

Recommendations Related to Reimbursement, Coverage and Cost Issues

Please note that because of an evidenced-based approach to reimbursement, research recommendations were categorized under the rubric of reimbursement, coverage, and costs issues.

- Create access to CAM therapies that are considered to be safe. However, embrace reimbursement only for those therapies that have strong evidence supporting their effectiveness.(**James Dillard, M.D., Oxford Health Plans**)

- Determine what are the most common guidelines for setting limits for access and apply them to CAM. Otherwise, carriers could be allowed to sell what is essentially an illusory benefit. (**Lori L. Bielinski, Washington State Office of the Insurance Commissioner**)

- Insert language for CAM in Federal entitlement acts, such as Medicare, Medicaid, Indian Health Service, and CHAMPUS for the military. (**Konrad Kail, Naturopathic Physician**)

- Support the passage of legislation currently in Congress, H.R. 1187 and S. 660, to provide outpatient medical care coverage for medical nutrition therapy for diabetes and kidney disease. (**Patsy Brannon, Registered Dietition, R.D.**)

- The expansion of Medicare and Medicaid coverage as recommended by the Institute of Medicine report for the treatment chronic diseases for which nutritional therapy has been documented to be effective. (**Patsy Brannon, R.D.**)

- Influence health plans to reimburse for evidence-based CAM interventions. (**Anna Silberman, High Mark**)

- Reimburse for Vedic medicine services that are shown to be effective and cost-effective in published, peer-reviewed scientific research, should be reimbursed, including by government payers, such as Medicare and Medicaid, and private reimbursers. (**Robert Schneider, M.D., Marharishi University**)

- Change the current reimbursement model, which favors the delivery of the modality over the healing art of the individual patient. (**Robert Duggan, President of the Traditional Acupuncture Institute, TAI**)

- Break down the barriers to reimbursement for CAM services. (**Milton Hammerly, M.D., of Catholic Health Initiatives, CHI**)

- Place a major focus on wellness and to recommend policies for reimbursing CAM providers for health promotion. (**Bruce Nordstrom, American Chiropractic Association**)

- Promote reimbursement of services rendered by Oriental Medicine physicians by all health insurance providers, both Federal and private. (**Doreen Chen, American Association of Oriental Medicine**)

- Promote the incorporation of new codes into Federally funded CAM research so that cost-effective CAM treatments can be identified as a solution to escalating health care expenses, especially where these procedures could have an impact on Medicare/Medicaid recipients. (**Melinna Giannini, Director of Alternative Link**)

- Examine three major reports on the cost-effectiveness of chiropractic as part of the Commissions deliberations. (**William Meeker, chiropractor**)

- Provide greater funding for the NCCAM. (**Konrad Kail, naturopath**)

- Increase research expenditures on the clinical efficacy of acupuncture in conditions such as musculoskeletal pain and analgesia, breech aversion, nausea and vomiting, dysmenorrhea (menstrual pain), and bladder disorders. (**Patricia Culliton, Licenced Acupuncturist, LAc**)

- Funding for large clinical effectiveness study and cost effectiveness studies of acupuncture for specific conditions as well as the development of CME courses and CEU courses for physicians in acupuncture and for CAM modalities and approaches in general. (**Patricia Culliton, LAc**)

- All CAM research should be conducted by neutral observers who are objective and impartial, neither strong negative skeptics, nor strong proponents, but people who are committed to scientific research. (**Paul Kurtz, Ph.D., The Committee for the Scientific Investigation of Claims of the Paranormal**)

- The Federal government should use the investigation of CAM as an opportunity to solve its most pressing health problem: controlling spiraling health care costs. (**Robert Atkins, M.D., private practice physician**)

- Promote the kind of research that will allow conventional and CAM to be compared side by side with a matched group of subjects to determine which gets better results and at lower costs. (**Robert Atkins, M.D.,**)

- Continue to support scientific investigations into CAM treatments to help separate what is effective from what is not. **(Anna Silberman, High Mark Blue Cross/Blue Shield)**

- Pay more research attention to the interface of the issues of spirit and the neurophysiology of craving and compulsion and reward. **(Alan Trachtenberg, M.D., Office of Pharmacologic and Alternative Therapies at the Center for Substance Abuse Treatment, CSAT)**

- Encourage the Public Health Service issue grants for research on the effects of vegetarian and vegan diets for a number of chronic illnesses, and encourage the Department of Agriculture review of federal policies that conflict with healthy nutritional goals. **(Neal Barnard, President the Physician's Commission for Responsible Medicine)**

- Require the National Institutes of Health and the Department of Agriculture to conduct new research on the efficacy of diets that seek to reduce or treat many behavioral, learning, and health problems in children by eliminating synthetic dyes, artificial flavors, and certain preservatives from their diet. **(Jane Hersey, Director of the Feingold Association)**

- Support research on the role of toxic chemicals in syndromes, such as multiple chemical sensitivities, auto-immune diseases, fibromyalgia syndrome, and chronic fatigue syndrome. There also is the need for research to investigate the role of nutritional supplements in enhancing improved metabolic function in these syndromes. **(Lawrence A. Plumlee, M.D., National Coalition for the Chemically Injured)**

Recommendations Related to Balance of Consumer Choice and Public Safety

- Allow use of any medical treatment that has been in use in another country, where there is no evidence of it posing a danger to the patient. Because there are not good treatments for most degenerative diseases, people with such conditions should have the right to try potentially beneficial treatments developed in other countries with out fear of government interference. **(Berkeley Bedell, NFAM)**

- Encourage FDA to require nutritional supplement and herbal remedy manufacturers to put labels on their products warning against possible adverse effects or toxicity, and recommendations for proper usage. **(Dennis Awang, Ph.D., herbalist)**

- Promote proven CAM interventions to the public. **(Anna Silberman, High Mark)**

- Establish initiatives to foster CAM and wellness education from the first grade onward. **(Robert Duggan, TAI)**

- Institute a system, such as that proposed by the World Health Organization, to establish guidelines for the assessment of herbal medicines and to ensure proper identity and quality of both raw materials and finished products. **(Dennis Awang, Ph.D., herbalist)**

- Involve well-trained herbalists be in studying the safety and efficacy of herbs on a scientific basis because many scientists have the view that herbs do not work until it is proven that they do work, which is the antithesis of how an herbalist would view them. **(Christopher Hobbs, herbalist, licensed acupuncturist)**

- Recommend passage of The Access to Medical Treatment Act, which would make it possible for experimental "non-toxic" treatments to be tried under strictly controlled circumstances. **(Berkeley Bedell, president of the National Foundation for Alternative Medicine, NFAM)**

- Establish a separate agency, other than the FDA, to deal with the issue of the quality of herbs. **(Robert Duggan, TAI)**

Recommendation Related to Needs of Special Populations

- The development demonstration projects around the country that will allow hospice programs to provide care without a reimbursement cap and without a criteria or prognostic cap. (**J. Donald Schumacher, Center for Hospice and Palliative Care**)

Recommendations Related to Cultural and Linguistic Challenges (Including Traditional Healing)

- Require the FDA to recognize a "traditional medicines" category that would take into account the historical and traditional use of an herb and to better educate consumers how to use them. Under such a system, manufacturers would be allowed to put the information on the known effects of nutritional supplements on the label so that it would greatly enhance both the effectiveness and the safety. (**Christopher Hobbs, herbalist**)

- The development of "peer" education programs to disseminate credible information on CAM to minority and ethnic communities. (**Denise Drayton, Exponents**)

Recommendations Related to Integration of CAM vs. CAM Separatism

- Any policies that the Commission recommends should not be biased in favor of full integration of CAM therapies into mainstream medicine. (**Mort Rosenthal, chairman and founder of Well Space, a for-profit CAM clinic**)

- Develop a 20-year plan to integrate conventional medicine into patient-centered, whole-person health care. (**Gary Sandman, founder of a community-based alternative medicine referral service**)

- Break down the barriers to collaboration with CAM practitioners. (**Milton Hammerly, M.D., of Catholic Health Initiatives, CHI**)

- Allow certified Vedic practitioners to practice, following the Minnesota model. States should adopt a licensure procedure for natural medicine practitioners, including Vedic medicine practitioners, and licensure would be dependent on certification and completion of other state licensing requirements, such as an exam or experience requirements. (**Robert Schneider, M.D., Marharishi University**)

Recommendations Related to Models of Service Delivery

- Embrace nutritional programs such as the Dean Ornish program by providing access to it for all populations. (**Richard Collins, cardiologist**)

- Use nurses as a resource in any effort to integrate CAM into conventional medicine. Nurses can serve as a bridge to help educate doctors. (**Charlotte Eliopoulos, American Holistic Nurses Association, AHNA**)

- Develop a system of integrative medicine in which a cadre of health care disciplines and practitioners, each with their own scope of practice, their own tools of their trade, but with a common understanding, common respect, and a shared commitment can coordinate care, cross-refer, and co-manage patients. (**Tori Hudson, N.D., National College of Naturopathic Medicine**)

- "Lifestyle behavior changes" should be listed as a prudent, first-choice medicine for people with heart disease. (**Richard Collins, cardiologist and Director of the Heart Disease Reversal and Prevention Program**)

- Federal grant should be made to educational institutions of higher learning for the training of Vedic medicine practitioners. (**Robert Schneider, M.D., Marharishi University**)

- Fund organized systematic reviews in a coordinated fashion on specific CAM methods and by clinical conditions. (**Harley Goldberg, D.O., Medical Director for CAM for Kaiser Permanente**)

- Increase research on the clinical implementation of specific CAM treatments for specific conditions. This research should involve CAM practitioners and experienced clinical researchers. (**Harley Goldberg, D.O., Kaiser Permanente**)

- Provide major medical schools and research centers throughout the United States with funding to set up models to study various CAM therapies, such as herbal medicine, homeopathy, and acupuncture. (**Nancy Dolores Kolenda, Director of the Center for Frontier Sciences at Temple University**)

Recommendations Related to CAM Service Delivery to Uninsured and Underinsured

- Support a bill currently before Congress that would forgive student loans to induce CAM practitioners who work in impoverished areas. (**Robert Duggan, TAI**)

- Develop a school loan forgiveness program for those people going to acupuncture schools, if they commit themselves to work in public health agencies after graduation. (**Patricia Culliton, LAc**)

Topic: Access and Delivery
December 4-5, 2000
Washington, DC: Commission Meeting
MEETING SUMMARY

The following is an overview of the presentations and major issues discussed during the recent meeting of the White House Commission on Complementary and Alternative Medicine Policy, held at the Hubert H. Humphrey Building in Washington D.C., December 4-5, 2000.

Session I: Overview
Commission chairman, Jim Gordon, M.D., began the meeting by saying that recent surveys (Eisenberg, 1998, Paramore, 1997) have established that approximately 40 percent of Americans are using some form of complementary and alternative medicine (CAM). He said, however, that this overall percentage of usage is based on phone surveys of English-speaking people. For many non-English-speaking populations, therefore, CAM may be, in fact, their source of primary care. Dr Gordon said, "one of the charges of the Commission is to address the needs of those people and to understand the importance of the contributions that those people make to our health care system, as well as the needs that they have from our health care system." He also noted that comparisons between recent surveys and earlier surveys (Eisenberg, 1993; Eisenberg, 1998) have shown a dramatic rise in the use of certain forms of CAM, particularly megavitamin, herbal treatments, and homeopathic remedies. Furthermore, recent studies show that although most people do not turn their back on CAM (Astin, 1998) but tend to use CAM to supplement their conventional treatments. He added that studies show CAM useage to be high among those facing chronic and life-threatening conditions (Eisenberg et al, 1998), that interest in and referrals to CAM by conventional physicians is relatively high (Astin et al, 1998; Bermen et al, 1995, 1998), and that the majority of medical schools in the U.S. are now offering at least elective courses in CAM therapies.

Dr. Gordon then went on to briefly summarize the problems that the commission was going to be addressing at this meeting, including the need for more data on effectiveness and cost effectiveness and the need for more research on the issue of integration. He said one of the "central purposes" of the meeting is for the Commissioners to hear testimony about some models of integration.

Panel Discussion:

Following Dr. Gordon's overview, Commissioners discussed whether the rise in use of certain CAM therapies was related to increase marketing of those therapies. Commissioner Jonas suggested that Commissioners may want to examine a book on the social dynamics of CAM use, which had just been released. Commissioners also discussed whether increased utilization of CAM therapies was linked with decreased access to health insurance. The consensus was that decreased access to health insurance did lead to increased use of CAM but was not the only explanation. Chairman Gordon said that in the homeless population, even though there was access to medical services through emergency rooms, CAM was appealing because homeless people do not feel particularly "cared for" when they go to hospitals.

Session II: Clinical and Cost Effectiveness of Selected CAM Services

Chiropractic:
William Meeker, D.C., MPH, testified that numerous studies have demonstrated the effectiveness of chiropractic manipulation, and it has been rated as an effective treatment for back pain by the United States Government, by the UK, Denmark, New Zealand, Australia, and Sweden, and others. In terms of cost effectiveness, he said studies suggest that the cost of chiropractic and conventional medical care is similar, although chiropractic patients tend to be much more satisfied with their care compared to patients receiving conventional care. He urged the Commission to examine three major reports on the cost-effectiveness of chiropractic as part of their deliberations.

Naturopathic Medicine:
Konrad Kail, N.D., P.A., testified that there are a number of studies demonstrating the effectivness of individual naturaopathic modalities. However, naturopathic medicine tends to combine many modalities in the treatment of a single condition. There have been few, if any, studies that have look at outcomes in naturopathic medicine in general. There is also only a short history of limited third-party reimbursement to look at utilization and cost effectiveness of naturopathic approaches. However, potential cost savings of naturopathic medicine include better education of patients about how to stay healthy and the greater knowledge and the home use of nutritional, botanical, and homeopathic medicines, both of which reduce costly visits to the physician. Dr. Kail urged the Commission to recommend greater funding for the NCCAM, and said it is extremely important for the Commission to recommend inclusionary language for CAM in entitlement acts, such as Medicare, Medicaid, Indian Health Service, and CHAMPUS for the military.

Acupuncture:
Patricia Culliton, LAc, testified that despite acupuncture's 4,000-year history, to date there have not been a great deal of studies done on the effectiveness of acupuncture for specific conditions. Therefore, she said, the acupuncture data, like the naturopathic data, is still in its infancy. She noted that in a recent NIH Consensus Conference on acupuncture, which was held in 1997, only two areas of utilization for acupuncture were considered to have definitive data, while several other areas had positive trends. Therefore, she "strongly" recommend further research expenditures on the clinical efficacy of acupuncture in conditions such as musculoskeletal pain and analgesia, breech aversion, nausea and vomiting, dysmenorrhea (menstrual pain), and bladder disorders. There have been no major cost effectiveness studies on acupuncture. However, several clinical studies have made cost-analysis and discovered that people in the experimental group that received acupuncture had significant financial savings compared to the control group. She urged the Commission to recommend large clinical effectiveness study and cost effectiveness studies of acupuncture for specific conditions as well as the development of CME courses and CEU courses for physicians in acupuncture and for CAM modalities and approaches in general. She also urged the Commission to consider a school loan forgiveness program for those people going to acupuncture schools, if they commit themselves to work in public health agencies after graduation.
Homeopathy:
Joyce Frye, DO, MBA, FACOG, said there are an estimated 2,500 medical practitioners using

homeopathy in the U.S.. Research on both clinical efficacy and cost effectiveness of homeopathy has suffered from limitations that are common to all of the CAM practices. The most useful summary of clinical efficacy, she said, is provided by the meta-analysis of 89 placebo-controlled trials published by Linde (Linde et al, 1997), which indicated that patients using homeopathy were 2.5 times more likely to have a therapeutic effect compared to placebo in a variety of conditions. The most complete data on cost effectiveness, she said, comes from the French Government Social Security statistics, which demonstrated significantly reduced costs using homeopathic versus conventional medical care. She said that these data are particularly compelling in view of France's ranking as the "number one" health care system in the world in terms of performance, in comparison to the United States, which is ranked 37th. She added that France also ranks third in life expectancy compared to 24th for the U.S.

Massage:

Tiffany Field, Ph.D., of the Touch Research Institute (TRI), testified that massage therapy, along with acupuncture, is one of the oldest therapies, dating back to Hippocrates in 400 B.C. She said that most of the research on the effectiveness of massage has been conducted at TRI during the last decade. TRI studies have demonstrated that massage can reduce prematurity and low birth rates associated with pregnancy, stress, and anxiety; can enhance the growth of preterm babies; can affect the outcomes of a number of psychiatric disorders; and can impact on immune problems, including asthma, diabetes, dermatitis, HIV, and cancer. The only study on the cost effectiveness of massage was in pre-term infants and was able to demonstrate a hospital cost savings of $10,000 per premature baby (Field et al, 1986). Multiplied by the 470,000 pre-term babies born in the U.S. each year, it equals a cost-savings of $4.7 billion per year, according to Dr. Field.

Panel Discussion:

Commissioners asked the panel to comment on: 1) their profession's attempts to teach self-management techniques patients, 2) where they thought cost-effectiveness studies should be directed, 3) what are the barriers to delivery of their therapies, 4) how their approaches to disease prevention might be broken down into reimbursable segments of time and services, and 5) what are the education priorities. Although all said teaching patients self-care is integral to their approaches. Dr. Meeker said he was not in favor of teaching self-manipulation to patients, however, because of the degree of skill needed to avoid self-injury. In regard to cost-effectiveness studies, Dr. Kail said that naturopathic studies must look at the whole system of care, because naturopathic physicians rarely deliver a single modality for condition. In regard to barriers, Dr. Fields said that in the field of massage, the traditional training of doctors not to touch patients is a major barrier. She said underlying mechanism studies to persuade the physicians that massage approaches work are necessary. In regard to reuimbursement, Dr. Kail said there are new reimbursement codes for time spent in discussion and patient education that are being underutilized by the insurance industry. He said that inclusionary language in Medicare and Medicaid is the fastest way to get those codes better utilized. In terms of education, Ms. Culliton said that education resources should be directed to training medical students and physicians in the effectiveness and cost benefits of CAM approaches as opposed to delivering the modalities themselves. Dr. Meeker said he agreed with Ms. Culliton. He added that there is an even greater need to train all health professionals, not just medical doctors, but CAM professionals as well, in how to interrelate to each other.

(Session II Continued)

Herbal Medicine:
Dennis Awang, Ph.D., SCIC, said herbal medicine's potential contribution to health care appears to be fundamentally related to the ability of the consumer to have access to safe and efficacious products. However, knowledge of the nature of active principles and the mechanisms of action of herbals remedies is severely limited. He recommended the institution of a system, such as that proposed by the World Health Organization (1978), to establish guidelines for the assessment of herbal medicines and to ensure proper identity and quality of both raw materials and finished products. Since most of the adverse reactions attributed to herbal remedies have been due to substitution, adulteration, misidentification, or linguistic confusion, he said it is not wise to leave the establishment of the identity and quality of these materials to manufacturers.

Christopher Hobbs, an herbalist and a licensed acupuncturist, said that he has received funding from a pharmaceutical company to sift through the literature on a hundred herbs in great detail. He and his colleagues have researched 26 international electronic databases and accessed a great deal of foreign material. Unfortunately, very few herb studies to date that have met high scientific standards. He recommended that well-trained herbalists be involved in studying the safety and efficacy of herbs on a scientific basis because many scientists have the view that herbs do not work until it is proven that they do work, which is the antithesis of how an herbalist would view them. He added, that although herbs can have side effects, generally speaking, herbs are far safer than drugs.

Nutritional Supplements:
Alan Gaby, M.D., provided examples of the superior cost effectiveness of nutritional supplementation versus conventional therapy for 10 common, but costly ailments. He added that he has seen many patients spend thousands of dollars on care that didn't work, when, in fact, all they were suffering from was a food allergy. Therefore, he recommended the better teaching of nutritional information in medical schools. If implemented, he said, the cost of care will undoubtedly come down by billions of dollars.

Patsy Brannon, Ph.D., R.D., a registered dietition, testified that the recent Institute of Medicine report on the role of nutrition and malnutrition in maintaining health in the nation's elderly (Institute of Medicine, 1999) defines two tiers of nutritional services that impact the consideration of CAM. The first is basic or general nutrition education or advice that can be provided by a variety of health care professionals. The second tier is medical nutrition therapy, which involves nutritional assessment, evaluation of nutritional needs, intervention, counseling, enteral and parenteral nutrition, and other modalities, as well as follow-up care. This type of therapy is generally provided by registered dietitians in a health care team of physicians, nurses, pharmacists, physical therapists, and psychologists. Beyond these two tiers, however, the vast majority of consumers get their nutritional information through the mass media. She said that nutrition therapy is "strongly supported" by observational studies, consensus documents, systematic reviews, and extensive clinical trials for a number of condtions. Furthermore, several

recent reports have examined the cost effectiveness of nutritional therapy and have found potential savings ranging from the millions to billions of dollars for the health care system. She said there are a number of barriers to nutrition therapy, including the lack of recognition of nutritional therapy by Medicare and Medicaid and private practice health plans. She recommended the passage of legislation currently in Congress, H.R. 1187 and S. 660, to provide outpatient medical care coverage for medical nutrition therapy for diabetes and kidney disease. She also recommended the consideration of expanded Medicare and Medicaid coverage as recommended by the Institute of Medicine report for the other chronic diseases for which nutritional therapy has been documented effective.

Integration Overview:

Harley Goldberg, D.O., Medical Director for CAM for Kaiser Permanente in Northern California, said his job is provide information on CAM practices to Kaiser's physicians, members, and health care providers, to coordinate a research program, and to evaluate education and training needs for providers. It is also his responsibility to identify the appropriate access and delivery systems. He said that a recent Kaiser-funded survey (Gordon et al, 1998), which found a very strong interest about CAM amongst Kaiser's members, patients, and physicians and clinicians, formed the basis of Kaiser's CAM strategy. Based on the survey, areas of modalities and conditions were identified in which to conduct systematic reviews. The systematic reviews, in turn, drive the activities of Kaiser's Education Committee, informs Kaiser's research agenda, and the consideration which CAM services to deliver. To be considered an appropriate for a specific condition, there must be reasonable evidence of safety and effectiveness. He, therefore, asked the Commission to recommend funding of organized systematic reviews in a coordinated fashion on specific CAM methods and by clinical conditions. He further suggested the need to increase research on clinical implementation of specific CAM treatments for specific conditions involving CAM practitioners and experienced researchers.

Panel Discussion

Commissioners asked Dr. Goldberg: 1) which CAM services Kaiser is currently providing, 2) who fills the role of the gatekeeper for these services, 3) what the process is for generating consensus, and 4) to explain Kaiser's system for CAM education. Dr. Goldberg replied that Kaiser is integrating acupuncture as one component of its chronic pain delivery system and provides manual therapies through Kaiser's Physical Therapy Departments. He said that the role of gatekeeper depends on whether a service requires physician referral and whether a service is available on self or patient referral. Treatments for a specific clinical condition require a primary care physician referral, although referrals can come from any specialist or any provider in the system. He said consensus was generated by the survey he mentioned, but members were not involved in reviewing the evidence. He added that Kaiser uses many different formats for imparting information on CAM, including in written summaries of the research, full practice guideline including the bibliographies and evidence tables, summaries of clinical information, and video conference presentations.

The Commissioners also asked panel members to make recommendations for improvements in

labeling regulations for herbal and dietary supplements, and on licensing and credentialling. Mr. Hobbs recommended a "traditional medicines" category that would take into account the historical and traditional use of an herb and to better educate consumers how to use them. Dr. Gaby suggested that manufacturers be allowed to put the information on the known effects of nutritional supplements on the label so that it would greatly enhance both the effectiveness and the safety. Dr. Awang noted, however, that much of the information currently put on labels is unreliable. He said that the most useful information that can be put on labels is warnings against possible adverse effects or toxicity, and recommendations as to use. On the other hand, he agreed with Dr. Gaby that limiting claims about efficacy is problematic because many people are buying herbs and nutritional supplements for treating specific conditions and they need accurate information on efficacy. For example, he noted that Saw Palmetto is often labeled as promoting prostate health rather than as a treatment for symptoms of benign prostatic hyperplasia, which is what most people buy it for. Dr. Brannon agreed with Dr. Awang that there needs to be added focus on potential adverse effects and not focus on those that do not have adverse effects. Finally, Dr. Goldberg said because it is such a long process to conduct randomized clinical trials on herbs for specific condition, to get relatively good answer questions more quickly, one can use epidemiologic data and other types of studies in the meantime.

Session III: Use of CAM for Selected Health Conditions

Substance Abuse/HIV-AIDS

Howard Josepher, Executive Director of Exponents, Inc., a not-for-profit drug treatment program in New York City, testified that because of AIDS, Exponents created an alternative approach to engaging and working with drug addicts, called ARRIVE. ARRIVE does not require abstinence for participation, but instead focuses on risk reduction for sex, drug use, and opportunistic infections and promotes proper nutrition through counseling and vitamin supplementation. ARRIVE also promotes stress reduction through a variety of CAM approaches including acupuncture, aromatherapy, music therapy, and meditation.

Denise Drayton, a graduate of the ARRIVE training program, and currently a staff member at Exponents, testified that she was first introduced to CAM during detoxification for heroin addiction. Her treatment including conventional treatment methods along with acupuncture for stress and pain management, which she continued using on an outpatient basis. She said the ARRIVE program also taught her visualization and deep breathing meditation and she has been drug-free for 10 years as a result. She said that in her community, however, CAM therapies are not readily available and even when it is, there a natural distrust of anything that is not traditional (i.e., conventional).

Cancer

Barrie Cassileth, Ph.D., Chief of Integrative Medical Services at Memorial Sloan Kettering Cancer Center in New York City, did not testify by submitted written testimony to the Commission, in which she described Sloan Kettering's CAM integration program and preliminary data on how its CAM services compare with conventional services. She said the CAM integration is extremely important to the treatment of cancer patients, because cancer is "a massive biological event and its treatments are often extremely difficult." She said that it is absolutely essential the CAM therapist work along side of oncologists at every stage of treatment and rehabilitation to ensure that therapies and their administration are consistent with patients' physiologic status and that patients receive only care that benefits them.

Jeanne Andrews, a cancer patient, testified that 21 months ago she was diagnosed with Stage IV colon cancer, after which she underwent colon resection and six months of chemotherapy. She was first introduced to CAM when a friend recommended that she see massage therapist. After her oncologist gave her the book, Comprehensive Health Care, she read it and contacted its author, Dr. Jim Gordon [Commission Chairman] and began attending programs at Dr. Gordon's center. There, she learned deep meditation, visualization, and a number of other forms of relaxation and also began undergoing acupuncture and intensive medical Qigong at another center. She said she is currently cancer-free and that she believes CAM treatments played a major role in her recovery. She said, however, there were a number of obstacles to her gaining access to CAM, including lack of insurance coverage and no central location for gaining credible information on CAM.

Heart Disease

Richard Collins, M.D., a cardiologist and Director of the Heart Disease Reversal and Prevention Program in Omaha, Nebraska, testified that traditional approach to cardiovascular disease management in this country is not cost-effective because there is a 30 to 50 percent restenosis rate after angioplasty or stent placement, and after typically bypass operations only last 7 years before costly recurrent admissions for heart failure occur. On the other hand, he said, the Dr. Dean Ornish program for heart disease reversal and prevention strikes at the very root cause of the disease process, by stabilizing plaques, reducing angina and costly readmissions to the hospital, and improving quality of life and well-being. He said several studies have documented and reconfirmed the programs effectiveness with multi-year follow-ups (Ornish et al, 1983; 1998). He said the Mutual of Omaha demonstration project has documented a cost savings $29,000 per patient. Similar finding also have recently been found by Highmark, Blue Cross/Blue Shield of Pennsylvania, which has embraced the Ornish program. For the insurees in Pittsburgh, a cost savings has been noted of more than $17,000 per person, improvement in SF well-being scores, outcomes, and reduction of angina. He, therefore, recommended that lifestyle behavior should be listed as a prudent, first-choice medicine for people with heart disease and said that the Commission also should "embrace" the Ornish program by providing access to it for all populations.

Walter Czapliewicz, a 45-year-old participant in Dean Ornish's program for reversing heart disease, testified that he came to the program after having had three heart attacks and bypass surgery. The bypass worked for about two years, but then he started having chest pains again.

However, within 10 days of starting the program, he said, he said his chest pain had diminished greatly and was completely gone after six weeks. He hasn't had any chest pain since then and has lost 64 pounds. In addition, his resting blood pressure has dropped from 160/80 to 128/72, his cholesterol is down from 196 to 114, and his triglycerides are down from 311 to 116. He said he truly believes this program saved his life.

Hospice Care

J. Donald Schumacher, Psy.D., of the Center for Hospice and Palliative Care, testified that in many ways hospice care is the epitome of high-quality CAM. Many of the nurses in his program are trained in therapeutic touch, and oftentimes engage in stress reduction using guided meditation and visualization. His program also employs homeopathy, chiropractic care, and acupuncture, the latter of which helps patients significantly reduce their dependence on narcotics and other debilitating medications. Unfortunately, one-third of the patients that receive hospice care die within seven days. As a result, most hospice care today is brink-of-death care, rather than true hospice care. He said that patients facing end-of-life problems need to be able to get access to hospice care sooner in order to be able to experience its full benefit.

Panel Discussion

The Commissioners asked Dr. Schumacher: 1) why referrals to hospice care have declined so dramatically in recent years, 2) what the hospice movement is doing increase access to hospice care for hospitalized patients, and 3) if hospice care could be delivered at home to save costs. Dr. Schumacher answered that cost is the major reason referrals to hospice have declined dramatically in recent years. "Our median length of stay has gone from about 29 days down to 14 days, and that is absolutely wrong for patients who need this care," he explained. He said that the hospice movement, with funds from the Robert Woods Johnson Foundation, has begun an innovative pilot project, called the Center to Advance Palliative Care, to help increase hopitalized patients' access to hospice are. He said that 80% of hospice care is provided at home. He emphasized, however, that there is a major distinction between hospice care and home health, particularly in regard to prescription benefits. For hospice patients, prescription drugs are paid for, for home health care patients, they are not. He said the largest obstacle to providing hospice in this country is the six-month criteria for Medicare coverage (i.e., the person has to have six months or less to live). He said he believes the Federal Government needs to develop demonstration projects around the country that will allow hospice programs to provide care without a reimbursement cap and without a criteria or prognostic cap.

The Commissioners asked Mr. Czapliewicz and Dr. Collins to make recommendations on how best to educate people of the benefit of lifestyle changes on the prevention and treatment of heart disease. Mr. Czapliewicz said that developing effective programs to educate people about what they are doing to their bodies through their diet is key. Dr. Collins added that it is extremely difficult to get people to listen to lifestyle advice until they are faced with the reality of increased risk. He said, however, that the new emerging technology, such electron beam CT scanner that can detect plaque in peoples' arteries and veins and determine total plaque load may change that. He cautioned, however, that lifestyle changes can only affect heart disease if an artery has not

been touched. "There is evidence that once an artery is touched, either through a stent or angioplasty, lifestyle cannot control it," he explained

Commissioners asked Mr. Josepher to elaborate on the ARRIVE program's efforts to reach out into the jails and prisons, and how such efforts may help prevent recidivism as well as prevent increasing illness from HIV, and if good studies existed that indicate there is a positive value of using CAM approached to help manage individuals in drug withdrawal. Mr. Josepher answered that ARRIVE does a substantial amount of outreach in the institutions in New York, primarily by engaging prisoners before they are released. Therefore, a whole new area that is being developed in addiction work with the criminal justice population is transitional planning, where the idea is to engage people in the institution and inform them of the various kinds of services that are available out in the communities. He added that most of the innovation and inroads that are currently occurring in addiction treatment are because of HIV and AIDS. In regard to research, Mr. Josepher said a Dr. Mike Smith from New York City, who developed auricular acupuncture has a substantial documentation on its effectiveness for managing drug withdrawal. However, he noted, that in the substance abuse field evidence of effectiveness often does not mean very much because it is a field that still prefers to treat drug use primarily through incarceration.

Commissioners asked Ms. Drayton if there was a single, key ingredient that helped her the most and to suggest ways that the Public Health Service and other agencies can get the message out to the African-American community that CAM is not necessarily second-rate medicine
Ms. Drayton answered her first contact with ARRIVE gave her a newfound sense of self-worth and spirituality, which then led her to the use of acupuncture. She said that the most influential way to deliver health messages in her community is through peer education. "If it is coming from someone who has experienced it and has a working knowledge of it through first-hand experience, they tend to believe it," she explained. Mr. Josepher added that although race is sometimes a barrier, if teachers had information and have conviction, they can transcend those barriers.

Commisssioners asked Ms. Andrews to describe all of the CAM treatments that were not paid for by her insurance in her effort to try to create integrative cancer care for herself. Ms. Andrews replied that she has done Reiki, massage therapy, support groups, Chinese herbs, various vitamin supplements, acupuncture, and art therapy. The only one that was covered by insurance has been acupuncture when it is administered by a medical doctor. She added that prayer has been a very important part of her healing. She said that if one does not have hope or faith, it is extremely hard to beat something like cancer.

Session IV: Issues in Integrating CAM in Service Delivery

Richard B. Miles of Health Frontiers testified that 30 years ago he began organizing and managing major conferences on CAM, including the first national symposium on acupuncture at Stanford in 1972. He said the prevailing attitude of our conventional medical system has been that when an individual presents with a disease, they are essentially ill and need to be made well

with interventions. There is an emerging perspective, however, that people are essentially well and need to be made ill. If one can get the factors that are contributing to this illness out of the way, the system will heal itself. He said that he is currently working with organizations and programs that are trying to develop this particular kind of concept. Mr. Miles said that doctors should be better listeners and to help people reestablish connections with nature and allow the diseases of this culture to heal themselves rather than try to fix them.

Berkeley Bedell, former congressman from Iowa and current president of the National Foundation for Alternative Medicine, testified that he believes the Commission has a genuine opportunity to make a difference. He said that 3 years ago, he and his wife formed the National Foundation for Alternative Medicine to conduct CAM field trials that NIH was unwilling to conduct itself. He said the Foundation currently is focused on cancer treatments and is sending teams led by a medical doctor to visit alternative cancer clinics and go over their patient records. He said the foundation is finding clinics in Europe administering low-cost, non-toxic cancer treatments with success that would not be expected at major cancer clinics here in the United States. He, therfore, pleaded with the Commission to recommend passage of The Access to Medical Treatment Act, which would make it possible for these non-toxic treatments to be tried under strictly controlled circumstances. He also said the Commission should recommend that any medical treatment that has been in use in another country, where there is no evidence of it posing a danger to the patient, to be allowed here in the United States.

Paul Kurtz, Ph.D., a representative of The Committee for the Scientific Investigation of Claims of the Paranormal, said he was troubled by the lack of skepticism in the Commission's deliberations. He said that he and his colleagues are committed to scientific medicine because it has been the most effective way of curing disease and promoting human health. He said he was also troubled by the Commission's having categorized too many things as alternative, when some clearly are not. For example, he said that lifestyle management in cardiology should not be labeled as alternative medicine. As commissioners on a Presidential Commission, he said there is obligation to see that CAM methods are carefully judged by double-blind tests, that they are backed up by coherent theories, that there are studies of mechanisms to explain why they work. He emphasized that CAM research needs to be conducted by neutral observers who are objective and impartial, neither strong negative skeptics, nor strong proponents, but people who are committed to scientific research.

Panel Discussion:

Several Commissioners disagreed with Dr. Kurtz's assessment that most conventional medicine treatments have been scientifically proven to be effective while most CAM therapies have not. It was pointed out that most prescription drugs have not been shown to be more effective than placebos. Dr. Kurtz replied that even conventional medicine should be continually questioned. He said he is not defending conventional medicine, per se, but the system of scientific inquiry used to test it.

Commissioners asked Mr. Miles whether he viewed CAM as being able to co-exist with western

medicine or something that should be integrated into it. Mr. Miles answered that the groups he has worked with achieved their best results when there was collaboration between conventional and CAM practitioners. He said, however, that one of the main determinants of collaboration is the reimbursement system. The movement toward medical savings accounts appears to be a step in that direction, particularly, for separating routine preventive care from more catastrophic "insurance" care. He cautioned, however, that unless we change the mindset that people can do whatever they want to their bodies and the insurance system will bail them out, we will be facing an uphill battle.

Commissiors then asked Mr. Bedell to elaborate on his proposal to allow acceptance of use of therapies that have been shown to be relatively safe in other countries. He replied that because there are not good treatments for most degenerative diseases, people with such conditions should have the right to try potentially beneficial treatments developed in other countries with out fear of government interference. He said there is a need to "open up" the present regulatory system so that these new treatments can be at least tried. He said, however, that it would be a very different situation if there is any evidence that a treatment is toxic. Mr. Kurtz argued that "determining toxicity" is a difficult problem. There was not agreement among panel members regarding who should be responsible for determining toxicity--with Mr. Bedell saying that he didn't trust the FDA to do it because it is too closely alligned with the pharmaceticial companies—however, there was general agreement that the Federal Government should play some role in the process.

Session V: Meeting Public Needs/Systems of Delivery

Private Practice Integration:

Robert Atkins, M.D., a private practice physician, said he began practicing a "different kind" of medicine in the early 1960s in order to get better outcomes as well as to disprove prevailing medical notions about diet and illness. After many years of practicing medicine differently, he said he and his colleagues believed they had succeeded in achieving better outcomes in many areas than when they were practicing strictly conventional medicine. In the early 1970s, he wrote a book about his experiences. He said the term "complementary medicine" aptly applies to practicing physicians and, in fact, should be the future of mainstream medicine. He said complementary medicine should not be viewed as adding complementary therapies to mainstream medicine, but an entire system of patient care, a different system, a system which is based on a "working knowledge" of all of the healing arts. He said that complementary medicine offers the Federal government an opportunity to solve its most pressing health problem: controlling spiraling health care costs.

Nursing Integration of CAM:

Charlotte Eliopoulos, a representative of the American Holistic Nurses Association (HNA), said the nursing profession has a long history of providing holistic care. For a number of reasons--including their large relative numbers, the diverse clinical setting in which they practice, and their multi-disciplinary education--she said nurses must have a significant role in this integration of CAM into the health care system at large. She said there is a need for nurses to increase their knowledge about CAM through continuing education for the existing work force, as well as the integration of this within the undergraduate nursing programs.

Stand-Alone CAM Center:
Mort Rosenthal, chairman and founder of Well Space, a for-profit CAM clinic, said that Well Space has been open in Cambridge Massachusettes for 27 months. It has 21 treatment rooms, 70 practitioners, and offers massage, acupuncture, Chinese herbs, chiropractic, naturopathic medicine, and nutritional classes. To date, the clinic has served approximately 10,000 patients and will take in approximately $2 million year, a very small amount of which is profit. He said 45 percent of the Well Space visits are related to stress or the need for relaxation. The rest of the condition range form headaches, back and neck pain, sleep disorders to fibromyalgia, fatigue, and cancer. He emphasized that Well Space is complementary, not integrated, and that Well Space's patients, for the most part, are not interested in integrative care. He said that in more than 40,000 visits, no patient has asked to have information sent back to their conventional physician. He added, however, that Well Space has an excellent relationship with local physicians, whom often give them informal referrals, as opposed to a traditional referral. He said that in a recent six-month pilot study, among 2,000 people who essentially offered free CAM care without referral, 70 people took advantage of the program and 50 of those, or 71%, continued their care even though they now had to pay out of pocket. From a policy perspective, he said he believes that the delivery system for CAM will continue to be largely stand-alone. He suggested that any policies that are made should not be biased in favor of full integration.

Panel Discussion:
Commissioners asked Dr. Atkins to describe some of the obstacles he faced in setting up and implementing his practice. He answered that there were many areas that they believed their methods were getting good results, but that the insurance companies would not reimburse for them. For example, he said, he and his colleagues often use a high resolution microscope for diagnosing the presence of various bacteria, yeasts, and parasites, but that they could not get reimbursed for the use of this expensive equipment because there was not an insurance code for it. He added that very few of the cancer treatments he and his colleagues use as alternatives to chemotherapy and radiation are eligible for insurance reimbursement. Furthemore, he said that he and his colleagues us a number of treatments that have been approved in Europe but that have not been approved here in the U.S. for various conditions that are not being reimbursed. The solution to all of these obstacles is to fund the kind of research that will allow everyone to see the two systems of medicine—conventional and CAM--compared side by side with a matched group of subjects to determine which gets better results and at lower costs.

The Commissioners asked Mr. Rosenthal: 1) what Well Space was doing to increase access for low-income people; 2) if it has an approach for improving the dissemination prevention materials; 3) why more people didn't take advantage of its pilot program; 4) why Well Space chose to be complementary rather than integrative; and 4) to make recommendations for research. Mr. Rosenthal said Well Space does provide discounts to needy patients but that its prices are fairly inexpensive already. In terms of prevention information, he said that there are great deal of preventive CAM and non-CAM treatments that are not reimbursed, so reimbursement of these approaches certainly would enhance their access and delivery. Although the pilot program was not a great success, it was still worth trying. He said that education is key

because the people who know about CAM seem willing to pay for it and those who don't know much about it are not willing to pay for it. In terms of Well Space's model, he said there were three basic reasons that Well Space chose to be complementary rather than integrative: 1) concerns that physicians would be reluctant to treat CAM practitioners as equals; 2) there are several other clinics who have physicians in their models and they have not done too well; and 3) in order to be profitable, Well Space did not want to spend too many resources dealing with issues of reimbursement and the other problems inherent in a traditional health care system. In terms of research, he said that Well Space has more than 40,000 computerized records that should be useful for research purposes.

The Commissioners asked Dr. Eliopoulos to elaborate on the role nurses could play in helping to integrate complementary alternatives into mainstream. Dr. Eliopoulos answered that nurses can play a crucial role in educating physicians about complementary medicine. She added that perhaps one of the reasons that patient seen in a complementary medicine clinic did not want their records sent back to their physicians was because they did not want to be admonished by their doctors. She said that this is where nurses can play a vital role, because nurses are in private practices doctors as well as in hospitals and can help educated doctors about which CAM treatments may be effective and which have not been shown to be effective.

(Session V Continued)

Community Based Center:
Tom Trompeter, M.P.A., Executive Director of Community Health Centers (CHC) of King County, Washington, said that his organization is a private non-profit, tax-exempt organization, with six medical and four dental clinics in suburban Seattle. Each year, the CHC provide about 90,000 visits for people who are mostly poor and uninsured. Those patients who do have insurance are generally insured either by Medicaid or by the Washington Basic Health Plan, which is a sliding-scale, managed-care product designed for people with incomes significantly below poverty level. In 1995, CHC competed for and won a grant to establish an integrative medicine clinic. During that process, CHC developed a partnership with Bastyr University. The grant required the CHC to provide conventional primary care, along some elements of CAM. An evaluation component also was required. He said the process for determining which products and practices to make available for which conditions is based on soliciting input from the clinical and administrative leadership from both Bastyr and CHC. Through this process, four CAM disciplines were identified, including naturopathic medicine, acupuncture, chiropractic, and therapeutic massage. The decision was made to offer naturopathy and acupuncture on site, and to offer chiropractic and massage via referral. Just recently, however, he said that CHC hired a licensed massage practitioner to provide on-site therapeutic massage.

Hospital-Based Center:
Sylver Quevedo, M.D., Director of the Center for Integrative Medicine at the O'Connor Hospital in San Jose, California, testified that he believes integrative medicine is THE MEDICINE of the future. Any hospital not considering an integrative approach will be seen as obsolete within 10 years from now, he asserted. On the other hand, programs that take a proactive and serious look

at integration will have a competitive advantage. Indeed, integrative medicine offers advantages over the narrow biomedical model of care because it takes seriously the notion that culturally appropriate care in our increasingly pluralistic society is a necessity rather than an afterthought. He said that although there was initially resistance from the hospital medical staff, which was due primarily to unfamiliarity with CAM, once the dialogue began, such resistance largely disappeared. Now, the hospital medical staff are asking the Center to organize a department of integrative medicine to bring these therapies into the in-patient setting.

Integrated Academic Centers:
Woodson Merrell, M.D., Executive Director of the Beth Israel Medical Center's Continuing Center for Health and Healing in New York City, said that his Center, which just opened in June 2000, comprises 16 clinicians, nine physicians, and seven allied health and CAM providers covering most aspects of integrative medicine in a hospital-based practice. He said several years ago Beth Isreal Hospital quickly understood that integration is the future of medicine and put together a team of people to set up an integrative medical center that would be academically based and combine the best of the traditional healing practices with the best of conventional western bioscience. The Center includes all aspects of research, education, and clinical care and provides patients access to most CAM treatment modalities and approaches. Because Beth Israel Medical Center is a teaching hospital, it is very focused on integrating CAM into all aspects of training and has the nation's first required residency rotation in integrative medicine. It has just received funding to set up a two-year fellowship in integrative medicine. The Clinic is primarily fee-for-service, but there are a number of programs for uninsured and underinsured patients, including a program called Helping Hands Fund, which has raised approximately $50,000 to date to provide free care for the uninsured. He said it is "critically important" that most licensed fields of CAM be incorporated in these integrated centers and be allowed to be primary care providers, and, by doing so, it actually allows for many of these patients to come back into the traditional medical care model.

Panel Discussion:
The Commissioners asked Dr. Quevedo to elaborate on the "culturally appropriate" medical care offered in his clinic and how CAM practitioners are interacting with conventional physicians in the hospital setting. He answered that one of the most important issues to address with patients is language and belief systems. He said that all of us operate in a given belief system, and that belief matters, particularly in mind-body connections. In terms of CAM practitioner interactions with hospital staff, he said that the Center's agreement with the medical executive body is to limit the scope of CAM practice and credentialling to the out-patient setting until enough experience was gained. To date, therefore, the Center has declined the opportunity to provide CAM in the in-patient setting, a decision that has been greated with disappointment among the staff in the hospital who would like to give their patients access to these treatments. However, he said the Center staff is just beginning the process of helping the hospital to develop a CAM integration and credentialing strategy.

The Commissioners asked the panel about funding strategies that would facilitate integration and whether they believed they were at an economic disadvantage compared to other CAM stand-

alone models. Dr. Merrell said he thinks it is very difficult for these types of centers to exist without private funding and government grants, because it is very difficult to make money for the first three years of operation. He added that his Center is lucky because Beth Israel made the development of integrative medicine an integral part of it mission statement. By doing this, the Center gained access to the hospitals donor lists and the development office resources. Dr. Quevedo said that being associated with a hospital increases the value of what his Center is doing because it increases their visibility but is also adds additional burdens because of the heavy overhead and administrative costs inherent to being part of a hospital system. He said that for many reasons, however, his group decided against developing a proprietary model for its center. Mr. Trumpeter said having both conventional and CAM modalities under one roof has been a big boost for his program. He added that his group developed a rather elaborate protocol for informing patients of their options and their choices and ways of making sure that people knew what they wanted. However, he said they gave it up because people absolutely knew what they wanted to choose. Dr. Merrell added that the quality of the practitioners is key to success.

(Session V Continued-Reimbursement)
Oxford Health Plan:
James Dillard, M.D., said that in the mid-1990s, he was asked by Oxford Health Plans to help build a comprehensive CAM program inside the insurance company. To date the program has credentialed almost 3000 CAM providers in six areas. Although the program has, in many ways, been successful, the company had some financial challenges at the end of 1997, which has led to an incomplete experiment in building a CAM program. Oxford has had very remarkable financial turnaround recently. However, the widespread financial problems that have occurred throughout the managed care industry, making it a challenge to build these kinds of programs within a managed care environment. In terms of integration, he said there are a number of barriers, including resistance on the part of the physicians, resistance on the part of the CAM practitioners, and resistance on the part of patients. He said that many patients simply do not want their primary care physician to know that they are seeing a CAM practitioner and, thus, often are resistant to having their records shared by both their conventional and CAM physicians. Overall, he said, it is appropriate to create access to the therapies that are considered to be safe. However, reimbursement should only be embraced those therapies that have strong evidence supporting their effectiveness.

Highmark Blue-Cross/Blue-Shield:
Anna Silberman, a representative of High Mark Blue Cross/Blue Shield in Pittsburgh, Pennsylvania, said that in 1997, Highmark became the first insurance company in the country to both provide and pay for the Dean Ornish program. Highmark did this because if heart disease is managed with only surgery without also addressing the root causes, bypasses need to be redone in 7 to 10 years and angioplasties within six months. The Ornish program, which has four components and is delivered by a team of physicians, exercise physiologists, registered dieticians, yoga instructors, behavioral health clinicians, and other professionals, both alternative and conventional. She said Highmark's senior management supported the Ornish program because of the science behind it, and, to date, patients have experienced 57% less angina; 50% less depression; improved cholesterol (an average of 22 points); and a 10% reduction in body.

Most importantly, there has not been a single heart attack or death since 1997, when the program was implemented. There has been only one bypass surgery, one stroke, and four angioplasties among these 400-plus very high risk patients. Moreover, there has been a cost saving of $17,000 per patient, which translates into a little over $8 million in savings for the entire group of patients. As a result, Highmark has started a new company, called Lifestyle Advantage, to significantly influence the way heart disease is managed and financed in this country. She asked the Commission to: 1) continue to support scientific investigations into CAM treatments to help separate what is effective from what is not; 2) promote proven CAM interventions to the public; and 3) influence health plans to reimburse for evidence-based CAM interventions.

Washington State Office of Insurance:
Lori L. Bielinski, Senior health policy analyst for the Washington State Office of the Insurance Commissioner, gave the Commission background about how the Washington State law is being implemented. It allows consumers a choice of the provider who will treat the condition in which they are seeking care. There are currently several different coverage models of CAM services used in Washington State, including: 1) a dollar-cap model, 2) a condition-based model, 3) a gatekeeper model, 4) an open-access model, 5) a self-referral and preventive care model, and 6) a discount networks model. She explained the advantages of disadvantages of each of these models.

Panel Discussion:

The Commissioners asked Dr. Dilliard to explain: 1) the method of access to Oxford's CAM benefits program, 2) whether there has been a difference between when services that are covered as a benefit versus those that are discounted, and 3) how Oxford sets limits on access. Dr. Dilliard said that Oxford began by paying for chiropractic with referral from a primary care physician and mandated that patients could make up to eight visits before the chiropractors had to file a care plan. To date, three states have a standard benefit for chiropractic, which is managed the same as any other benefit. In Connecticut there is also a mandated naturopathic service, which Oxford treats exactly the same way as it does chiropractors. Finally, acupuncture was put into a rider, which was sold to about 60 large groups and was delivered in the same way and managed the same way as the chiropractic was in terms of an eight-visit limit. He said that recent surveys have shown that the most popular parts of the program have been chiropractic, nutrition, massage, and acupuncture, in that order. He added that there is discounted network program for chiropractic, in which patients can go to a chiropractor without a physician referral and simply pay the Oxford rate. The vast majority of utilization has been through the benefit with the primary care physician referral. He added that the direct access riders have been very popular products as well. He said, however, that Oxford has not had the resources to capture all of the data on CAM utilization rates that is available. In regard to limiting access, he said Oxford adopted mandated benefits that were fully in compliance with the Insurance Equality Act in New York State. If patients feel they have been wrongfully denied access, he said there is a peer-based appeals process. He added that Oxford is generally considered to be the most generous payer in the Mid-Atlantic, so consequently there hasn't been much of a problem in terms of limiting access.

Commissioners asked Ms. Silberman how Highmark chose to offer the Dean Ornish program and if it is planning to offer other CAM modalities in a similar way. She answered that choosing Dr. Ornish's program was simply a matter or her hearing Dr. Ornish speak at a conference, and presenting what she heard to Highmark's board of directors. They were very receptive to it, she said. In terms of expanding CAM offerings, she said that Highmark has a delivery system, called Health Place, with 17 centers delivering various CAM programs on a daily basis to about 40,000 people a month.

Commissioners asked Ms. Bielinski to help the Commission understand how the Department of Insurance in Washington looks at access. She answered that the State does not have a formula, statute, or a rule. However, there have been significant number of complaints filed by consumers about lack of access. In Washington State, CAM is not really differentiated with conventional medicine any more. The part where it gets to be confusing, she said, is when plans set an arbitrary limit. She, therefore, recommended that the Commission try to find out what are the most common guidelines for setting limits and apply them to CAM. Otherwise, she warned that the carriers could be allowed to sell what is essentially an illusory benefit.

(Session V Continued—CAM Systems of Medicine)

Ayurvedic Medicine:
Robert Schneider, M.D., of the Marharishi University in Fairfield, Iowa, submitted evidence on the effectiveness of Vedic medicine, which include meditation, herbal approaches, diet, purification therapies, behavioral approaches, and even the influences of architecture on the environment. He said the clinical syndromes that have shown to be most responsive to various approaches of Vedic medicine include cardiovascular disease and its risk factors, psychological disorders, cancer prevention and treatment in terms of quality of life improvements, chronic pain, age-related disorders, and many disorders commonly seen in primary care. In terms of cost effectiveness, several studies have reported 50 to 80 percent reductions in health care utilization and related health care costs, with meditation and other Vedic medicine approaches. This has been true for both in-patient and out-patient utilization. Patient satisfaction with Vedic medicine also is almost twice as high as is patient satisfaction with conventional medicine, he said. Based on these data, he asked that the Commission recommend that Vedic medicine services that are shown to be effective and cost-effective in published, peer-reviewed scientific research, be reimbursed by third-party payers, including government payers, such as Medicare and Medicaid, and private reimbursers. He also asked that certified practitioners be allowed to practice in their areas, following the Minnesota model. He said that over time, states should adopt a licensure procedure for natural medicine practitioners, including Vedic medicine practitioners, and licensure would be dependent on certification and completion of other state licensing requirements, such as an exam or experience requirements. He also asked the Commission to recommend Federal grant to educational institutions of higher learning for the training of Vedic medicine practitioners.

Naturopathic Medicine:

Tori Hudson, N.D., of the National College of Naturopathic Medicine in Portland, Oregon,said that naturopathic doctors, or NDs, essentially are licensed primary care family physicians with a specialty in natural medicine. NDs utilize nutrition and lifestyle counseling prescribe nutritional supplements, plant extracts, and other natural therapeutic substances and techniques, as well as selected pharmaceuticals. She noted that womens' health is an area in which an integrative medical framework could bring about a more reliable understanding of and treatments for a number of poorly understood and treated conditions, such as interstitial cystitis, vulvodinia, fibromyalgia, PMS, fibrocystic breasts, pelvic infections, menopause, endometriosis, and uterine fibroids. Her experience in Portland, Oregon, she said, is one of having a women's integrative clinic with ND, MD, DC, acupuncturists, massage therapists and counselor working together, referring back and forth, discussing the co-management of shared patients. Thus, she said her vision of integrative medicine is basically a cadre of health care disciplines and practitioners, each with their own scope of practice, each with their own tools of their trade, but also each with a common understanding, a common respect, and a shared commitment to coordinate care, cross-refer, and co-manage patients. The Federal government could go a long way towards providing a framework in which all of this can take place, she explained.

Traditional Chinese Medicine:

Robert Duggan, M.A., MAc, President of the Traditional Acupuncture Institute (TAI) in Columbia, Maryland, said that his school currently has 700 graduates across the country, many of whom are earning higher than average salaries. He emphasized that TAI students are trained not only in the modality of acupuncture but also in the art of healing, which is completely different than the reductionistic model of conventional medicine. In TAI's model, he said, the patient is the primary care provider. Only when the American health care system understands that by making the patient the primary health care provider, will it be able move the majority of the visits out of the sick care system into a wellness culture, he explained. Traditional acupuncturists who see themselves as educators of the empowerment of the patient, therefore, do better than those that are simply delivering a modality. He asked that the Commission consider changing a reimbursement model that favors the delivery of the modality over the healing art of the individual patient. He also suggested that all schools of medicine, complementary and mainstream, foster relationship-centered care. He suggested that a separate agency be established to deal with the issue of the quality of herbs and that a bill currently before congress that would forgive student loans to induce CAM practitioners work in impoverished areas should be fostered. Finally, he said there should be an initiative to foster CAM and wellness education from the first grade onward.

Panel Discussion:

The Commissioners asked Mr. Duggan to elaborate on his comments about the regulation of herbal therapies as well as his proposal about educating people about wellness and lifestyle choices. Mr. Duggan replied that he believed it was wrong to turn plants into products. He said the policy issue for the Commission would to look at ways restore an awareness of plants as healing and then begin to define where is that line between what is food and what is medicine and must be professionalized. That is why he believes there needs to be a separate agency from the FDA to address the questions about herbs differently that it is currently being dong. Mr.

Duggan said that education about wellness and healing needs to start from the first grade, by teaching children an awareness of breathing, of drinking, of sleeping, of eating. He added that there need to be incentives for people to learn how to take care of themselves.
The Commissioners then asked the panel members to tell what their institutions are doing to reach out to the less advantaged in their communities. Dr. Hudson said that her clinic has three tiers of pricing to give people different cost options as well as some free clinics. In addition, she said that she practices one month a day at a rural clinic. Mr. Duggan said that TAI commits aproximately $200,000 a year to an inner-city clinic and that a several TAI graduates have established similar clinics. Dr. Shneider said that his institution is part of a federally funded center that has conducted a number of randomized trials of mind-body approaches in high risk African-Americans for the treatment and prevention of cardiovascular disease. Also, it has been very involved with the nation's historically black medical institutions in rolling out CAM approaches in lower socioeconomic and ethnic communities, particularly African-American communities. It also is planning initiatives in Native American and Hispanic communities and other ethnic communities.

Session VI: CAM Integration in Existing Delivery Systems

Alan Trachtenberg, M.D., medical director for the Office of Pharmacologic and Alternative Therapies at the Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA), said that a vital part of SAMHSA's mission is the full integration of CAM services with the rest of the public health and medical care system. He said the bulk of his activities at CSAT are currently involved with taking over from FDA in the regulation of opiate addiction treatment providers. For example, the kind of CAM clinic CSAT is now dealing with includes a group of Yale who recently published the results of randomized trial of ear acupuncture for cocaine addiction that achieved highly significant results. He said CSAT supports a variety of alternative practices that maybe included as elements of comprehensive treatment programs, including acupuncture, meditation, and culturally-specific healing practices, such as sweat lodge and traditional Hawaiian medicine. He said alternative therapies and traditional healing practices have been included in CSAT's programs, primarily as culturally relevant elements of a comprehensive treatment and outreach program. If an alternative therapy brings patients into the treatment setting and keeps them coming longer, then it has utility over and above whatever specific efficacy it may have. He said CSAT is presently requesting funds to assemble a consensus panel to make recommendations about how acupuncture should be incorporated into more existing drug treatment programs.

Milton Hammerly, M.D., of Catholic Health Initiatives (CHI), said that the system he represents encompasses more than 100 facilities in 22 states, employing more than 75,000 people. He said the incorporation of CAM services into this system has been an evolutionary process, beginning with a steering committee consisting of CAM proponents Early on, there was a steering committee, but now there is a more heterogeneous cross-section of the organization involved, including skeptics. He said CHI now has unanimous organizational buy-in and support of the philosophy of integration. He said the essence of CHI's philosophy, which is to provide comprehensive mind-body spirit care which personalizes care and which has to be, of necessity,

collaborative. He said, however, CHI faces a number of barriers in integration. The first is research. CHI has not been successful in accessing research funding, which seems to be mostly finding its way to academic centers, he said. In an effort to remedy this, CHI have approached pharmaceutical companies with synergistic combinations of supplements and pharmaceuticals which are, in fact, patentable, providing an incentive for them to want to pay for the research. Another barrier is the issue of reimbursement. He said, however, that reimbursement is only a barrier because the system is still trying to put the new clinical model of integrative health care in the old reimbursement model. He said clinicians can have far greater impact by working together as an orchestra than they can by practicing as individuals. He said that the Commission, by helping to break down the barriers to collaboration as well as the barriers to reimbursement in clinical areas, can actually help lead that orchestra.

Panel Discussion:
The Commissioners asked Dr. Trachtenberg if there was research looking at the effects of CAM on compulsive behaviors as well as to elaborate on his organizations efforts to reach the untreated populations and Native Americian populations. Dr. Trachtenberg said unfortunately there has been too much attention on withdrawal and not enough attention paid to compulsion to date. He added, however, that addiction treatment in this country, even in fairly conventional circles, has traditionally had a spiritual dimension. He said that the Commisson could perhaps urge that more attention be given to the interface of the issues of spirit and the neurophysiology of craving and compulsion and reward. In terms of reaching out to those who currently want treatment but are not receiving it, Dr. Trachtenberg said that our society is often too willing to blame people for their problem and put such a moralistic judgment on this particular category of illnesses [sustance abuse], that there is a significant barrier to treatment even when it is available. He said, therefore, that stigma, in addition to resources and the lack thereof, has much to do with that treatment gap. In terms of programs for Native Americans, Dr. Trachtenberg said those programs are part of community-based treatment programs that are serving specific Native American communities. The leaders from the communities themselves being served usually provide the culturally resonant aspects of the overall treatment program, such as sweat lodge or vision quest. He noted that such programs typically begin as grants to local groups and are used a method for the Federal Government to gain access to these groups.

Commissioners asked Dr. Hammerly if CHI has any ongoing data monitoring program related to CAM interventions and to comment further on the environmental aspects and obstacles encountered in CHI's CAM program. He answered that CHI has a comprehensive care assessment tool, which has the SF-36 embedded in it. Unfortunately, with the lack of research funding, CHI has not actually started collecting data. In terms of addressing the hospital environment, he said that program looks at a number of factors in the hospital environment that can impact on patients' heath, including the lighting, the food, the presence of plants. He said there is no organized initiative, but that several hospitals have Healing Environment Committees and are looking at models that are changing the environment to more holistic, and not as sterile a setting. In terms of obstacles, he said that to make integration work, there is a need to address the underlying philosophy of patient care. If the philosophy it is not coherent, there is organizational dissonance and nothing works. He added that the integration program needs to be very much

tailored to the specific location and environment. The approach needs to be sensitive to consumer interests and readiness, the availability of services, physician readiness, and to politics.

Public Comments:

Francine Butler, Executive Director of the Association for Applied Psychophysiology and Biofeedback, said that biofeedback is one of the most well-established of the CAM therapies, and here is a large body of scientific work demonstrating its treatment efficacy without adverse side effects. She said largest problem with access and delivery of biofeedback is denial by third-party payers because biofeedback is still branded as experimental. Nancy Dolores Kolenda, Director of the Center for Frontier Sciences at Temple University, said that it is important that the major medical schools and research centers throughout the United States have access to funding to set up models to study various CAM therapies, such as herbal medicine and homeopathy and acupuncture. Because our nation's major medical schools are facing critical financial crises, they are now more open now than ever to incentives to advance the research in CAM. Diana Chambers, of Friends of Health, said "whole person healing" as best describe most CAM practices, which primarily focus on prevention, wellness, and health. She said that Friends of Health wants the Commission to focus carefully on issues of language and philosophy of CAM as well as access and delivery issues for the poor, both urban and rural. Rustrum Roy, a representative of the University of Arizona Program for Integrative Medicine, said there are three primary communities that need to have better access to knowldege about CAM: 1) the approxmately one-half million practicing physicians, 2) academic research scientists, and 3) the general attentive public. He said there is a need for an emergency, crash education program for these groups. Bruce Nordstrom, on behalf of the American Chiropractic Association, encouraged the Commission to focus on wellness and to recommend policies for reimbursing CAM providers for health promotion. He said a good example of how prevention is cost effective can be found in an HMO in Illinois called Alternative Medicine, Inc., (AMI), which utilizes doctors of chiropractic as traditional gatekeepers and has reduced the rate of hospitalization for its members by about 75 percent. Neal Barnard, President the Physician's Commission for Responsible Medicine, said that nutrition is the most fundamental medical treatment, and esearch proves that when patients change their diets, in combination with other lifestyle changes, they can reduce cholesterol levels, reverse heart disease, improve and sometimes even cure Type II diabetes, and hypertension. He recommended that the Commission promote initiatives to integrate nutrition into the core curricula at American medical schools, encourage the Public Health Service issue grants for research on the effects of vegetarian and vegan diets for a number of chronic illnesses, and encourage the Department of Agriculture review of federal policies that conflict with healthy nutritional goals. Doreen Chen, chair of the Chinese Medicine Advisory Council of the American Association of Oriental Medicine, said that integrative medicine is the future of medicine and asked that the services rendered by an Oriental Medicine physician be covered by any health insurance, both Federal or private. Gary Sandman, founder of a

community-based alternative medicine referral service in the Washington, D.C., area, said CAM tends to teach empowerment, and individuals that are empowered tend to heal. He said there needs to be a 20-year plan to integrate conventional medicine into patient-centered, whole-person health care. Danny Freund, a cancer survivor, said he has tried many CAM therapies in the course of his recovery and now teaches a course on CAM. He said there is a great deal of information on CAM but there is no central source on information to help people decide how to find and interpret it. Melinna Giannini, Director of Alternative Link, said that her company has developed about 4,000 codes that describe what is said, done, ordered, prescribed, or distributed by alternative care practitioners, and each one of these codes has a relative value unit attached to it so that a rate can be developed for each procedure. She asked that the Commission promote the incorporatation of this code into Federally funded CAM research so that cost-effective CAM treatments can be identified as a solution to escalating health care expenses, especially where these procedures could have an impact on Medicare/Medicaid recipients. Jane Hersey, Director of the Feingold Association, said that a the Feingold Association show families how to reduce or eliminate many behavior, learning, and health problems in their children by eliminating synthetic dyes, artificial flavors, and certain preservatives from their diet. Despite the potential of this healthy option to help medical and social problems, and despite all of the supporting evidence, it is opposed, ignored, or misrepresented by Government agencies and professional organizations that should embrace it. She asked that the Commission urge the National Institutes of Health and the Department of Agriculture to conduct new research on the efficacy of the elimination diet. Boyd Landry, Executive Director of the Coalition for Natural Health, said the Commission needs to seize the opportunity "to look outside the box," rather than looking at ways to fit CAM inside the box. He said the Commission should focus on what consumers want, not what practitioners want. He, therefore, urged the Commission to seek out consumer input. Lawrence A. Plumlee, M.D., President of the National Coalition for the Chemically Injured, said there is a great need to conduct research on the role of toxic chemicals in syndromes, such as multiple chemical sensitivities, auto-immune diseases, fibromyalgia syndrome, and chronic fatigue syndrome. Currently, he said, patients with these conditions are subjected to dangerous and ineffective psychiatric drugs which prolong the illnesses, because the causes are not recognized and eliminated. There also is the need for research to investigate the role of nutritional supplements in enhancing improved metabolic function in these syndromes. Another area requiring scientific research and better medical education is the induction of mild immunodeficiency by some toxic chemicals with resultant super infections by viruses, bacteria, parasites, and fungi. Appropriate diagnosis and treatment of these infections will enable substantial gains in health. Michael John Rohrbacher, Director of music therapy at Shenandoah University in Winchester, Virginia, said that music therapy is the use of music in the accomplishment of therapeutic gains, the restoration, maintenance, and improvement of mental and physical health. He said there are over 3,700 individuals currently hold American Music Therapy Association membership, and mationwide, there are 69 undergraduate music therapy programs, 25 graduate programs, and 159 internship sites approved by AMTA. Andrew Rubman, of the American Association of Naturopathic Physicians, said the present needs of our citizens and the enormous body of emerging medical information leaves us no choice but to produce a better model of health where no one approach to medical care is forced to stand in judgement of others. He said that incorporating naturopathic medicine as a guiding principle to help shape and implement the new

medicine will allow our citizens to become better, more objective consumers, limiting high-priced procedures and pharmacy by increasing their wellness and thereby avoiding disease. Marshall Sager, President-elect of the American Academy of Medical Acupuncture, said that medical acupuncture, which is the practice of acupuncture by fully trained and licensed physicians, falls within the scope of the practice of medicine. The fact that most health care plans do not reimburse for physician acupuncturists services has forced patients from their primary medical care providers and out of the health care system. Medical students and physicians must be educated about the use and effectiveness of all complimentary medical modalities, especially medical acupuncture and must understand that medical acupuncture is not a threat to their practice. Diana Miller, an attorney, said she is committed to research, education, and designing laws that take away the legal barriers for consumers for access to alternative health and other kinds of health care that they deem necessary for their healing. She said the current system is disempowers consumers, and anything that disempowers consumer makes healthcare more expensive and impedes wellness. She said the exception is the State of Minnesota, which believes consumers have the right to access any person or treatment they deem helpful to bringing them to full health. Courtney Banks, a former Hodgkin's Disease patient, said that CAM saved her life. After radiation therapy, she began exploring and using acupuncture, eating only organic fruits and vegetable and whole foods, and using homeopathy. She said she has never felt healthier, had more energy, and a more positive outlook. Richard Pavek, from the Biofield Research Institute, said that he was concerned that the movement toward integration would disenfranchise alternative practitioners who are not doctors. He said that every alternative practice, teaching, method, or philosophy was developed outside of conventional medicine. He recommend that alternative practitioners be enfranchised with as much legal right to practice as possible.

Session VII: Commissioners' Discussion:

Chairman Gordon began the discussion by saying it was very much an open discussion and he wanted to give everyone a chance to share their thoughts, observations, and concepts about the meeting and about future directions. Commissioner Chappell said he believed the Commission needed to affirm the equal importance of promoting wellness as well as healing and to see CAM as having two charges: equal rights and equal accountabilities. He said that if the Commission seeks to create equality, then integration can occur wherever it is natural.

Commissioner Bresler said that another recurring theme appears to be the need for early education the let people know two things: first, what are they doing that is deleterious to their health, and second, what they can do in order to enhance and improve their health. Commissioner Gutierrez said that it would be helpful for her to know what is the intent and purpose of each provider group. Commissioner Rolin emphasized that the Commission needs to focus on those that aren't being served, such as Indian tribes living on reservations, because she said those are areas where CAM can make vast improvements within the communities. Commissioner Kerr said that in the future she would like to hear from agencies and organizations that may be impacted by the Commission's recommendations, such as the Department of Agriculture or a Fortune 500 company or a pharmaceutical company or public health people. She

said such agencies and companies are willing to help and want to be called to service. Commissoner Chow said that the Commission is talking about more than health care but also about lifestyles. She agreed that the conversation needs to be expanded and more skeptics included. She added that new paradigms and spiritual issues also needed to be considered. Commissioner Fins endorsed Commissioner Kerr's comments and added that he there needs to be a broad articulation of principles that will set the agenda for the next 20 years, in addition to concrete recommendations. He also said that the Commission needs a better sense of the sociology of CAM and to consider the mechanisms and agencies and collaborations that will allow dialogue to continue when the Commission is no longer around. Commissioner Paz said that as culture here in the U.S. becomes more and more diverse it will be necessary to continually expand the list of potential CAM therapies. Commissioner Bernier said the time is ripe to take a major step in integrating CAM. Nevertheless, there remain a number of issues, including guaranteeing the safety and efficacy of treatments of all types. One of the problems, he said, is that the term "CAM" means so many different things, and many CAM disciplines are not necessarily eager to see themselves integratied with convetional medicine. Chairman Gordon suggested that the Commission should begin to dialogue more with the conventional medicine community, particularly the American Medical Association and the American Association of Medical Colleges. Commissioner Bernier agreed to help begin the dialogue with those groups. Commissic medicine for conditions affecting people who are not valued in the community. Commissioner DeVries encouraged the Commission to create recommendations tcan be applied to multiple tracks, regardless of which way our country moves forward with its health care policy.

Commissioner Low Dow said that there have to be social policies in place that allow for healthy communities and healthy families and healthy children. She said that as the Commission discusses various issues, she hoped it didn't lose track of the bigger issues. Commissioner Fair expressed concern that there was a great need for education but that the Commission had heard nothing concrete about how to increase education. He said the Commission should stress the develop of plan for universal health education. By educating people universally, the personal, family and community improvements will follow, he said. Chairman Gordon reminded the Commission that the next two meetings were going to focus primarily on professional education and on public information, which includes education in the schools and in other places. Commissioner Jonas added that the most effective use of resources may be health care advertising, maybe even more than education. He added that the two types of activities that can lead to more specific items that deal with wellness are the area of health support and health promotion. He added that a focus on accountability was also necessary, including accountability of care and services on the part of the CAM providers. Commissioner Low Dog agreed, saying that she hopes the Commission looks at access as givng people the freedom to seek the practitioners they want as long as there is some type of accountability. Commissioner Chappell added that he would like to see a focus on bringing health promotion and health support to the public in an affordable way. He said his concern about the discussion on reimbursement is that it is not in the control of the consumers' hands. So affordability is the language to use as a goal to try to get that. Commissioner Tian said the Committee has to make sure that it adequately defines the CAM modalities what it is considering. It also needs to answers three important questions: where we are; where we are going; and how to get there? He said that each professional group can help with these answers. He also suggested that the

Commission invite the FDA as well as consumers, because when the Commission dicusses herbal nutrition, for example, a lot of these are controlled by FDA policy. Commissioner DeVries said that one critical issue the Commission needs to remember is that the individual states, not the Federal government, regulates the individual licensures of providers. The Commission, therefore, can consider recommending licensing statutes for acupuncture, massage, and naturopathy. This would go along way toward helping this modalities gain access to reimbursement and create the ability to access benefits. Chairman Gordon then thanked everyone for coming and participating, whereupon the meeting was adjourned.

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WHITE HOUSE COMMISSION ON COMPLEMENTARY AND ALTERNATIVE MEDICINE POLICY

Meeting Site: Academy for Educational Development
1825 Connecticut Avenue, NW, Room 800, Washington, DC

May 14-16, 2001

PRELIMINARY AGENDA*

****Final Agenda will be posted by May 10, 2001***

DAY ONE: Monday, May 14, 2001

7:30 a.m. **Registration Opens**

Meeting Topic I.
Complementary and Alternative Medicine: UNDERSTANDING COVERAGE AND REIMBURSEMENT

8:15 a.m. Opening Remarks and Introductions

- **Stephen C. Groft, PharmD**, Executive Director, White House Commission on Complementary and Alternative Medicine Policy
- **James S. Gordon, MD**, Chair

8:30 a.m. **Panel I: Overview of Health Care Financing in the US**

(1) Michael O'Grady, Project Hope

- *Discussion*

9:25 a.m. **Panel II: Federal Purchasers**

(2) John Whyte, MD, Health Care Financing Administration
(3) Abby Block, US Office of Personnel Management

- *Discussion*

10:45 a.m. – 11: 00 a.m. **BREAK**

11:00 a.m. **Panel III: State and National Perspectives**

(4) Joy S. Wilson Johnson, National Conference of State Legislators
(5) Marilyn Francis, American Association of Health Plans

(6) Alan Korn, MD, Blue Cross Blue Shield Association

- *Discussion*

12:00 p.m. – 1:00 p.m. **LUNCH BREAK**

1: 00 p.m. **Panel IV: Employer Perspectives**

(7) Tom Sawyer, William M. Mercer
(8) Kathleen King, Washington Business Group on Health
(9) Judith MacPherson, CACI International Inc

- *Discussion*

2:10 p.m. **Panel V: Health Plan Perspectives**

(10) Rick Gallion, Blue Cross Blue Shield of South Carolina
(11) John Kelly, MD, Aetna/U.S. Healthcare
(12) John Weeks, *The Integrator*

- *Discussion*

3:10 p.m. – 3:25 p.m. **BREAK**

3:25 p.m. **Panel VI: Special Populations: Minorities, Uninsured, Underinsured**

(13) Nathan Stinson, MD, PhD, Office for Minority Health, DHHS
(14) Dorianne C. Miller, MD Robert Wood Johnson Foundation
(15) Daniel Hawkins, National Association of Community Health Centers

- *Discussion*

4:15 p.m. **Breakout Groups: Access and Delivery***
**(review of December 4-5, 2000 meeting discussion)*

5:15 p.m. **Group Reports and Discussion**

6:00 p.m. **Adjourn**

DAY TWO (Topic I Continued): Tuesday, May 15, 2001

7:30 a.m. **Registration Opens**

Meeting Topic I.
CAM: UNDERSTANDING COVERAGE AND REIMBURSEMENT continued

8:00 a.m. **Opening Remarks**

- **Stephen C. Groft, PharmD**, Executive Director
- **James S. Gordon, MD**, Chair

8:05 a.m. **Panel VII: Issues and Ideas**

(16) Melinna Gianninni, Alternative Link, Inc.
(17) Linda Bedell-Logan, Solutions in Integrative Medicine
(18) Wayne Sickles, Massage Therapist

- *Discussion*

(19) Max Heirich, Professor Emeritus, University of Michigan

- *Discussion*

9:25 a.m. **Break/Breakout – Small Group Discussion (CAM Reimbursement)**

10:50 a.m. **Group Reports and Discussion**

11:30 a.m. – 12:30 p.m. **Lunch Break/Adjourn Meeting Topic I.**

DAY TWO: Tuesday, May 15, 2001

Meeting Topic II.
Complementary and Alternative Medicine: RESEARCH CHALLENGES

12:30 p.m. **Opening Remarks**

12:40 p.m. **Panel I: Overview of CAM Research Challenges**

(20) David Eisenberg, MD, Harvard University

- *Discussion*

1:25 p.m. **Panel II: Foundation Support for CAM Research**

(21) M. Bridget Duffy, MD, Medtronic Foundation
(22) Dorianne C. Miller, MD Robert Wood Johnson Foundation
(23) Susan Braun, Susan G. Komen Breast Cancer Foundation
(24) Ronald Chez, MD Samueli Institute for Information Biology

- *Discussion*

2:35 p.m. – 2:50 p.m. **BREAK**

2:50 p.m. **Panel III: Approaches to Evaluating Research Literature**

(25) Donald A. Lindberg, MD, National Library of Medicine
(26) Douglas B. Kamerow, MD, MPH, Agency for Healthcare Research and Quality
(27) Brian Berman, MD, University of Maryland

- *Discussion*

4:10 p.m. **Panel IV: Concerns about CAM and CAM Research**

(28) William M. London, EdD, MPH, National Council Against Healthcare Fraud
(29) Simeon Margolis, MD, PhD, Johns Hopkins University
(30) Arthur P. Grollman, MD, State University of New York at Stonybrook

- *Discussion*

5:30 p.m. **Adjourn**

DAY THREE (Topic II Continued): Wednesday, May 16, 2001

7:30 a.m. **Registration Opens**

Meeting Topic II.
CAM: RESEARCH CHALLENGES continued

8:00 a.m. **Panel V: Research Methodology**

(31) John A. Chabot, MD, Columbia University
(32) Marcia Angell, MD, Editor-in-Chief Emeritus, New England Journal of Medicine
(33) Jennifer Jacobs, MD, MPH, American Institute of Homeopathy

(34) B. Alex White, DDS, DrPH, Kaiser Permanente Center for Health Research
(35) Bruce Rabin, MD, PhD, University of Pittsburgh

- *Discussion*

9:25 a.m. **Panel VI: Training of Conventional and CAM Investigators**

(36) Nancy Pearson, PhD, National Center for Complementary and Alternative Medicine
(37) Neal West, PhD, National Center for Complementary and Alternative Medicine
(38) Robert H. Blanks, PhD, University of California at Irvine
(39) Russell Phillips, MD, Harvard University
(40) Richard Hammerschlag, PhD, Oregon College of Oriental Medicine

- *Discussion*

10:35 a.m. – 10:50 a.m. **BREAK**

10:50 a.m. **Panel VII: Publication of Peer-Reviewed CAM Research Results**

(41) Edward W. Campion, MD, New England Journal of Medicine
(42) Jackie C. Wootton, MEd, Journal of Alternative and Complementary Medicine
(43) Phil B. Fontanarosa, MD, Journal of the American Medical Association
(44) David Riley, MD, Alternative Therapies in Health and Medicine
(45) Christine Laine, MD, MPH, Annals of Internal Medicine
(46) Arnold Relman, MD, Editor-in-Chief Emeritus, New England Journal of Medicine

- *Discussion*

12:30 p.m. – 1:30 p.m. **LUNCH BREAK**

1:30 p.m. **Breakout – Small Group Discussion (CAM Research Challenges)**

2:50 p.m. **Group Reports and Discussion/Adjourn Meeting Topic II.**

4:00 p.m. **BREAK**

4:15 p.m. **Public Comment Session – 3-Minute Oral Statements***

**this list will be revised and posted on the website no later than May 10*

(47) Candace Campbell, American Preventive Medical Association
(48) Diane Davis Cole, University of Virginia Cancer Center
(49) Katherine Gorton, American Dietetic Association
(50) Audrey Di Maria, Secretary of Art Therapy Credential Board
(51) Judy Simpson, American Music Therapy Association

- *Discussion*

(52) Richard Goldberg, Private Practice
(53) Nancy Kristine Haller, Feldenkrais Guild of North America
(54) Christina Herlihy, NCCAOM
(55) Su Liang Ku , FITCM
(56) Alice McCormick, NCCAOM

- *Discussion*

(57) Barbara E. Moquin, NNMC
(62) Matt Ward Russell, National Integrative Medicine Council
(63) Carolyn Jones Sabatini, Pharmavite Corp.
(63) James S. Sensenig, AANP

- *Discussion*

5:30 p.m. **Adjourn**

4:15 p.m. **Public Comment Session – 3-Minute Oral Statements***

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- *Discussion*

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- *Discussion*

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(63) Carolyn Jones Sabatini, Pharmavite Corp.
(63) James S. Sensenig, AANP

- *Discussion*

5:30 p.m. **Adjourn**

Steve -

this is the full list of registrants.

Y
Yvette Benjamin P.A., M.P.H.
Consultant
108 Pembrooke View Lane Giathesburg, MD 20877
301-963-5822

ginger32147@aol.com

Y
Paul A. Berns M.D.
Institute for Molecular Medicine
15162 Triton Lane HUNTINGTON BEACH, AA 92649
714-846-6360
714-846-0398
peers@westworld.com

1:2:3:4
Observe and interested in the above agenda....I am director of medical education for the INSTITUTE FOR MOLECULAR MEDICINE in Huntington Beach Ca. and chairman of the IRB for clinical trials which include integrative medicine...and conference director for Feb 23,2002 WOMEN'S HEALTH AND INTEGRATIVE MEDICINE..SEE WEBSITE...www.immed.org Thankyou

Y
Maria Bianchi MA
American Association of Naturopathic Physicians
8201 Greensboro Drive Suite 300 McLean, VA 22102
703-610-0265
703-610-9005
mbianchi@naturopathic.org
Y
E. Borchini
HRSA
Bethesda, MD
301-594-4464

Y
Dannion Brinkley
Compassion in Action
PO Box 1919 Aiken, SC 29801
803-643-3441
803-648-7271
dannion.mailexcel.com

Y
Candace Lee Campbell B.A.
American Preventive Medical Association
Box 458 Great Falls, VA 22066
703-759-0662
703-759-6711
candace@apma.net

2
I would like to tell the Commission about the Access to Medical Treatment Act, which would give Americans the right to use therapies that have not been approved by the FDA.

need to call

Y
Diana L Chambers
Friends of Health
2014 Kalorama Rd. NW Washington, DC 20009
202-483-3080
202-483-3050
diana@friendsofhealth.org

4
Access to CAM practices and interventions for the poor

Y
S Elizabeth Clay
US House of Representatives
2157 Rayburn House Office Building Washington, DC 20515
202-225-5074
202-226-1274
beth.clay@mail.house.gov

Y
Diane Davis Cole Master of Public Health
University of Virginia Cancer Center
P. O. Box 800334 Charlottesville, VA 22908
804-243-6015
804-982-0918
ddc2d@virginia.edu

4

Y
Audrey Di Maria MA, ATR-BC
Sectretary of Art Therapy Credential Board
4200 Cathedral Ave., NW #901 Washington, DC 20016
202.576.5141
202.576.8804
adimaria@msn.com

3
Summary: Report qualitfication standards of Art Therapists; report establishment of state liscensure across US

Y
Mark L Dreher PhD
Mead Johnson Nutritionals
2400 West Lloyd Expressway Evansville, IN 47721
812-429-5539
812-429-5054
mark.dreher@bms.com

Y
Richard Ira Goldberg MSW

Private Practice
4330 E_W Hwy. Ste. 306 Bethesda, MD 20814
3016527792

goldberg@erols.com

05/04/2001 03:13 PM
1:2
This oral commentary concerns the use of Emotional Transformation Therapy: light and color combined with specialized interactive guidance. We shall identify the scientific research with respect to light stimulation, identfy obstacles to research and suggest remedies.

Y
Katherine Jane Gorton MS
American Dietetic Association
1120 Connecticut Avenue, NW, #480 Washington, DC 20036
(202) 775-8277
(202) 775-8284
kgorton@eatright.org

Y
Nancy Kristine Haller Guild Certified Feldenkrais Practitioner, LMP, BA
Feldenkrais Guild of North America
821 S 219th #8 Des Moines, WA 98198
253 852 7167
253 850 8164
nkhaller@aol.com

Y
Nancy Kristine Haller Guild Certified Feldenkrais Practitioner, LMP, BA
Feldenkrais Guild of North America
821 S 219th #8 Des Moines, WA 98198
253 852 7167
253 850 8164
nkhaller@aol.com

Y
Christina Herlihy PhD
NCCAOM
11 Canal Center Plaza, Ste. 300 Alexandria, VA 22314
703-548-9004 x 3250
703-548-9079
cherlihy@nccaom.org

need to call

Y
Libby Hogen Master of Science
Council for Responsible Nutrition
1875 Eye Street, NW Ste. 400 Washington, DC 20006
202-872-1488
202-872-9594
lhogen@crnusa.org

Y
Jeanie Kennedy
American Academy of Othopaedic Surgeons
6300 N. River Road Rosemont, IL 60018
847/384-4308
847/823-9769
jkennedy@aaos.org

Y
Su Liang Ku A.P., Professor
FITCM
5335 66th Street N. St. Petersburg, FL 33702
727-546-6565
727-547-0703
fitcm@gte.net

2
Will discuss thrid party reimbursement for CAM to include all types of health insurance inlcuding Medicare and Medicaid. Standardization of diagnostic and treatment procedures and coding. Assuring access to safe and effective CAM practices and treatment.

Y

Boyd J. Landry M.P.A.
The Coalition for Natural Health
1220 L Street NW, PMB 100-408 Washington, DC 20005-4018
202-216-9488
800-598-4264
boydlandry@naturalhealth.org

1:2:3:4

Y
Sheldon Lewis
InnerDoorway
642 Amsterdam Avenue New York, NY 10025
212- 769-9028
212-769-0616
Sl110548@aol.com

Y
Ingrida Lusis
American Chiropractic Association
1701 Clarendon Boulevard Arlington, VA 22209
703/276-8800
703/243-2593
ilusis@amerchiro.org

need to call

1

Y
EKATERINI MALLIOU
OFFICE ON WOMEN'S HEALTH/OS/HHS
200 INDEPENDENCE AVE SW #730B WASH, DC 20201
202-205-2385
202-690-7172

EMALLIOU@OSOPHS.DHHS.GOV

Y
Alice McCormick Dipl. Ac. & C.H. (NCCAOM)
NCCAOM
11 Canal Center Plaza, Ste. 300 Alexandria, VA 22314
703-548-9004
703-548-9079
amccormick@nccaom.org

need to call can she or Christina Herlihy testify not both??

agree

Y
Leo Moody
HRSA, Bureau of Primary Health Care
4350 East-West Hwy. Bethesda, MD, MD 20814
301-594-3726
301-594-4987
lmoody@hrsa.gov

Y
Barbara E. Moquin PhD(cand),RN,MSN,CS-P
NNMC
8901 Wisconsin Ave. Bethesda, MD 20878
(301)295-4041

tieda@aol.com

Y
Annette Oestreicher M.S., Biology
Oestreicher Medical Communications, Inc
300 East 54th Street, #9H New York, NY 10022
212-758-7092
212-371-6193
Annetteoes@cs.com

Y
Kathleen Quain CSW
Foundation for Health and the Environment
177 Prince St., 3rd floor New York, New York, NY 10012
212.946.2172
212.982.2850
globalpeace4u@aol.com

need to call

Y
Rustum Roy
Pennsylvania State University
102 MRL University Park, PA 16802
814-865-3421
814-863-7040
rroy@psu.edu

need to call

1
I will be sending a copy of my written comments on research issues to your office by May 7, 2001

Y
Matt Ward Russell
National Integrative Medicine Council
5151 E. Broadway, Suite 1095 Tucson, AZ 85711
520-571-1110
520-571-1177
mrussell@nimc.org

Y
Carolyn Jones Sabatini BA, MBA
Pharmavite Corp.
11904 Cherokee Lane Leawood, KS 66209
(913) 338-2640
(913) 338-2815

csabatini@pharmavite.net

Y
James S. Sensenig ND
AANP
2558 Whitney Avenue Hamden, CT 06518
203-230-2200

jsensenig@aol.com

2
I will speak on the need for pluralism in American medicine. Give examples of reimbursement systems for naturopathic medicine that work, and give reccomendations to the commission for reimbursement of naturopathic services for inclusion of naturopathic physicians in federal programs.

Y
Judy Simpson MT-BC
American Music Therapy Association
8455 Colesville Rd, Suite 1000 Silver Spring, MD 20910
301-589-3300 x108
301-589-5175
Simpson@musictherapy.org

1:2
Music therapy has a 50 year history of contributing to the treatment of individuals with a variety of disabilities and illnesses in the U.S. However, the lack of understanding by the federal government regarding music therapy applications, along with limited funding for research, direct services, and reimbursement, seriously restricts access to services. We would appreciate the Commission's assistance in accessing research funding and third party reimbursement for music therapy interventions.

Y
Christina Lee Walker RN MA

need to call

The Schenk Human Energetic Instiutute
220 East 26th St. New York, NY 10010
212-951-7107
212-684-5692
cwalkerrn@aol.com

1:2
will fax oral statement

Y
Sally M. Yamini DHM
Yamini Consulting
7010 Woodland Dr. Dallas, TX 75225
214-692-0540
214-987-0540
smywolf@aol.com

5/1

Michele,

When you were sent

(1) Doreen Chen, 718-217-7764 called to make sure she was registered to speak

(2) Diane Chambers, 202-483-3083 called to make sure Ruston Roy was registered to speak

(I think they both spoke at earlier meeting —) ?

Harry

White House Commission on Complementary and Alternative Medicine Policy

Meetings

Registration Information

Washington, DC

Academy for Educational Development

This report is a list of all Registrants for the meeting in alphabetical order. Those giving oral comment are denoted by a "Y" in the Talk column.

Note: Michele, I will be adding options to this report in the future. (possibly a printer-friendly version, and other sort options)

Talk	Name (first, middle, last, degree)	Organization	Address (s
~~Y~~	~~Yvette Benjamin P.A., M.P.H.~~	Consultant	108 Pembr
~~Y~~	~~Paul A. Berns M.D.~~	Institute for Molecular Medicine	15162 Trit
~~Y~~	~~Maria Bianchi MA~~	American Association of Naturopathic Physicians	8201 Gree
~~Y~~	~~E. Borchini~~	HRSA	Bethesda,
~~Y~~	~~Dannion Brinkley~~	Compassion in Action	PO Box 19
Y	Diana L Chambers	Friends of Health	2014 Kalo
~~Y~~	~~S Elizabeth Clay~~	US House of Representatives	2157 Rayb
Y	Diane Davis Cole Master of Public Health	University of Virginia Cancer Center	P. O. Box
Y	Audrey Di Maria MA, ATR-BC	Sectretary of Art Therapy Credential Board	4200 Cath
~~Y~~	~~Mark L Dreher PhD~~	Mead Johnson Nutritionals	2400 West
Y	Katherine Jane Gorton MS	American Dietetic Association	1120 Conn
Y	Nancy Kristine Haller Guild Certified Feldenkrais Practitioner, LMP, BA	Feldenkrais Guild of North America	821 S 219t
~~Y~~	~~Nancy Kristine Haller Guild Certified Feldenkrais Practitioner, LMP, BA~~	Feldenkrais Guild of North America	821 S 219t
Y	Christina Herlihy PhD	NCCAOM	11 Canal C
Y	~~Libby Hogen Master of Science~~	Council for Responsible Nutrition	1875 Eye S

Y	~~Jeanie Kennedy~~	American Academy of Othopaedic Surgeons	6300 N. Ri
Y	Su Liang Ku A.P., Professor	FITCM	5335 66th
Y	~~Boyd J. Landry M.P.A.~~	The Coalition for Natural Health	1220 L Str
Y	~~Sheldon Lewis~~	InnerDoorway	642 Amste
Y	Ingrida Lusis	American Chiropractic Association	1701 Clare
Y	~~EKATERINI MALLIOU~~	OFFICE ON WOMEN'S HEALTH/OS/HHS	200 INDEI
Y	Alice McCormick Dipl. Ac. & C.H. (NCCAOM)	NCCAOM	11 Canal C
Y	~~Memberware (test - no oral)~~	Memberware	, AA
Y	~~Memberware (test -oral)~~	Memberware	, AA
Y	~~Leo Moody~~	HRSA, Bureau of Primary Health Care	4350 East-
Y	~~Annette Oestreicher M.S., Biology~~	Oestreicher Medical Communications, Inc	300 East 5
Y	~~Craig (test) Powers (test)~~	self (test)	11111 stre
Y	~~Craig (test) Powers (test)~~	self	, AA
Y	~~Craig (test2) Powers (test2)~~	self	, AA
Y	~~Craig(test3) Powers(test3)~~	self	, AA
Y	~~Craig(test4) Powers(test4)~~	self	, AA
Y	Kathleen Quain CSW	Foundation for Health and the Environment	177 Prince
Y	Rustum Roy	Pennsylvania State University	102 MRL
Y	Matt Ward Russell	National Integrative Medicine Council	5151 E. Br
Y	Carolyn Jones Sabatini BA, MBA	Pharmavite Corp.	11904 Che
Y	James S. Sensenig ND	AANP	2558 Whit
Y	Judy Simpson MT-BC	American Music Therapy Association	8455 Cole
Y	Christina Lee Walker RN MA	The Schenk Human Energetic Instiutute	220 East 2
Y	Sally M. Yamini DHM	Yamini Consulting	7010 Woo

Y
Yvette Benjamin P.A., M.P.H.
Consultant
108 Pembrooke View Lane Giathesburg, MD 20877
301-963-5822 NO
ginger32147@aol.com

Y
Paul A. Berns M.D.
Institute for Molecular Medicine
15162 Triton Lane HUNTINGTON BEACH, AA 92649
714-846-6360 left message
714-846-0398 (fax)
peers@westworld.com

1:2:3:4
Observe and interested in the above agenda....I am director of medical education for the INSTITUTE FOR MOLECULAR MEDICINE in Huntington Beach Ca. and chairman of the IRB for clinical trials which include integrative medicine...and conference director for Feb 23,2002 WOMEN'S HEALTH AND INTEGRATIVE MEDICINE..SEE WEBSITE...www.immed.org Thankyou

Y
Maria Bianchi MA
American Association of Naturopathic Physicians
8201 Greensboro Drive Suite 300 McLean, VA 22102
703-610-0265 NO
703-610-9005 (f)
mbianchi@naturopathic.org

Y
E. Borchini
HRSA
Bethesda, MD
301-594-4464 NO

Y
Dannion Brinkley
Compassion in Action
PO Box 1919 Aiken, SC 29801
803-643-3441 Will call back tomorrow
803-648-7271
dannion.mailexcel.com

2

Y
Diana L Chambers spoke @ March mtg
Friends of Health
2014 Kalorama Rd. NW Washington, DC 20009
202-483-3080 Wants to speak. Spoke before advised her re: priorities + suggested
202-483-3050 she send written material
diana@friendsofhealth.org

4

Access to CAM practices and interventions for the poor

Y
S Elizabeth Clay
US House of Representatives
2157 Rayburn House Office Building Washington, DC 20515
202-225-5074 NO
202-226-1274
beth.clay@mail.house.gov

Y
Audrey Di Maria MA, ATR-BC
Sectretary of Art Therapy Credential Board
4200 Cathedral Ave., NW #901 Washington, DC 20016
202.576.5141 Wants to speak, has not spoken before, advised to
202.576.8804
adimaria@msn.com check web site for final list

3

Summary: Report qualitfication standards of Art Therapists; report establishment of state liscensure across US

Y
Mark L Dreher PhD
Mead Johnson Nutritionals
2400 West Lloyd Expressway Evansville, IN 47721
812-429-5539 NO
812-429-5054
mark.dreher@bms.com

Y
Katherine Jane Gorton MS
American Dietetic Association
1120 Connecticut Avenue, NW, #480 Washington, DC 20036
(202) 775-8277 Yes

(202) 775-8284
kgorton@eatright.org

Y
Christina Herlihy PhD
NCCAOM
11 Canal Center Plaza, Ste. 300 Alexandria, VA 22314
703-548-9004 x3250 left message
703-548-9079
cherlihy@nccaom.org

Y
Libby Hogen Master of Science
Council for Responsible Nutrition
1875 Eye Street, NW Ste. 400 Washington, DC 20006
202-872-1488 NO
202-872-9594
lhogen@crnusa.org

Y
Jeanie Kennedy
American Academy of Othopaedic Surgeons
6300 N. River Road Rosemont, IL 60018
847/384-4308 NO
847/823-9769
jkennedy@aaos.org

Y
Su Liang Ku A.P., Professor
FITCM
5335 66th Street N. St. Petersburg, FL 33702
727-546-6565 Yes
727-547-0703
fitcm@gte.net

Will discuss thrid party reimbursement for CAM to include all types of health insurance inlcuding Medicare and Medicaid. Standardization of diagnostic and treatment procedures and coding. Assuring access to safe and effective CAM practices and treatment.

Y
Sheldon Lewis
InnerDoorway
642 Amsterdam Avenue New York, NY 10025

212- 769-9028 left message
212-769-0616
Sl10548@aol.com

Y
Ingrida Lusis
American Chiropractic Association
1701 Clarendon Boulevard Arlington, VA 22209
703/276-8800 left message
703/243-2593
ilusis@amerchiro.org

Y
EKATERINI MALLIOU
OFFICE ON WOMEN'S HEALTH/OS/HHS
200 INDEPENDENCE AVE SW #730B WASH, DC 20201
202-205-2385
202-690-7172 No
EMALLIOU@OSOPHS.DHHS.GOV

Y
Alice McCormick Dipl. Ac. & C.H. (NCCAOM)
NCCAOM
11 Canal Center Plaza, Ste. 300 Alexandria, VA 22314
703-548-9004
703-548-9079
amccormick@nccaom.org

Y
Leo Moody
HRSA, Bureau of Primary Health Care
4350 East-West Hwy. Bethesda, MD, MD 20814
301-594-3726 No
301-594-4987
lmoody@hrsa.gov

Y
Annette Oestreicher M.S., Biology
Oestreicher Medical Communications, Inc
300 East 54th Street, #9H New York, NY 10022
212-758-7092 No
212-371-6193
Annetteoes@cs.com

Y
Kathleen Quain CSW testified @ March mtg
Foundation for Health and the Environment
177 Prince St., 3rd floor New York, New York, NY 10012
212.946.2172
212.982.2850
globalpeace4u@aol.com

Y
Rustum Roy
Pennsylvania State University
102 MRL University Park, PA 16802
814-865-3421
814-863-7040
rroy@psu.edu

1

I will be sending a copy of my written comments on research issues to your office by May 7, 2001

Y
Matt Ward Russell
National Integrative Medicine Council
5151 E. Broadway, Suite 1095 Tucson, AZ 85711
520-571-1110 Yes
520-571-1177
mrussell@nimc.org

Y
Carolyn Jones Sabatini BA, MBA
Pharmavite Corp.
11904 Cherokee Lane Leawood, KS 66209
(913) 338-2640 Yes, has not testified before
(913) 338-2815
csabatini@pharmavite.net

Y
James S. Sensenig ND
AANP
2558 Whitney Avenue Hamden, CT 06518
203-230-2200
jsensenig@aol.com Yes - has not testified before, has talked to Steve re testifying

2

I will speak on the need for pluralism in American medicine. Give examples of reimbursement

systems for naturopathic medicine that work, and give reccomendations to the commission for reimbursement of naturopathic services for inclusion of naturopathic physicians in federal programs.

Y
Christina Lee Walker RN MA
The Schenk Human Energetic Instiutute
220 East 26th St. New York, NY 10010
212-951-7107
212-684-5692
cwalkerrn@aol.com

1:2

will fax oral statement

Y
Sally M. Yamini DHM
Yamini Consulting
7010 Woodland Dr. Dallas, TX 75225
214-692-0540 left message
214-987-0540
smywolf@aol.com

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Washington, DC 20009-5721

Phone: 202.884.8600
Fax: 202.884.8996
www.aedconferencecenter.org

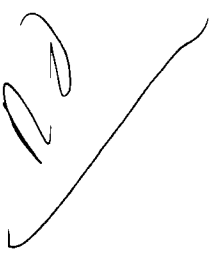
Pollen, Geraldine (NCCAM)

From: Donald M. Marcus, MD [dmarcus@bcm.tmc.edu]
Sent: Wednesday, May 02, 2001 4:43 PM
To: Pollen, Geraldine (NCCAM)
Subject: RE:

That worked - thank you.

At 04:35 PM 5/2/2001 -0400, you wrote:
>try www.whccamp.hhs.gov without adding members. Let me know if this works.
>
>-----Original Message-----
>From: Donald M. Marcus, MD [mailto:dmarcus@bcm.tmc.edu]
>Sent: Wednesday, May 02, 2001 4:36 PM
>To: Pollen, Geraldine (NCCAM)
>Subject:
>
>
>Dear Ms.Pollen,
>
> I am a Professor of Medicine and Immunology at Baylor College of
>Medicine, and I am involved in educating students and physicians about CAM.
>I tried to access the Commission web site at: www.whccamp.hhs.gov/members,
>and I received an error message. Is the address incorrect, or is the site
>restricted?
>
> Donald Marcus
>
>
>Dept. of Medicine
>Baylor College of Medicine
>1 Baylor Plaza
>Houston, TX 77030
>Tel. 713 798-6014
>Fax 713 798-5780
>E-mail dmarcus@bcm.tmc.edu

Dept. of Medicine
Baylor College of Medicine
1 Baylor Plaza
Houston, TX 77030
Tel. 713 798-6014
Fax 713 798-5780
E-mail dmarcus@bcm.tmc.edu



Marcia Angell, M.D.
Senior Lecturer, Department of Social Medicine
Harvard Medical School
641 Huntington Avenue
Boston, MA 02115
Telephone: (617) 576-6934
Fax: (617) 576-7926
E-mail:

Linda Bedell-Logan,
President/CEO
Solutions in Integrative Medicine
P.O. Box 207
Saco, ME 04072
Telephone: (207) 282-5110
Fax: (207) 286-1866
E-mail: mbc.on@gwi.net

Brian Berman, M.D.
Professor of Family Medicine
University of Maryland School of Medicine
2200 Kernan Drive
James L. Kernan Mansion
Baltimore, MD 21207
Telephone: (410) 448-6871
Fax: (410) 448-6875
E-mail:
bberman@compmed.ummc.umaryland

Susan Braun,
President and CEO
Susan G. Komen Breast Cancer Foundation
5005 LBJ Freeway, Suite 250
Dallas, TX 75244
Telephone: (972) 855-1611
Fax: (972) 855-1612
E-mail: sbraun@komen.org

Edward Campion, M.D.
Deputy Editor
New England Journal of Medicine
10 Shattuck Street
Boston, MA 02115
Telephone: (617) 734-9800
Fax: (617) 739-9864
E-mail:

John Chabot, M.D.
Associate Professor of Clinical Surgery
New York Presbyterian Hospital, New York City
161 Fort Washington Avenue
New York, NY 10032
Telephone: (212) 305-9468
Fax: (212) 305-3992
E-mail: jac4@columbia.edu

Ronald Chez, M.D.
Professor of Obstetrics and Gynecology
University of South Florida
2101 East Pacific Coast Highway, #220
Corona del Mar, CA 426251900
Telephone: (949) 760-4417
Fax: (949) 759-5707
E-mail: rchez@siib.org

Phil Fontanarosa, M.D.
American Medical Association
515 North State Street
Chicago, IL 60610
Telephone: (312) 464-2427
Fax: (312) 464-5824
E-mail: phil_fontanarosa@ama-assn.org

Merilyn Francis, R.N., M.P.P.
Director, Quality Management and Health Services
American Association of Health Research Plans
1129 20th Street N.W., #600
Washington, DC 20036
Telephone: (202) 778-3224
Fax: (202) 778-3287
E-mail: mfrancis@aahp.org

Derrick Gallion, A.A.
Director, Complementary and Alternative Medicine
Blue Cross and Blue Shield of South Carolina
I-20 at Alpine Road, AF-325
Columbia, SC 25209
Telephone: (803) 788-0222
Fax: (803) 419-3338
E-mail: rick.gallion@bcbssc.com

Melinna Giannini,
President/CEO
Alternative Link, Inc.
1065 South Main, Building C
Las Cruces, NM 88005
Telephone: (505) 527-0636
Fax: (505) 523-4152
E-mail: mg@alternativelink.com

Arthur Grollman, M.D.
Professor
State University of New York at Stoney Brook
BHS T8, 160
Stony Brook, NY 117948651
Telephone: (516) 444-3080
Fax: (516) 444-7641
E-mail: apg@pharm.som.sunysb.edu

Richard Hammerschlag, Ph.D.
Research Director
Oregon College of Oriental Medicine
10525 S.E. Cherry Blossom Drive
Portland, OR 97216
Telephone: (503) 253-3443
Fax: (503) 253-2701
E-mail: rhammerschlag@ocom.edu

Max Heirich, Ph.D.
Professor, Director, and Research Scientist Emeritus
The University of Michigan
1111 East Catherine
Ann Arbor, MI 48109
Telephone: (734) 763-1187
Fax: (734) 763-0913
E-mail: mheirich@umich.edu

Jennifer Jacobs, M.D., M.P.H.
Clinical Assistant Professor
University of Washington
23200 Edmonds Way, Suite A
Edmonds, WA 98026
Telephone: (206) 542-5595
Fax: (206) 771-4789
E-mail: jjacobs@igc.org

Douglas Kamerow, M.D., M.P.H.
Director, Center for Practice & Technology Assessment
Agency for Healthcare Policy and Research
6010 Executive Boulevard, Suite 300
Rockville, MD 20852
Telephone: (301) 594-4026
Fax: (301) 594-4027
E-mail: dkamerow@ahrg.gov

Kathleen King,
Vice President
Washington Business Group on Health
50 F Street N.W., Suite 600
Washington, DC 20010
Telephone: (202) 628-9320
Fax: (202) 628-9244
E-mail: king@wbgh.org

Donald Lindberg, M.D.
Director
National Library of Medicine
8600 Rockville Pike
Bethesda, MD 20894
Telephone: (301) 496-6221
Fax: (301) 496-4450
E-mail: lindberg@nlm.nih.gov

William London, Ed.D.,M.P.H.
President
The National Council Against Health Fraud, Inc.
P.O. Box 141
Fort Lee, NJ 07024
Telephone: (201) 723-2955
E-mail: ncahf@worldnet.att.net

Simeon Margolis, M.D., Ph.D.
Professor of Medicine and Biological Chemistry
Johns Hopkins School of Medicine
Room 336, 1830 Building
Johns Hopkins Hospital
Baltimore, MD 21287
Telephone: (410) 955-1777
Fax: (410) 955-8172
E-mail: smargoli@jhu.edu

Doriane Miller, M.D.
Program Vice President
The Robert Wood Johnson Foundation
Route 1 and College Road East
Princeton, NJ 085432316
Telephone: (609) 627-5772
Fax: (609) 514-5520
E-mail: dmiller@rwjf.org

Nancy Pearson, Ph.D.
Program Officer
National Center for Complementary and Alternative Medicine
6707 Democracy Boulevard, Room 106
Bethesda, MD 20892
Telephone: (301) 594-0519
Fax: (301) 480-3621
E-mail: pearsonn@mail.nih.gov

Russell Phillips, M.D.
Director, Harvard Fellowship Program
Harvard Medicine School
330 Brookline Avenue
Boston, MA 02215
Telephone: (617) 667-5384
Fax: (617) 667-2755
E-mail: rphillip@caregroup.harvard.edu

Bruce Rabin, M.D., Ph.D.
Professor of Pathology
University of Pittsburgh Medical Center
200 Lothrop Street
Pittsburgh, PA 152132582
Telephone: (412) 647-6150
Fax: (412) 647-7741
E-mail: bsr@pitt.edu

Arnold Relman, M.D.
Professor Emeritus of Medicine and of Social Medicine
Harvard Medical School
181 Longwood Avenue, 5th Floor
Boston, MA 021155804
Telephone: (617) 525-2185
Fax: (617) 525-2186

David Riley, M.D.
Editor-in-Chief, Alternative Therapies in Health and Medicine
University of New Mexico Medical School
P.O. Box 4310
Santa Fe, NM 87502
Telephone: (505) 983-0546
Fax: (505) 983-4196
E-mail: dsriley@integrativemed.org

Wayne Sickels, M.T.S.,M.Div
Message Therapist
489 A Carlisle Drive
Herndon, VA 20170
Telephone: (703) 481-6411
Fax: (703) 481-0304
E-mail: tmasters@erols.com

Nathan Stinson, Jr., M.D., Ph.D.
Deputy Assistant Secretary for Minority Health
Office of Minority Health
5515 Security Lane, Suite 1000
Rockville, MD 20852
Telephone: (301) 443-5084
Fax: (301) 594-0767
E-mail: nstinson@osophs.dhhs.gov

John Weeks,
Principal
Integration Strategies for Natural Health Care
3345 59th Avenue S.W.
Seattle, WA 98116
Telephone: (206) 933-7983
Fax: (206) 933-7984
E-mail: pihcp@aol.com

Neal West, Ph.D.
Program Officer
National Center for Complementary and Alternative Medicine
6707 Democracy Boulevard, Room 106
Bethesda, MD 20892
Telephone: (301) 402-5867
Fax: (301) 480-3621
E-mail: westn@mail.nih.gov

B. Alex White, D.D.S., DrPH

Senior Investigator and Assistant Program Director
Kaiser Permanente Center for Health Research
3800 North Interstate Avenue
Portland, OR 972271110
Telephone: (503) 335-6765
Fax: (503) 335-6311
E-mail: alex.white@kpchr.org

Jackie Wootton, M.Ed.
Executive Editor
Journal of Alternative and Complementary Medicine
5411 West Cedar Lane, Suite 205-A
Bethesda, MD 20814
Telephone: (301) 581-0116
Fax: (301) 581-0119
E-mail: jcw@amfoundation.org