

1 lifetime limits on public assistance coverage for low-  
2 income populations and people dependent on public  
3 assistance; a marked decline in charity care by private  
4 physicians and community hospitals, thanks not to  
5 Medicaid managed care but the kind of managed care that  
6 you and I have through our commercial coverage, and the  
7 demand by those managed care providers for significantly  
8 reduced payment rates, which has immediately eliminated  
9 the cost shift that covered what we still like to call  
10 uncompensated care -- it is really cost-shifted care --  
11 and then, the loss of Medicaid revenues as well.

12           Now, with respect to health centers and  
13 complementary and alternative medicine, as I indicated  
14 earlier, health centers serve almost eight million people  
15 of color, and they strive to provide linguistically and  
16 culturally appropriate care.

17           Many health centers -- I ran a health center  
18 down in south Texas 30 years ago -- actually provide  
19 complementary and alternative medicine modalities,  
20 particularly traditional folk healing. My health center  
21 used to make referrals to Curanderos for cases of susto,  
22 literally fright, mal de ojo, evil eye, which our

1 physicians were more than happy to refer to the  
2 Curanderos for because, quite frankly, they didn't have a  
3 modality or treatment that would work for that. We  
4 recognized it. We paid the Curanderos for their  
5 coverage. No other third party payer at that time, 30  
6 years ago, and I think no other third party today,  
7 recognizes Curanderos and provides payment for those  
8 services.

9 Health centers continue to provide it. Native  
10 Hawaiian and Native American health services among many  
11 of the health centers, also, acupuncture and herbal  
12 medicine. In fact, two surveys done just a couple of  
13 years ago found that on average 25 to 50 percent of  
14 health centers offer one or another forms of  
15 complementary and alternative medicine. The most common,  
16 acupuncture, massage, chiropractic, and folk healing.

17 There are obviously barriers to greater use of  
18 CAM by health centers, including the refusal of Medicare,  
19 in most states, Medicaid, and CHIP programs to cover it,  
20 as well as private insurers, and quite frankly, a lack of  
21 awareness and appreciation by health center physicians.

22 We have some recommendations for you, the most

1 important of which is the establishment by the federal  
2 bureau that funds health centers in Integrative Medicine  
3 and Alternative Health Practices, IMAP Initiative, to  
4 track better the use of alternative therapies and  
5 modalities by health centers, and to provide more  
6 information, which we hope to gain in the near future.

7 Obviously, the biggest barrier is the lack of  
8 adequate funding, something that this Commission might  
9 have something to say about, about providers like health  
10 centers. Thank you.

11 **Panel Discussion**

12 DR. GORDON: Great. Thank you. Thank you very  
13 much.

14 While the Commissioners are getting their  
15 questions ready, it looked to me that the Bureau of  
16 Primary Health Care and the community health centers only  
17 provide care to a relatively small fraction of those who  
18 are uninsured.

19 Why is that? What are the limitations there?

20 MR. HAWKINS: The biggest limitation is  
21 funding. The support for the care of the uninsured comes  
22 from four principal sources. First, is the federal

1 grant, which, as I indicated, even at \$1 billion now, the  
2 federal funding for health centers is only about a  
3 quarter of health center operating budgets. They, like  
4 all providers of care to uninsured and underserved  
5 populations, have cobbled together resources from a  
6 variety of locations and payers to support the cost of  
7 care for the uninsured.

8 State and local funding, although it represents  
9 about 18 percent of health center budgets, is actually  
10 growing faster than the federal support. And then, the  
11 patient payments themselves, but the patients, with 86  
12 percent of all health center patients being members of  
13 families with incomes below 200 percent of poverty, have  
14 a very limited ability.

15 Health centers often face the issue of, do we  
16 raise our minimum fee or our sliding charge fees, knowing  
17 full well that even a dollar increase is going to  
18 establish a barrier to some number of people coming in  
19 for care when most importantly they need it for good  
20 preventive care, early primary care. People will, just  
21 as the uninsured do today, react to the barrier by  
22 delaying care until it is more costly and more

1 complicated, more complex conditions.

2 So funding is the single greatest barrier.

3 DR. GORDON: So if you were us and you were  
4 going to recommend funding, and recommend funding that  
5 would include CAM approaches, what kind of recommendation  
6 would you make?

7 MR. HAWKINS: I would look at two ways of doing  
8 it. During the Carter Administration, I worked with  
9 Secretary Joe Callifano, and a guy named Hale Champion,  
10 who was the undersecretary, as they called them in those  
11 days, the deputy secretary at HHS.

12 Hale was a wonder at making sure that you put  
13 things in many different cubicles and cubbyholes so that  
14 it wouldn't all jump out at somebody as being too large.  
15 Creative budgeting. I would use that approach here.

16 First of all, within HHS, on the discretionary  
17 program side, you have any number of programs that serve  
18 identified populations that could benefit from, and very  
19 much need, complementary and alternative medicine  
20 therapies and modalities. You have the Indian Health  
21 Service; you have the Maternal and Child Health Program;  
22 you have the Ryan White AIDS Program; you have health

1 centers; you have the National Health Service Corps,  
2 which is an important program that provides support in  
3 the form of scholarships or loan repayment to health  
4 professionals in return for obligated service in  
5 underserved communities. Many of those National Health  
6 Service Corps assignees serve at health centers.

7 Today, NHSE assignees are pretty much limited  
8 to physicians, nurse practitioners, physician assistants,  
9 nurse midwives, dentists, hygienists, very little in the  
10 way of CAM therapists. That might be something that you  
11 could identify as well.

12 You have many centers for disease control, CDC  
13 programs, and even NIH, which on its way doubling to the  
14 tune of about \$23 billion this year, provides some form  
15 of care for clinical trials and other activities.

16 Each of these discretionary accounts could be a  
17 target for increased funding, and within that increase  
18 then, some identified priority. I hate earmarks, but  
19 some priority or incentive to utilize some of that  
20 increase to establish or enhance the use of complementary  
21 and alternative medicine.

22 I know if you asked health centers tomorrow to

1 make greater use of complementary and alternative  
2 medicine, the response would be, what, you want us to  
3 throw uninsured people out in the street, to turn this  
4 money over to provide more CAM therapies to a smaller  
5 group? The battle always is, do you a lot for a few  
6 people, or a little bit for many. Health centers  
7 struggle with that. Every health center in this country,  
8 all 4,000 communities served, every day.

9 But there is a second thing I would recommend,  
10 and I think you have touched upon it earlier today, and  
11 that is third party payment. As I indicated today,  
12 Medicaid is the single largest source of revenues for  
13 health centers, and yet there are at least 1.5 million  
14 children, children, low-income, being served by health  
15 centers today who are uninsured. Unconscionable, in my  
16 book. It is an indictment of health centers as much as  
17 of the system that supposedly is out there to enroll them  
18 and cover them.

19 Every one of those kids is eligible for  
20 Medicaid. We fought like heck with many state Medicaid  
21 agencies to get out-station eligibility workers,  
22 enrollment workers, at health center sites to eliminate

1 the barrier of having to travel. Most states still do  
2 Medicaid eligibility through their welfare office, and  
3 many people will not do that. They won't go there. They  
4 are either afraid or they feel treated with no dignity  
5 whatsoever.

6 We need to try to get more kids covered, but  
7 then, those programs need to extend the coverage that  
8 they provide to include complementary and alternative  
9 medicine therapies.

10 Now, I understand you heard from a HCFA source  
11 this morning, much more knowledgeable than I about what  
12 states do or don't do under Medicaid, what they do or  
13 don't do under the Child Health Insurance Program. This  
14 Commission could strongly recommend that all states under  
15 Medicaid and CHIP ought to provide coverage for  
16 appropriate and recognized, and you can best determine  
17 what that mechanism and methodology is for doing that.

18 These programs which are the major insurer of  
19 record for low-income people in communities, for  
20 communities of color, for immigrant populations in this  
21 country -- I listened to the question about what  
22 populations use complementary and alternative medicine to

1 the gentleman from Blue Cross Blue Shield of South  
2 Carolina this afternoon with interest.

3 I am not surprised, because, as he indicated,  
4 among low-income populations and people of color, the  
5 major coverage source is going to be public. It is going  
6 to be Medicaid, CHIP, and Medicare. Those programs are  
7 subject to public policy edicts. That is where the  
8 coverage extension ought to be pushed most forcefully.

9 DR. GORDON: Thank you.

10 Dr. Miller or Dr. Stinson, do you have any  
11 additional thoughts about these issues of how we would  
12 move this agenda ahead?

13 DR. MILLER: I agree with the comments that Mr.  
14 Hawkins made regarding promoting coverage through public  
15 policy, particularly through Medicare/Medicaid, and also  
16 the SCHIP programs.

17 I must say that there needs to be a linkage  
18 between performance measurement and evidence with the  
19 expansion of coverage in the same way that through  
20 Medicaid and HCFA and some of the peer review  
21 organizations that there are standards of measurement for  
22 treatment of diabetes and congestive heart failure, in

1 terms of best practices that will help to promote the  
2 increased use of complementary and alternative medicine.

3 DR. STINSON: I would also like to agree with  
4 the two previous comments, and also to add that one of  
5 the things that our office is doing in the Department is  
6 tying in the importance of cultural competency, as far as  
7 the delivery of quality health care. We, over this next  
8 year, are actually going to be starting some new policy  
9 initiatives that are going to look at what changes in the  
10 health care system are going to be necessary to really  
11 implement a way of dealing with diverse populations in a  
12 way that guarantees the quality outcome.

13 I think that in addition to, certainly, looking  
14 for opportunities to build in that funding support, we  
15 are going to help build up the scientific base to show  
16 why it is important to pay for it, because it is  
17 something that improves health as a whole.

18 DR. GORDON: Thank you.

19 Charlotte.

20 SISTER KERR: My statement isn't related to a  
21 particular group, but specifically here, I am thinking  
22 many of us feel that self-care is primary care. I am

1 wondering, with CAM practices, for example, therapeutic  
2 touch, reflexology, mind-body work, group prayer, where  
3 are we with doing that? What is your sense about  
4 creating your practitioners locally? What has been done?  
5 I want to know what you think about it.

6 DR. MILLER: I'll be brave. I can talk to you  
7 about it from the perspective of not just my position at  
8 the Foundation but someone who has spent more than 10  
9 years in clinical practice at community health centers,  
10 and I continue to practice a half day a week at a  
11 federally qualified health center.

12 The urgency of problems that come up on a day-  
13 to-day basis in the number of patients that need to be  
14 seen presents significant barriers to the practice of CAM  
15 for those physicians who are interested in the services.

16 When I was in practice at a federally qualified  
17 health center in San Francisco, we set up not necessarily  
18 an integrative practice but a parallel practice with the  
19 American College of Traditional Chinese Medicine in order  
20 to provide services and attention to the patients who  
21 were interested in receiving those services. About 15  
22 percent of my practice was HIV and AIDS at that point.

1           Our practitioners wish that they had had more  
2 of an opportunity to have a true integrative practice  
3 with the Chinese Medicine physicians, and unfortunately,  
4 because of time constraints and pressures of the  
5 practice, that was not possible.

6           There is interest, but I think that, given the  
7 current practice structure that exists within medicine,  
8 the barriers are significant. Many providers end up  
9 taking CME courses or setting up parallel practices in a  
10 way that they are able to satisfy the needs of their  
11 patients in other settings, but as I said, the barriers  
12 are certainly challenging.

13           SISTER KERR: I just want to clarify my  
14 statement. It had more to do with the patients being the  
15 practitioners. When I ran a diabetes clinic, I was  
16 adjusting heroin and insulin, like many of us have had to  
17 do. As I have moved into other areas of healing, I  
18 realize that we could be bartering the practices, the  
19 moms doing therapeutic touch on the babes, and the foot  
20 reflexology.

21           I don't see any of us doing it at any  
22 socioeconomic level yet, but I am curious since sometimes

1 the poor people know a lot more about healing than other  
2 folk.

3 DR. MILLER: I would agree with you on that,  
4 Commissioner. I think that, oftentimes, in order to have  
5 that shared type of practice, it is a question of people  
6 going and seeking the information. Also, if it happens  
7 in conjunction in a medical practice, it is a question of  
8 time.

9 Before we set up the Chinese medicine practice  
10 within our health center, we surveyed our patients. As I  
11 said, 70 percent were uninsured. The balance of our  
12 funds were a disproportionate share of funds, Medicaid  
13 and Medicare, very little private third party payment.

14 Almost half of our patients in this low-income,  
15 inner city clinic were going out and seeking CAM services  
16 on their own. Usually, acupuncture, massage therapy,  
17 spiritual healers, and mind-body work.

18 DR. GORDON: Joe.

19 DR. PIZZORNO: A question for Mr. Hawkins.

20 I was surprised that in your testimony you did  
21 not mention the King County Natural Medicine Clinic, and  
22 I was wondering if you were aware of it.

1 MR. HAWKINS: Which clinic is this?

2 DR. PIZZORNO: The King County Natural Medicine  
3 Clinic.

4 MR. HAWKINS: King County --

5 DR. PIZZORNO: Washington State.

6 MR. HAWKINS: Oh. I am going to be up there  
7 fairly soon. As a matter of fact, there are several  
8 locations. I didn't identify them. Waianae Coast Health  
9 Center in Hawaii has a whole separate facility with  
10 Native Hawaiian medicine.

11 I have heard of King County as part of the King  
12 County Community Health Centers, Tom Trumpeter's outfit.  
13 Yes, he has talked to me about that. That is one  
14 important point. Data is fairly scarce. It has been to  
15 date. The two studies that I mentioned, or surveys, that  
16 were done, were good surveys, but they were done four  
17 years ago, and they were spot surveys of individuals at a  
18 couple of different conferences.

19 I am pleased to report, though, that as part of  
20 the IMAP Initiative at the Bureau of Primary Health Care,  
21 beginning this year, data will be collected on exactly  
22 how many health centers and at how many of their

1 locations offer many of the various CAM modalities by  
2 type. So we should be able to be back here a year from  
3 now, and be able to tell you exactly by state and across  
4 the country how many health centers offer each of the  
5 different modalities.

6 DR. PIZZORNO: I think the key element  
7 important, when you go to visit, to take a look at, is  
8 that it is a fully integrated care clinic. They don't  
9 have separation of CAM here and conventional medicine  
10 here. They actually work much more collaboratively  
11 together, and there has been tremendous patient  
12 satisfaction. They are now replicating this throughout  
13 the rest of the nine clinics in their system.

14 MR. HAWKINS: Wonderful.

15 DR. GORDON: Tom, and then George.

16 MR. CHAPPELL: Daniel Hawkins, I just would be  
17 interested in knowing more how these clinics are funded,  
18 originally, and then sustained. I see it is a  
19 public/private partnership, but could you be more  
20 explicit about, for instance, what funds are coming from  
21 the government, if any.

22 MR. HAWKINS: Right now, health centers in

1 somewhat of a growth mode, having been targeted by the  
2 President and by a majority in Congress to double in size  
3 over the next five years in order to serve twice as many  
4 people in order to meet more of the need, especially  
5 among uninsured and underserved Americans.

6 Right now, this year, at least 100 new health  
7 centers will be funded for the first time in communities  
8 that today do not have a health center in their community  
9 or within reach. The typical process is one in which a  
10 community organization or a facility that is already  
11 providing care, perhaps a health department or a  
12 hospital-affiliated facility or a community clinic that  
13 is already up and running but has limited resources,  
14 relies on volunteers, et cetera, meets the requirements  
15 and applies for funding to be a community health center.

16 That is a process in which one has to meet two  
17 sets of factors. One is the need criteria. You have to  
18 serve an area or a population that is designated or can  
19 be designated on the numbers as medically underserved.  
20 There is a whole process one goes through for that.

21 Then secondly, you have to submit an  
22 application that provides sufficient detail, and also go

1 through a site visit, to satisfy folks that you, in terms  
2 of general operation, financial management, clinical  
3 management and quality of care, and community involvement  
4 in the policy making, convinces federal officials that  
5 this is a good investment.

6 Federal investment begins with an operating  
7 grant of 5- or \$600 million, unless it is a very small  
8 community where services are to be developed. That grant  
9 provides a foundation.

10 It is, oftentimes, what you don't see. What  
11 you see is everything above ground. This is the below-  
12 ground foundation, the basement, if you will. Once the  
13 health center opens its doors, it has to have an open-  
14 door policy. Within the limits of its capacity, it must  
15 accept within the door whomever walks in, regardless of  
16 whether they do or do not have coverage, whether they can  
17 or cannot pay for services.

18 Typically, the word gets out very fast among  
19 the low-income community, especially those who are  
20 uninsured, that the new health center is open. And so, a  
21 majority of those who do come in the door, particularly  
22 once it is up and running, tend to be uninsured or

1 underinsured.

2 But then, the health center must, must,  
3 identify and bill and attempt to collect for any third  
4 party payer, for anyone who has third party coverage.  
5 They can't just fall back on the grant to cover the cost  
6 of care for those who do have coverage, and they cannot  
7 turn away someone who does have coverage, to say, no, no,  
8 no; we are only a clinic for the uninsured.

9 The whole point is, once their door is open,  
10 they really have to be an open-door health center  
11 program, not discriminating against people who wish to  
12 get their care there.

13 MR. CHAPPELL: [Off mike.]

14 MR. HAWKINS: Absolutely. I would be happy to  
15 get to the Commission a pie chart that shows where  
16 revenues come from.

17 MR. CHAPPELL: I would like that.

18 MR. HAWKINS: Seven percent of a typical house  
19 owner's budget is patient payments. As I mentioned, 18  
20 percent is state and local support, from state and local  
21 governments.

22 MR. CHAPPELL: But it is all initiated with a

1 federal grant.

2 MR. HAWKINS: That is what really starts the  
3 ball rolling.

4 MR. CHAPPELL: Thank you.

5 DR. GORDON: I have a sense that we want to be  
6 talking with you more afterwards in more detail about  
7 some of these proposals.

8 We only have time for one more question now.  
9 George.

10 DR. BERNIER: I actually have a question for  
11 Dr. Stinson.

12 And that is, from what you said about the  
13 Office of Minority Health, that a diminution in the  
14 utilization of CAM-related activities is a bell weather  
15 that says that that decrease in the number will reflect  
16 the decrease in any kind of overall health care.

17 I don't know if I am making that clear, but it  
18 seems to me that the utilization of CAM products is, in  
19 some ways, proportional to the affluence of the  
20 population that is using it.

21 Contrary-wise, as people are decreasing the  
22 level of CAM activities, it is a reflection of decreased

1 access to other kinds of health care as well.

2 DR. STINSON: I'm not sure. Could you repeat  
3 your question again, because I'm not clear.

4 DR. BERNIER: I think you said that nationally  
5 there was, among minority groups who were underserved, a  
6 relatively low amount of CAM activities in their health  
7 care program.

8 Is that correct?

9 DR. STINSON: Well, I think what I said, or  
10 what I intended to say -- let me put it to you that way  
11 -- that if you look at several different studies, some  
12 will show that, and some will show other things,  
13 depending on what specific modality you may be looking  
14 at.

15 DR. BERNIER: So that, the extrapolation that I  
16 just made would not necessarily be a valid one.

17 DR. STINSON: I think that the statement is too  
18 general, at least from my own perspective. We have  
19 resisted in getting into discussions with interested  
20 parties about, is it high here, or low here, or high in  
21 this population, low in this population, because as you  
22 go through and look through the literature, the

1 literature is as diverse in its conclusions as the  
2 populations we deal with.

3           What we have tried to focus on instead is the  
4 fact that the use of complementary and alternative  
5 medicine modalities is something that plays a very  
6 prominent role in health care delivery in this nation,  
7 and it is important and incumbent upon the health care  
8 system to recognize that and work with that, and  
9 understand the role that it does play in making decisions  
10 that lead to the ultimate improvement in health of  
11 whatever population we are dealing with.

12           DR. BERNIER: Thank you.

13           DR. GORDON: I just want to add one thing,  
14 George, that may help clarify it. I have worked, over  
15 the last 10 years, with HIV-positive ex-addicts and  
16 current addicts in New York City, with over 5,000 now.

17           Where CAM services are available, they will use  
18 them. There are tremendous barriers. There are economic  
19 barriers, there are the primary, but what we have  
20 observed is, the people who have never heard of CAM at  
21 all and may have had no previous interest, once they are  
22 exposed and once they experience, and this speaks to some

1 of what Charlotte was talking about, once they have  
2 experiences with self-care, whether through mind-body  
3 techniques or through physical exercise or through  
4 acupressure, they get it and they are very eager to use  
5 those therapies.

6 I think that some of the disparity in the  
7 research has to do with different kinds of populations,  
8 but also, that in some areas, for example, rural areas,  
9 there is very, very little access at all. I think it is  
10 a sort of chicken or egg question in many instances.

11 I want to thank you all very much, and we look  
12 forward to continuing the discussion individually with  
13 you. We are going to breaking up into small groups now.  
14 Again, thanks so much for your very helpful testimony.

15 DR. STINSON: You are welcome.

16 DR. MILLER: You are welcome.

17 [Applause.]

18 DR. GORDON: If Commissioners could just sit  
19 for a moment. Steve is going to tell us about the  
20 procedure for this next period of time.

21 DR. GROFT: We are now going to enter into a  
22 breakout session to discuss access and delivery of CAM

1 practices and products. So Group IA, if you have your  
2 list, Julia Scott will be the chair, and Corinne Axelrod  
3 will be the staff person who will work with the group  
4 there. They will meet right here in this main conference  
5 room.

6 Group IB will go upstairs to the Balcony  
7 Conference Room E, and that will be chaired by Tom  
8 Chappell and Gerry Pollen. Gerry is sitting over there.  
9 She will be the staff person.

10 Again, members of the audience who would like  
11 to attend either session, Group IA will be Access and  
12 Barriers to CAM Practices and Products, and Group IB will  
13 be Delivery of CAM Practices and Products. So you can  
14 break yourself out however you would like.

15 Again, there will be no public participation in  
16 either of these two breakout sessions. We have about an  
17 hour to formulate recommendations on these issues, and  
18 the information has already been provided to the  
19 Commission members from the December meeting and a  
20 synthesis of other recommendations that came in from the  
21 various Town Hall meetings and other meetings that we  
22 held as a commission.

1           So if you have written comments, or any  
2 comments or suggestions, please present them just to the  
3 staff members who are present, and then we will take  
4 those back and provide them to the Commissioners at a  
5 later date.

6           DR. GORDON: We will reassemble back here  
7 promptly at 5:20, and each of the breakout groups will  
8 present its recommendations.

9           So Julia and Tom, you and your staff person who  
10 is working with you will be in charge of giving us some  
11 recommendations.

12           We will see you then. Thank you, everybody.

13           [Breakout session.]

14           DR. GORDON: Julia, do you want to go first?

15           **Group IA: Access and Barriers to CAM**

16           **Practices and Products**

17           MS. SCOTT: Well, we weren't as disciplined to  
18 actually write down our remarks, but we had a lot of  
19 discipline in the room in terms of keeping on the mark  
20 and getting back here on time.

21           DR. GORDON: Yes. Noted.

22           MS. SCOTT: Clearly, 50 minutes is not enough

1 to do justice to this, but it is the first broad-brush  
2 recommendations. So in that spirit, we will offer you  
3 what Group IA came up with, and this was a group effort.

4 Recommendations related to access.

5 Recommendation Number one, we recommend that all health  
6 professionals, not just medical doctors, but CAM  
7 professionals as well, be trained in how to interrelate  
8 to each other, and in collaboration skills.

9 Number two, we recommend that there be  
10 established a public information campaign on CAM  
11 therapies, modalities, and philosophy for practicing  
12 physicians, academic research scientists, and the general  
13 public.

14 Three, we recommend that a federal office be  
15 established to oversee regulation and standardization for  
16 natural products.

17 The remaining ones, we really like we didn't  
18 have enough time to do justice to them, but we thought it  
19 was important to just get them up on the piece of paper.

20 DR. GORDON: Absolutely.

21 MS. SCOTT: And we will go back and be more  
22 detailed about that. One was in the area of the special

1 populations, because clearly, there are specific  
2 recommendations for each of the populations.

3 I think, in our group, there was a general  
4 feeling that we shouldn't have too different classes,  
5 those that can afford and those that can't, but that is  
6 the reality right now in terms of these services not  
7 being provided, wholesale, by reimbursement. So we felt  
8 that there needs to be a recommendation on special  
9 populations and their access to CAM modalities and  
10 therapies that are not disparate, but as I said, we  
11 didn't have time to talk about each one of those  
12 communities.

13 The next recommendation is related to that  
14 thinking, as Dr. Stinson was reminding us how healthy  
15 2010 --

16 DR. GORDON: Healthy People 2010, yes.

17 MS. SCOTT: -- Healthy People 2010, the push  
18 has been not to have different recommendations for  
19 different populations, but to have general  
20 recommendations for the whole area, say, for diabetes.  
21 So that, we want to encourage an integrative model of CAM  
22 and allopathic therapies to address health disparities.

1           Then finally, one other recommendation. We  
2 felt it very important that we have a recommendation  
3 related to safety, related to consumer access and safety.  
4 We didn't have enough time to work out the words, but we  
5 are very interested in a recommendation that would look  
6 at allowing use of medical treatment that has been in use  
7 in other countries for which that country's regulatory,  
8 or equivalent body, have found to be safe.

9           We understand there is a lot of disparity  
10 there. We know that some of these therapies may have  
11 been used for years, but may not be safe. So we have to  
12 go back to this recommendation and be a little more  
13 specific about the kinds of data we would look at from  
14 other countries.

15           DR. GORDON: Terrific. Thank you, Julia.

16           Anybody else from that group want to add  
17 anything?

18           [No response.]

19           DR. GORDON: That basically sums it up, then?

20           [No response.]

21           DR. GORDON: Good. This is great. This  
22 doesn't have to be precise now. We are going to be

1 filling these in, working on them, and then presenting  
2 them to everybody. Then we will all have those two full  
3 days to go over and refine them. So this is great for  
4 general outlines.

5 Tom.

6 **Group IB: Delivery of CAM Practices and Products**

7 MR. CHAPPELL: We seemed to have consensus on  
8 almost everything. There was just one issue we didn't  
9 resolve, but specifically asking, how can we improve CAM  
10 services, and to the theme of, should we integrate or  
11 keep separate, our recommendation is that we offer the  
12 CAM professions a choice of whether they want to  
13 integrate or to maintain a separate professional, free-  
14 standing service, that the marketplace will work that  
15 out.

16 Secondly, if the professional chooses to  
17 integrate with other physicians and services, the CAM  
18 professional will need to use the standards of practice  
19 in credentialing and licensing, and to provide experience  
20 data on safety and efficacy. Much of what we have heard,  
21 throughout, is the state credentialing, licensing, the  
22 professional standards of practice that each group has,

1 we are affirming the reports of that as a principle.

2 In addition, get is much experience data, as is  
3 available, experience on safety and efficacy. We were  
4 saying that in order to integrate CAM, the burden is to  
5 demonstrate as much experience data as possible on  
6 efficacy or safety.

7 Again, continuing this theme of integration, we  
8 want to help facilitate more funding and support for  
9 better and more research in CAM services, research on  
10 both safety and efficacy.

11 In that spirit, we are recommending  
12 collaboration wherever possible or desirable among  
13 physicians and CAM practitioners. There has been a lot  
14 said throughout the process, that collaboration helps  
15 everybody get down to the details and understand and  
16 respect and gain a greater appreciation for the mutual  
17 services.

18 Last, on this integrate versus separate, we  
19 encourage loan forgiveness programs that promote CAM  
20 services, that they pursue those services in areas of  
21 special need.

22 DR. GORDON: I just want to ask a quick

1 question.

2 MR. CHAPPELL: Sure.

3 DR. GORDON: Did you cover the issues of  
4 whether or not your group felt we should try to establish  
5 any national standards? Or, were you just focused on the  
6 standards that the different professions were  
7 establishing?

8 MR. CHAPPELL: We handled that under the  
9 products section, and I think the group would probably  
10 feel the same would apply to the services section, but I  
11 can check it out with the group when we get there.

12 DR. GORDON: The only reason I raise it, is  
13 because I know this is an issue that we need to be  
14 thinking about in many different ways and many different  
15 times. So I was just wondering if there was any  
16 preliminary thinking about it.

17 MR. CHAPPELL: Well, just to segue to that  
18 point while we are on it, one of the things we thought  
19 about in improving CAM products would be to -- where is  
20 that point? Oh, under modeling?

21 I don't think it is under products after all.

22 It is not under products. It is under education.

1 DR. GORDON: Okay. Come back to it later.

2 That's okay. I'm sorry.

3 MR. CHAPPELL: What was the question?

4 [Laughter.]

5 DR. GORDON: What is the answer?

6 [Laughter.]

7 DR. GORDON: It was about national standards.

8 MR. CHAPPELL: The models. We thought we  
9 learned a lot from models on CAM services, and we are  
10 recommending that state boards do more to protect solo  
11 practitioners who may choose to focus on CAM practices  
12 exclusively, or those that choose to add CAM practices to  
13 their existing. So there is some protection from state  
14 boards being sought here as they try to expand their  
15 services, or focus their services, around CAM.

16 Again, on the models. To increase federal  
17 funding for models like the King County Community Health  
18 Clinic, as well as some of the community concepts we  
19 heard this afternoon, but we focused on the King County  
20 clinic because it had so much of the collaboration,  
21 community partnership, community management, and  
22 integration of Western and CAM modalities.

1           Again, on models. Wherever these community  
2 models are involved, to provide tax incentives to  
3 encourage their community development all the more.

4           The third model that we talked about was  
5 partnering, to create a partnering concept where we bring  
6 CAM services to the uninsured, and that the partnership  
7 would consist of the university, the CAM providers, the  
8 physicians, the health plan providers, like those that  
9 were here today, and to wrap that, perhaps, in a  
10 community health clinic or not.

11           But again, it is the idea of partnering for  
12 learning. This is mentioned specifically for the  
13 research in improving the health of the uninsured.

14           We want to encourage Congress to include CAM  
15 benefits language in Medicare. Similarly, with states,  
16 on Medicaid, and to bring, wherever possible, the  
17 evidence of efficacy.

18           Now I get to education. We are recommending  
19 that self-care wellness education be introduced into our  
20 schools at the high school level, and be maintained in a  
21 continuous curriculum throughout the educational program.

22           Secondly, to create or build upon NCCAM to

1 provide information about different wellness modalities,  
2 their theories and practices, and to create an  
3 educational body of material.

4 The only piece that we didn't have enough time  
5 to resolve was the integration model, where you have a  
6 private hospital, a university, and trying to integrate  
7 CAM and physicians in those various models that we were  
8 part of the hearings. We were unable to resolve whether  
9 that was an idea worth continuing or not.

10 DR. GORDON: I'm sorry, resolve what, though?

11 MR. CHAPPELL: Whether we would help with  
12 policy recommendations that would promote the  
13 continuation or development of that particular model.

14 DR. GORDON: What were the discussions on  
15 either side of the issue?

16 MR. CHAPPELL: On the positive, it was seen as  
17 very healthy to include the university system in the  
18 community. On the negative, the question was whether we  
19 could break through the professional dogma into a true  
20 working partnership.

21 DR. GORDON: So it was considered a good idea,  
22 but whether or not it was feasible was the question. Is

1     that right?

2                 MR. CHAPPELL: Yes. So it is left with the  
3     need for more discussion as to whether we would recommend  
4     that.

5                 DR. GORDON: Great.

6                 MR. CHAPPELL: Products, oh yes. CAM products  
7     need to be accompanied by a responsible, truthful  
8     information about safety and efficacy.

9                 Secondly, to have the government fund research  
10    on the top 20 most popular herbs, that is, for their  
11    safety, and then more in-depth research for their  
12    efficacy.

13                DR. GORDON: Can you say a little bit about  
14    where that is coming from.

15                MR. CHAPPELL: As to why they are separated,  
16    safety and efficacy?

17                DR. GORDON: No. Where that recommendation  
18    came from.

19                MR. CHAPPELL: Let's see.

20                DR. GORDON: I mean, for several reasons.  
21    Since we weren't talking about research, but also,  
22    clearly, there is some --

1 DR. LOW DOG: We were talking about delivery of  
2 them, and part of delivery is also safety, because that  
3 is the issue that keeps coming up, is that people's  
4 access to these things actually may be removed if DSHEA  
5 is overturned. Part of the big reason for that is  
6 because of a few products on the market that are causing  
7 a lot of problems for the whole field.

8 So what we were talking about was that 80  
9 percent of sales are made up of only 20 herbs. If those  
10 could be studied, instead of more obscure herbs, those  
11 could be studied for toxicology, genotoxicity,  
12 mutagenicity, carcinogenicity, these types of things,  
13 p450, drug interactions, if that could be funded while we  
14 are doing efficacy, because people are already using  
15 these, it might go a long way to protecting people's  
16 rights and access to these products.

17 MR. CHAPPELL: And the concern is that because  
18 these are being consumed by the public and they are not  
19 patentable and don't encourage private research, then we  
20 feel the government needs to do the research for public  
21 safety, on both safety and efficacy.

22 DR. GORDON: Terrific. This is all very good.

1 One of the things that is so interesting, of course, in  
2 looking at these, is seeing how interrelated everything  
3 is to everything else. So we may be talking about access  
4 or services, and we are also talking about education and  
5 public information and research at the same time, because  
6 they are all connected. Terrific.

7 Any other comments?

8 DR. CHOW: I have a question. Can we get the  
9 list of 20 herbs?

10 DR. LOW DOG: Sure.

11 DR. CHOW: You say 80 percent of the people use  
12 only 80 --

13 DR. LOW DOG: Eighty percent of sales.

14 DR. CHOW: I would really love to get that.

15 DR. LOW DOG: You got it.

16 DR. CHOW: Just what you were saying, Jim, is  
17 that we found we kept coming back to finances, even  
18 though we weren't talking about that today; access. We  
19 kept coming back to reimbursement and finance. So it is  
20 all interrelated.

21 DR. GORDON: These are great and these will  
22 definitely focus our attention. One thing, also, that

1 jumped out at me about that last recommendation is it is  
2 imaginative. It is taking a little piece, and using the  
3 piece to open up the whole field.

4 So it just occurs to me that one of the things  
5 we need to think about is that we can come at this in  
6 many different ways. We can come at these issues in many  
7 different ways, and I think that is an interesting way of  
8 coming at something indirectly, but that may be very  
9 powerful and may be relatively easy to do. So thank you  
10 all.

11 Any final comments or questions?

12 [No response.]

13 DR. GORDON: It is getting very late. This was  
14 very helpful. What we are going to do with all the  
15 recommendations we get, is, we are going to pull them all  
16 together, we are going to synthesize them, we are going  
17 to give them back to everybody.

18 Probably, as we synthesize them and pull them  
19 together, we will give them back in a form that will be  
20 based on this form but that will include several  
21 recommendations that we will the discuss further, and  
22 that will provide the basis for what we are going to be

1 talking about at the July 2nd and 3rd meeting.

2 Is that reasonably clear, that this is like yet  
3 another round? Each time we do this, we are getting  
4 closer to major areas of agreement.

5 Okay, thank you everybody for your long day of  
6 work. We are starting tomorrow at 4:00 in the morning.

7 [Laughter.]

8 DR. GORDON: We are starting at 8:00 tomorrow.

9 Thank you.

10 [Meeting recessed at 5:55 p.m., to reconvene  
11 Tuesday, May 15, 2001, at 8:00 a.m.]

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