qualified CAM practitioners, as well as allopathic clinicians, consumers, and payers of health care, as appropriate, so that it all just reads as one.

DR. FINS: Okay.

DR. ORNISH: It is not entirely clear to me, as the conversation is evolving, what constitutes a profession. I mean, let's say we have the Jim Gordon method, and Jim Gordon says, I have a new system of healing --

DR. GORDON: I am glad you are using that as an example, Dean. It is an important one.

[Laughter.]

DR. ORNISH: I am trying to curry favor with the Chair, actually. It is not working, though.

Seriously, though, say I have got my own profession. I have this new, wonderful system of healing. I am going to police myself. I am going to set up a board of other people that I have trained to monitor and police it.

I think we need to make it really clear, particularly if we are evolving toward the direction of professions having their own self-regulating boards, who

defines what a profession is.

DR. WARREN: But your comment, it is pretty much like the medical and dental boards are right now. A bunch of good old boys get together and they assign their peers, their like minds, to be the regulatory, self-policing.

DR. ORNISH: So, does that mean that Jim should be able to set up his own board and do the Jim Gordon method, or the James Gordon method, as the case may be?

DR. WARREN: I guess if Jim got enough Jims out there, yes, he could set up his own board.

DR. FINS: I can't find my version of this, but it is in Access and Delivery. We actually have a taxonomy that we spent a lot of time working on, which helps to flesh out that question about whether or not you are a profession, or an emerging profession, or whether you are ever going to be a profession. It looks like it is pages 2 and 3, under Table 1.

MS. CHANG: When you all were sent your separate cover, it had a cover letter, and then at the back of that discussion there was Access and Delivery. Then there were the background reading materials, the Pew

Report, and then the medical school piece. Then there followed an overview of CAM practitioners.

DR. ORNISH: That all assumes that you have already defined what a profession is, though.

DR. FINS: Jim, I think it might be worth going through this just briefly.

DR. GORDON: Incidentally, I want to just check. George, you have to decide now whether you are going to need the full two hours.

MR. DEVRIES: What are you offering?

[Laughter.]

DR. GORDON: I am not planning to take it away. Rumor has it that you were saying you might not need it, and if you don't, I would like to know. We have time now, but we are clearly going to look at some background material.

MR. DEVRIES: I understand.

DR. GORDON: I want to know if you feel you can give up some of your time?

MR. DEVRIES: Why don't we go, say, 90 minutes. Let's give 30 minutes. These are obviously important issues, and I think we can do it in 90 minutes.

DR. GORDON: That is all you had, anyway. You had 90 and I had 30, and I was going to give you some of mine.

MR. DEVRIES: Okay.

MS. LARSON: We don't need to borrow time. We are fine.

DR. FINS: This clarification will help our friends in Coverage and Reimbursement, because it is related. It is a related kind of issue.

MR. DEVRIES: So, why don't we cut ours from two hours to an hour and a half, and then you and I will split the hour and a half.

DR. GORDON: All right. Let's cut it to an hour and 40 for now, and then let's see where we go from there.

MR. DEVRIES: Okay.

DR. FINS: This is certainly open to your commentary, but let's just go through this.

Dean, again, we are just trying to draw the boundaries.

On Table 1, No. 1 is: "The most evolved category of professional status is comprised of providers

with an established, well-articulated and cohesive healing philosophy, defined practice standards, and accredited education, state licensing, documented safety, and at least some research substantiation of effective outcomes.

DR. PIZZORNO: Joe, could you hold for a second until people can find this document?

MS. LARSON: It is the last before Coverage and Reimbursement, the last two pages.

DR. GORDON: Is this Table 4?

DR. FINS: No, Table 1.

DR. GORDON: Table 1. This is the one that says "Taxonomy of CAM Professional Readiness."

DR. FINS: Right. Maybe before I start there, I will just refer you to the definition of "professional" in the italics above, from the dictionary. It is defined as "One who adheres to technical and ethical standards of a given profession. Both imply standards for education and training, as well as a code of ethical practice."

What we sought to do was to set up four categories. That first category, I will just continue: "These holistic MDs may best fit into this category," as

an example, "although they may continue to identify themselves primarily as conventionally trained clinicians, practicing 'collaborative' or 'integrative' medicine."

The second category: "The most dynamic category of professional evolution is comprised of those groups of lay and inconsistently trained practitioners who are working to establish standards.

"It is important to note that many of the modalities or disciplines included in this category may have rich historical traditions that, in other countries, may be well-established as a healing practice, while, in this country, may still be considered innovative."

The third group are: "Self-proclaimed" --

DR. GORDON: Do you have an example or two of that, Joe, just to illustrate it?

MS. CHANG: Joe, lay homeopaths was one example that you had provided, I think, under this second category.

DR. FINS: The third group is: "Self-proclaimed or minimally educated healers who practice without apparent standards or community oversight, comprise the

currently least dynamic category of professional readiness. These practitioners may use titles associated with more evolved CAM professions, but do not adhere to educational training or other practice standards established by those professions."

Then the fourth are: "Two types of practitioners that lie outside of this evolutionary paradigm, and these are, (1) conventionally trained providers who utilize therapies and practices that are highly controversial or excluded from conventional standards of care, and usually do not identify with a specific CAM profession but may ascribe to certain empirical philosophies that tend to characterize CAM rather than allopathic approaches.

"Most often individual practitioners, they are unlikely to organize as a profession, so they are sort of Lone Rangers, and focus their efforts on the development of their particular and unique technology or approach."

A related group outside of the evolutionary paradigm are traditional healers who practice within a community that provide centuries-old traditions and oversight, such as Native American healers, shamans,

Curanderos.

They also do not identify with a specific CAM profession, and often relate only to their cultural origins in an organizational sense, with little interest in recognition outside of their own communities. These practitioners are also unlikely to evolve along organizational lines, which has relevance to what we were just talking about in the last session.

So, we are saying here this is not a recommendation, this is not necessarily something we have to vote on, but we wanted to try to flesh out a kind of a risk stratification that would be valuable to the states.

Ti?

DR. LOW DOG: I guess my only thing would be on Table 1. I don't think we should put holistic MDs as our example there. I think that there are examples of CAM professions that represent that, that have a cohesive healing philosophy, practice standards, accredited education, state licensing -- I think chiropractors may be a good example of that; registered dieticians are another -- that we continually sort of leave out of this dialogue, but we did include nutritional therapy.

So I think that there are some that might be better than putting sort of holistic MDs in our CAM document, or put it in addition.

MS. CHANG: Actually, we had examples under each of these categories and then decided that trying to be consistent about not identifying a singular profession, we took them out.

The holistic MD -- and, Joe Pizzorno, jump in any moment here -- we had a real difficulty where to place them, because they are not CAM professionals in that sense, they are truly a mix of the two, but we didn't want to create yet a third outside the paradigm.

DR. LOW DOG: I understand what you are saying, but when you read it, it sounds like they are the most evolved, the holistic MD. It doesn't read quite right to me, though I understand what you are saying. If you are going to give an example, I think you are going to have to give several.

MS. CHANG: And it should be an additional, almost a sub-component to this category, not as an example, classic example.

DR. FINS: As a group, do you all think is it

better to have examples, or is it going to be more offensive if we have examples?

Dean.

DR. ORNISH: Well, I am just confused. Putting aside the examples, which, to me, are less relevant right now, how does this taxonomy tie in? At what level are you suggesting that someone be able to develop their own self-regulating boards, as opposed to coming under the auspices of another existing board?

MS. LARSON: I don't think that we are saying that. I think that we are giving enough room to state, to establish within certain boundaries that really reflect the education in accredited institutions and to then set the standards for what constitutes a profession.

DR. ORNISH: I would agree with that approach, but I think it should be stated explicitly.

MS. LARSON: You want it tighter, is that what you are asking?

DR. ORNISH: Just clearer. I think you need to say just that. You say, we think it really belongs to the states to decide what level of evidence or what level of documentation or accreditation constitutes a

profession that can be self regulating versus an emerging profession that needs to be, for some period of time or whatever, under existing regulatory bodies.

I just think if that is what we are doing, then we should just say that.

DR. FINS: We actually, in the background section, again, above those four categories, there is some of that language there. Just trying to talk about the readiness of a profession for independent oversight.

DR. ORNISH: But not just in this section, but the one before it.

DR. FINS: I understand. Who is next?

MS. LARSON: I believe it was Effie and then Tom and Veronica.

DR. CHOW: Thank you. I think this is a great beginning on sort of the definition or defining the criteria, and it sort of matches with the mechanisms for regulation on your page 6, in your outline here. I think there should be more than holistic medical doctors example.

But also, do you mean, in No. 1, that it is a well-articulated, cohesive healing philosophy, defined

practice standards, does that mean national licensing?

DR. FINS: It is not licensing; it is that there is a consensus among the practitioners of that modality that everybody agrees to.

DR. CHOW: But you see that everybody doesn't really agree.

DR. FINS: The point then, Effie, is, that is not a most of all profession, it may be an emerging profession or it may never be a profession. In other words, to fit into this --

DR. CHOW: I am suggesting there is something in between one and two. For example, naturopath, there is still not total agreement in the naturopath, acupuncturists, there is not a total agreement.

DR. FINS: The point here is that we are saying that if these are points on a continuum, okay, then all of these groups could be plotted on that continuum. They are either stuck where they are or they could be moving towards a more evolved state. I think it is probably best we don't try to categorize groups, because there will be different interpretations.

What this is is a heuristic device to try to

get people to understand that this is a moving target and professions are in various states of movement. That is all we are trying to say here.

DR. CHOW: All I am suggesting is that there seems to be another definition needed between one and two, because you are talking about well articulated, cohesive healing philosophy.

DR. GORDON: This is a process question. How much time do you want to spend on this background piece? I think we really need to move toward the recommendations.

DR. CHOW: Okay.

MS. LARSON: We have about five more minutes. If you would like to work on this, Effie, I would really appreciate your writing something. Tom?

MR. CHAPPELL: I think this is a wonderful contribution. I would like to ask the subcommittee on CAM definition and guiding principles to look at this as a possible inclusion in the definition of CAM. It is a nice clarifier, because, as you remember, in our description of CAM, we have one chart that just has everything, every profession listed in alphabetical

order, and I am worried about the way we presented that in our piece, because the reader might say, well, this is what I have been talking about all along, you know, this is unmanageable, and so on. This begins to give some manageability to it. It is very well done.

MS. LARSON: Thank you. Are you suggesting that the two workgroups work together?

MR. CHAPPELL: I was only asking permission for our committee to consider including this in the definition of CAM, that's all.

DR. FINS: What we were trying to do here is, I think, to Tom's point, is that we say let's regulate CAM or let's reimburse CAM or let's do research on CAM. There are different elements of this very heterogenous group, and at least in the context of the practitioner moving towards professional, we were trying to just put it into categories.

MR. CHAPPELL: Throughout the hearing process, we have been encouraged to do something like this. People are saying all CAM practitioners are not the same.

MS. LARSON: Veronica and then Joe and then Dean.

MS. GUTIERREZ: My rubber stamp comment is there are many healing philosophies that are not appropriately classified as medicine. I would like to see collaborative or integrative care used as the descriptive phrase here, not medicine.

MS. LARSON: Joe.

DR. PIZZORNO: Two comments. Thanks, Tieraona, for bringing up that challenge here, because we are trying to figure out which category best fits the holistic MDs, but not to say that MDs are the example. I think it is important to realize that the purpose of this is to address a challenge that we have been experiencing, not just over the past couple days but in the last year, and that is it is such a heterogenous group. We have to develop striations to best determine what education, regulatory, practice standards, et cetera, are appropriate for each group. So this is our effort in doing that.

I personally like the idea -- and, Tom, I like your bringing this up -- of providing examples for each of these categories, but being really clear that they are not meant to be exclusive or prescriptive, because people

need to have some feeling for what belongs. So, Effie, I think it is important we not expect there to be utter cohesiveness within a particular profession. I think acupuncture has plenty agreed-upon commonalities that fit well into No. 1. Of course, there is diversity within the acupuncture profession, but it clearly fits into category No. 1, just like in conventional medicine, you take a given patient --

DR. FINS: Joe, in the interest of time, I think this is a very rich discussion, and I think that we can put this in the background section, it was meant to move towards the recommendations, but I want to go to Wayne, and then I want to move on, if possible.

DR. CHOW: Excuse me, can I just clarify? I didn't expect a cohesive -- it is just what is stated here. It is not my expectation.

DR. JONAS: Just in terms of including this in definitions, we actually had extensive discussion about this whole item. I think it would be possible, as long as there were other ways in which complementary medicine is classified according to different perspectives. This one is very much based on the regulation, and so I think

it clearly belongs here.

There are other ones on research that belong in research, for example. If we want to summarize those in some way in the overall definitions, so people see the diversity and the range of description, I think that might be useful, as long as they are not eliminated from each of the subsections.

DR. FINS: It was really an instrumental categorization. Jim?

DR. GORDON: I think including some of that in the beginning in definition might be very useful for all the sections.

I want to come back to the question that you raised, though, 39, and Dean's concern about it. The way I read this is it is saying as opposed to waiting for states to make the determination, I read this as saying to states, get with it, start licensing professions that have developed a body of knowledge, a body of education in schools that are accredited. So, I need to know what we are talking about here in this, what the effect of this is. Are we making a recommendation to states?

DR. ORNISH: I would say a third alternative,

which is the language that is in 39 I can live with, if it is qualified by saying that we defer to the states' determination on which of those are.

DR. GORDON: Right.

DR. ORNISH: I think it should be the states' determination, just like gambling or anything else. There are certain things that the states should be able to do.

I have a bigger question, which is, the Interim Report has gone out, and, presumably, we are going to be getting feedback based on that. We are making recommendations yesterday and today and tomorrow that, presumably, are going to be our, more or less, final recommendations, yet we are doing so without having had the benefit of the feedback of the people of the people that have read the Interim Report. I am wondering is there a time that we can modify this or go through this again based on what feedback we are going to be getting?

DR. GROFT: I think the idea is that we would provide all the feedback that we receive to the Commission members during the next six weeks, before we come to the finished writing of the draft report, I think

before December. So, the opportunity will be there to take into consideration what is sent back to us and then to modify as the workgroups feel appropriate. We will maintain the workgroup status, as far as looking at everything. So, any appropriate comment that would come in, not only will we give it to all the Commission members, but to the appropriate workgroups to consider, as well.

DR. GORDON: I think, just to respond, precisely because we didn't make recommendations, even though we gave a sense of what we are hearing, we are unlikely to get the kind of precise and pointed critiques or too many of them that we would if we had made recommendations. So, we will get feedback, but we may not get as much as we would like.

DR. ORNISH: I am hearing that as an implicit criticism, but that is okay. I do think we are going to be getting a lot more -- at least I hope -- feedback, even without the explicit recommendations, and I think that that feedback is going to be really helpful, and I am sure we will modify, at least to some degree.

DR. GORDON: I agree with you on that.

DR. FINS: Let's move on, because we want to have more recommendations to share with people to get feedback on.

DR. GORDON: Do you want to redevelop this recommendation, or do you want to --

DR. FINS: I think we have a sense of what the concerns are, and we will bring it back to committee, and we will work on it.

Let's move on. We did, I think, 40, with the changes that Tieraona suggested. No. 41 is that the Commission recommends that the federal government set up demonstration projects in states to develop and evaluate competency-based regulatory mechanisms and the effects of exclusive scopes of practice on access and delivery of care. Maybe Joe Pizzorno could just say a little more about that.

DR. PIZZORNO: Actually, this was your idea. I think you should say more about it.

DR. FINS: It is basically a way of helping the states resolve some of these kinds of issues and looking at mechanisms in a critical fashion, because we are saying we can do research on regulation and what is the

right balance in helping states understand. This is uncharted territory in a health services kind of context. Dean?

DR. ORNISH: I just think it needs to be clear what the role of the federal government is. I think licensure traditionally has been left to the states. I think it should be left to the states. It is not clear in this recommendation whether you are simply saying that they should make guidelines that might be helpful to states or they should make guidelines that states have to adhere to, and I think there is a big difference.

DR. FINS: I would say that the federal government, in the interest of addressing what we say up on No. 5 above, inconsistent licensing across the states, which may present a significant risk for consumers, assist the states in coming together and developing regulatory mechanisms. This is an area that we do not understand all that well. Jim?

DR. GORDON: Well, the recommendation is kind of cumbersome. If you could define where it is coming from. Are you saying, let's look at the Minnesota Model and let's see how it is doing, or are you saying

something -- I am not sure what you are saying in the recommendation.

DR. FINS: I am saying that states design an outcomes-based, or whoever would want to study this, an outcomes-based approach to this relationship between competency-based regulation, which if you demonstrate the competency and you have the legal authority to practice, what are the implications for the public health, for adverse events, et cetera, et cetera, and get a sense of whether or not the balance between regulation or access is appropriate.

DR. GORDON: It sounds so theoretical.

DR. ORNISH: I mean, it is unclear to me again whether you are saying that the states should be basically setting national regulations for licensure or just helping the states determine their own, because already there is state-to-state variability. You said something a moment ago that made it sound like that was a problem, but I think that is part of the strength of it.

DR. FINS: It is, but we don't know, I don't think, in a systematic way, what the heterogeneity of regulatory approaches means for the public health. If it

is too big, we can delete it.

DR. GORDON: I have a better idea of what you are saying. Why not say, let's look at what the states have done, let's look at the models that are in place now, and we don't have to set up anything, all we have to do is get the information from those models, perhaps back to CAM central, and let's see what is going on. I mean, that is kind of my sense of what you are getting at.

MS. LARSON: So your request for clarity and a little change of focus for the project. We will take that back to the committee.

Michele wanted to do a clarification.

MS. CHANG: I am beginning definitely to see the wisdom of Tom's suggestion that we do reference the Pew recommendations when we follow up with these further clarifications or expansions of the recommendations that they made. Several of the ones we just went through had that difficulty because they directly resulted from recommendations that were made by Pew. So, that is one thing, I think we can do that and that will help clarify.

The second is that I think our experience has been that the states are very receptive to guidance from

the federal government. They like to receive guidelines. They find it difficult to have to try to do that themselves because of the variability issue and other issues, budget issues, et cetera, but this is an appropriate and welcome input from the federal government, and that was a little bit along the lines of what we were going towards.

So, in answer to Dean's question, yes, we would be asking the federal government to provide clear guidance to states, based on what states are doing themselves that they don't have to do it themselves, and that is actually the intent of most of the recommendations here.

DR. FINS: Not to usurp the authority of the state, but to help the federal government catalyze the discussion.

MS. CHANG: Right.

MS. LARSON: Joe and then George, then we have got to move on.

DR. PIZZORNO: Despite the earlier flippant response, I actually think this is an excellent idea, because what we are trying to do is recognize that so

much of the regulatory process right now is politics-based, politically based. We are trying to make it more evidence-based. I think the more we can make it evidence-based, the more we are going to be able to contribute to the public health, and this is one way of doing that, by gathering good data and providing that as guidance and assistance to the states.

MS. LARSON: George DeVries.

MR. DEVRIES: Just as a reminder for those of us on the committee, when we first started talking about this, the concept really was to say that the CAM providers each have a certain scope of practice and education, and that education and scope of practice sometimes, not always but sometimes, allows them to examine, diagnose, treat a condition and, therefore, we believe and we are recommending that the states grant the appropriate legal authority, whether that is licensure, registration, certification, or otherwise, to those practitioners to be able to operate within the scope of their education and their scope of practice.

So, when it really comes down to it, we have broadened our discussion in terms of how we have defined

licensure and have discussed this issue, but ultimately it came back to saying, how was the provider educated, what is their scope of practice, what does that mean they should be able to do, therefore, it is our recommendation to the state to allow them to do that and give them the legal authority to do it. That really kind of comes down, I think, to the bottom line.

DR. FINS: And then this recommendation is to evaluate that change in any state law, to see what its impact is. It is not theoretical, Jim, because it is really the protect the public safety if you had an adverse event, adverse outcome, or if there is value added. So it is a demonstration project in either direction, because it does represent a change.

DR. GORDON: What I would say is that this is now clear to me, it is a separate recommendation, I think. There is a whole issue -- and, George, thank you, I really appreciate what you said -- that we have heard over and over again. I remember hearing it from nurses, well, if I do therapeutic touch, is that part of my nursing scope of practice or is that something different. I think we need a very specific recommendation, and I

would make this recommendation to you, regarding scopes of practice, because this is an issue that came up again and again and again. Then following up that with some feedback about evaluation of how it works.

I just see that as different and a more focused recommendation than the way 41 reads right now, because one is talking about state programs in general in dealing with CAM professions, the other has very specifically to do with scopes of practice as an issue that affects many different professions.

MS. LARSON: I can assure you that we will discuss it. I know for myself that I do not have enough information available to me to talk about scopes of practice, but we will bring it back to the workgroup.

No. 42 and 43 are actually put here, as our excellent staff member has said, as placeholders. I would actually like her to speak to that issue a little bit, and Joe.

MS. CHANG: Yes, we want to be sure to acknowledge that we have heard a lot of testimony and concern from the Commissioners, as well, about the interaction of state medical boards and CAM

practitioners. We will be addressing that in further discussions between now and December. We will have, hopefully, a couple of recommendations to address those concerns; however, as Gerri referenced in her section, we are still waiting for some critical background information on this issue from the Federation of State Medical Boards. That is about all I can say about that right now, but I just want to assure the Commission that this issue has not dropped off our radar, but we are not prepared to discuss it at this point.

MS. LARSON: Jim.

DR. GORDON: Michele, what you are saying is one issue has to do with disciplinary issues, broadly speaking, but it seems like there are other issues, as well, that you are thinking of in here?

MS. CHANG: We didn't even want to do a background piece on this, because we did not want to misrepresent the issues, and we felt that the information that was missing was too critical to go forward. So we made the strategic decision to wait until we have that information.

DR. GORDON: But the disciplinary issue is one

of them?

MS. CHANG: Oh, absolutely.

DR. GORDON: Okay, good.

DR. JONAS: May I suggest that this general approach, not exactly what you are doing with this waiting, but this interaction with an important body, agency, that is going to deal with one of recommendations here be something that the committee as a whole do in a more systematic way?

I think there are a number of recommendations in here that have direct implications on a variety of management, regulatory, including federal agency, bodies, and it would be, I think, very nice if we went through those, someone went through those, identified those individuals and then actually approached them about it, and said, here is a draft recommendation we are thinking about in this area, is this something you could give us feedback on, et cetera, which is sort of what is going on here with the State Federation. I would just like to make that as a general suggestion.

DR. GORDON: That seems to me that is a staff function, basically, Michele and Steve and the rest of

the staff will look. That is the plan, isn't it?

DR. GROFT: Yes, that has been the idea all along, that after we get recommendations, we would identify who they would be directed to, then we would approach them to have them review and give feedback to us, as far as what they think about it and maybe more appropriate language or language that would be easily implemented a little bit better. So, our intent is to go back to these various organizations.

In fact, I mentioned to Jim briefly, we have some correspondence from the National Governors Association that we have to get back with them. I think we were waiting for the approval of the Interim Progress Report. Now we can go back to them, and I think we would like to bring all of the various issues that we identify at this meeting to them, and perhaps we can establish a dialogue before we prepare the Final Report.

DR. JONAS: I think that is great.

DR. GORDON: One thing we can do, Steve, as we come up with those issues, send them out to all the Commissioners, so everybody will have a sense of the directions and the agencies, and so if there is any input

from anybody about who we should be talking to regarding those issues, that input can come in.

MS. CHANG: Can I just mention that that will happen naturally through the workgroup process as it currently is.

DR. GROFT: So that each workgroup will have it.

MS. CHANG: Yes, I think that as the contacts are relevant to the workgroups, we will do it probably that way.

DR. GROFT: We will do a better job of communicating with the Commission members to identify the correspondence that goes out and it comes back, the meetings that we are planning to hold, the teleconference meetings, so anyone who would like to participate will have access to the times and places.

DR. FINS: Let's move on now to page 17, which is the next group of recommendations. What these sort of cluster around are more not the personnel issues that we have just been talking about, how do you regulate practitioners who are part of a workforce and licensure and certification and those kinds of issues, this is now

sort of infrastructure issues and delivery system kinds of concerns.

With that, I will turn it over to Linnea for the recommendation No. 44.

MS. LARSON: Do you want me to read it?

DR. FINS: Or I can, whatever.

MS. LARSON: I thought we were trying to share the podium.

"The Commission recommends the Secretary of Health and Human Services expand current models of integrative service networks to incorporate safe and effective CAM services as appropriate."

I am going to read the next sentence, and say we still have some questions on the next sentence. "Special attention should be directed to address the needs of vulnerable or underserved populations."

Open to commentary, please. No additions? Discussion?

DR. WARREN: Who determines "as appropriate"?

DR. FINS: The Secretary.

DR. WARREN: With what background?

MS. LARSON: So you are asking for the specific

mechanism.

DR. WARREN: Yes, I am asking the Secretary is going to --

DR. FINS: I think it is related to some of the issues that come up in coverage and reimbursement in the next go-round about mechanisms, about what things would be considered for inclusion in packages. So, I think we can bracket that issue for maybe a little later on.

It is sort of the interface between the micro-economic and the macro-economic.

MS. CHANG: Additionally, I think that we can add some background information contextually, as well as models of integrated service networks that will give you better example of how it currently works, so that it gives you an example of how these things would be added on to that system, which we didn't do. We can do that.

DR. GORDON: I just have a question. When you say integrated service network, what are you referring to?

MS. LARSON: What are they?

DR. GORDON: Yes.

DR. FINS: It could be a vertically integrated

health care system, you know, from a community center, health center, all the way up to a tertiary care medical center or a quatinary medical center. It is basically trying to look at the infrastructure that exists and how those entities work well together and create a seamless continuum of care. Medical care is, though we like to fancy it, is not practiced in an individual office, it is practiced with a whole mix and panel of individuals. What we are trying to do is understand that better and understand the mechanisms in this section of how to integrate CAM into delivery, into integrated delivery systems.

DR. GORDON: Is there more guidance you should be giving? I am really asking that, it is not a rhetorical question, it is a real question. Does it serve us to give more guidance, because the Secretary is going to do what, getting this recommendation, is what I would like to know?

MS. LARSON: Julia?

MS. SCOTT: I own up to the fact that I was on this committee. It is a very good committee, but I have a certain level of frustration because there was not the

time to give to this. This is a big issue, access and delivery. In my more than 35 years working in the area of health, and in particular in women's health and African-American and people of colors' health, the issues having to do with special populations, vulnerable and underserved, somehow never get the kind of attention that is needed, especially when you put it in the context of developing policy recommendations. We somehow get further constrained with trying to be political and trying not to be too radical, and this is one area where I really think we need to try to step out of the box on.

I've been on too many committees looking at the underserved, and I do think we need to be very prescriptive here and very specific and even a little bold, because our health care system has not addressed this issue well at all. I think we have an opportunity here, and I would like to specifically ask that our committee, as we go back, really try to be much more specific here on a recommendation that would really and strongly address access to vulnerable and underserved populations.

MS. LARSON: I am very grateful that you have

said that. You and I have discussed it earlier. We will put that on the agenda. I want to move to Wayne.

DR. JONAS: I am going to go a little step further than that, actually. I think that this section doesn't at all communicate the importance of special populations, underserved populations. Originally when we proposed this Commission itself, we actually had that as a subsection, one of the tasks. Now that got subsumed under Access and Delivery. We have to separate it out from Access and Delivery.

Rather than focus so much on the Pew Report, which I think is important and we should have in there, we should also connect this to some of the tremendous other things that have been done on health disparities and closing the gap and that type of thing and really put that in here as one of the anchoring areas that we are relating to and our recommendations are relating to, and then have specific recommendations in here that address those.

MS. LARSON: Thanks. Conchita.

DR. PAZ: One of the things I think, as far as this No. 44, is to cross out where it says "effective CAM

services as appropriate." I would just cross out "as appropriate," because I think that is too nebulous, and I think we just need to state that it needs to just incorporate it.

MS. LARSON: Dean.

DR. ORNISH: I think it might actually strengthen the case that you both are making if we can talk about how CAM modalities may be, in many cases, more cost effective, and therefore it increases the access.

For example, over 90 percent of bypass surgery was done in white, upper-middle class men last year. They are certainly not the only people who get heart disease. In fact, it is declining in that group and rising in underserved groups. Now with the recession coming, more people are going to lose their health insurance because they are going to become unemployed, which means we will have more than 50 million uninsured.

So, I think that one of the only ways that we can address these issues is to highlight how one of the advantages of CAM is that they can make health, real health care, available to a larger group of people, particularly underserved, that we simply can't afford to

do otherwise.

DR. FINS: This sort of reminds me of the conversation some of us had with Steve, early on, about whether or not access and delivery, and coverage and reimbursement should be a single group or not, because a lot of the issues about the cost-benefit analysis, and showing that some CAM modalities might actually be more cost effective or value-added is addressed in the next section.

I think what we were trying to do here, and I agree that maybe we didn't realize its full potential, was to look at and try to understand the infrastructure that would support delivery of those modalities, or the access to those practitioners who we have just dealt with that are going to be regulated in various ways.

I think what we saw down at Beth Israel Hospital in New York City or at the King County Clinics, and the relationship with Bastyr and the University of Washington, we are trying to capture in this section a mechanism for the federal government to help, perhaps, stimulate and understand the delivery of an integrated model of care, beyond isolated, sporadic practitioners,

and how would they all work together. That is sort of what we are trying to capture here. So, that was our intent.

Jim?

DR. GORDON: I am really glad to see the recommendations and hear the discussion. For me, this can be one of the most powerful parts of the Report, and I think the more specificity we have -- I see this at every stage of the life cycle -- that there is enough evidence to recommend that there be doulas in every hospital for childbirth, there is enough evidence to recommend infant massage, there is enough evidence to recommend serious education about nutrition in all pediatric clinics, work with stress management for all chronic illness.

I think we can really take all the things that we have. We know the evidence, we have had the evidence presented. All of these approaches can be integrated at every aspect of health care for the whole population.

We talked previously about a vision statement. There was some discussion that I might do a vision piece that I would bring back based on this meeting, and that

we would then talk about next time. That is fine, but I think that much of the vision is embodied in Access and Delivery: what would we like to see for everybody in the United States; what would we like to see available; what do we know based on the evidence that we have had presented to us.

MS. LARSON: I want to make a comment. I do appreciate that, and I would actually couple that with the information that Wayne provided, as using the already-existing material that we do have, and research, and also linking it to what Dean said in cost benefit. Those are the three things.

We are quite well aware, I don't think that we have done enough with respect to uninsured populations. However, I think that our mandate to is to be very specific about the complementary and alterative medicine as it applies to the delivery of service.

DR. ORNISH: Just a follow-up. I think the two other implications of highlighting this, one of which ties into what we were talking about yesterday about defining the terms of the debate in a way that marginalizes opposition. If you say, we are in favor of

helping people who are underserved and who don't have much money, and who need the help, and here is one way that we can do that that is innovative, that forces people to say, well, we are really not in favor of that.

The other is, that so often CAM is associated with elitist, upper-middle class, wealthy people who pay out of pocket. The studies that Eisenberg and others have done that show more money is paid out of pocket is because it is mostly people who can afford to pay it out of pocket.

By putting it in these terms, it gets away from that both preconception and reality, that often CAM modalities are for people only who can afford them.

DR. FINS: I was just told we have 15 minutes left. Any burning comments?

Again, I think a lot of these issues are going to be brought up in George's group next, about how we allocate those resources. What I would just like to ask the Commission for is to send Michele any thoughts about infrastructure-building and integrative models of care, because I think that is an area that, as I see it, is what this section is about versus what the next section

is about.

Joe, did you want to say something?

DR. PIZZORNO: This is a fascinating conversation. And, Julia, I particularly appreciated your comments. I did not understand how that would relate to specific language that we should be including in No. 44.

Could you give us a couple of sentences that you would like us to think about, as this committee works with this?

MS. SCOTT: I really want the committee to discuss this, to have a full discussion on this. Really, I want to push the committee to be bold in this area. I am sensitive to something being cost effective and all the policy do's and don't's when you are putting a recommendation together.

I think there are a couple of places in this document where we have to be bold, and perhaps making a recommendation that may not initially be cost effective but that it is for the good of all of its citizens.

So, I think we have to be thoughtful about this, and I think people on the committee all have ideas.

I think it is a larger discussion. I don't have anything off the top of my head. I just know that I feel we can do a lot better.

MS. LARSON: I think it is really important that we need to do much better. I would appreciate your pointing out the two specific sections, and then really assisting on crafting recommendations that we, as a group, then can discuss. Thank you.

DR. FINS: Recommendation No. 45.

DR. GORDON: I just want to say one follow-up on what Julia said that I think is really important. It is important to talk about cost benefits. It is also important to talk about what our vision of a health care system informed by the best of CAM would look like, and then we will deal with the cost benefits also.

DR. FINS: The vision of my health care system is that we have universal access, and that, of course, is the largest gap, the greatest vulnerability. Again, I just want to say, to provide people who don't have access to conventional health care access to a CAM modality that is not proven to be cost effective or value-added, or replace a more expensive modality, is efficaciously

troubling.

DR. GORDON: I hear your point of view, and this is your committee, but there are also other perspectives that are being articulated strongly.

DR. FINS: I hear that.

Ti, and then we are going to move on.

DR. LOW DOG: I am in favor of offering effective treatments, but I just want to come back. We have got wellness at the end of this whole thing, wellness and self-care. It is kind of the last afterthought. Eisenberg says more money is spent out of pocket, and that is because people want to buy pills, and go to the doctor, and go to the acupuncturist, and go to the chiropractor. Everybody wants to go and have something done to them, when the reality is, in many of the underserved and poor populations what is really needed is better diets, self-care, wellness.

I think you are going to have to really focus on that, which I think we have come back to, but it is interesting that we shoved it to the end. After everything else, we have got wellness and self-care.

I am not sure that just spending more money on

other services is really the answer to our health care problems, and I am not sure that we have proven that many of these CAM therapies are really going to be the answer, or that they are effective.

So, I just want us to be mindful of that when we are making these recommendations.

DR. FINS: No. 45, we are going to skip, and cede to the Coverage and Reimbursement group and George.

No. 46 is that we recommend that there be more detail and epidemiologic information, which I think is hard to disagree with because it will help chart future strategic planning with a special focus on vulnerable populations.

David?

DR. BRESLER: It seems to me that a lot of the issues that we have been discussing are really resolved by good research. You think of the Barefoot Doctors movement and the large population in China and so forth, and it may well be that CAM offers a lot of benefits to underserved populations.

I would like to see this one stretched a little bit, maybe in terms of demonstration projects, maybe in

terms of more research orientation to really answer these questions that we have just been debating; to what extent would mind-body medicine, for example, help people have better lifestyle issues, and things of that sort, and education in underserved populations be an effective intervention for them.

A lot of these questions can be answered by good research. If we want to put some teeth in, let's get some funding to support this type of research for these populations, and let's find out.

DR. FINS: Sort of in tandem with the recommendation that Joe Pizzorno made earlier about the partnering between the naturopathic and allopathic doctor, let's see what that kind of investment does for wellness and prevention and cost, as well. I mean, there are values and there are cost benefit considerations.

So, is there anything else on No. 46?

DR. GORDON: David, I didn't understand. Is that in addition to No. 46? Or, are you saying something about No. 46?

DR. BRESLER: Well, basically, as I read it, No. 46 is just asking for surveys to be done about

patterns of use. I am saying we need to answer the questions that we have just posed as to the cost effectiveness, the benefits to these populations, access issues to these kinds of modalities, and so forth. I would like to see this expanded, not just to be a survey on the pattern of use but answer the questions we have just been debating.

DR. FINS: For this particular part of the story, I think it is really not particularly studying a modality like acupuncture, but acupuncture, say, in the context of a primary clinic, in the context of a county health care system, what does that do for overall costs.

So, it is a systems approach. It is modalities or clusters of modalities within, not a specific study about whether one modality works or not. It is proven modalities, how do they bring value to structures and systems of care. That is what we are trying to get at in No. 44, and I think what we will bring back to the group.

We want to move on to No. 47. This is concurring with the AAMC report, which suggested strategies to improve medical student education on spirituality, cultural issues, and end-of-life care. It

recommends the federal government establish an institute to address the needs of seriously ill and dying patients, and their families: "The Commission believes that the collaborative integration of many CAM approaches is both appropriate and will add critical value."

Now, the reason why this is here, other than the fact that I happen to be on this subcommittee and I care a lot about end-of-life care, because it is an experience we are all going to have, right? As Woody Allen says, "I don't mind dying, as long as I am not there when it happens."

The reason why this is here is because we think that of all the delivery systems that we have heard about, the place where the diagram really comes together most nicely, where the allopathic and the complementary all come together best is in the context of hospice, the hospice model.

So, we think there are lessons to be learned. You can get music therapy, you can get spiritual counseling, you can get visualization, you can get a PCA pump, and you can get radiation therapy, all in hospice.

So, we think that by a confluence of almost

serendipity and a lot of hard work, the people in palliative medicine, that hospice is a model that we need to understand better, and it may be a way of disseminating this integrative approach, which I think we are collectively endorsing.

Jim?

DR. GORDON: I agree that hospice is a very good model. It is not the only one. I know it is your passion. I just realized a couple of days ago that we are all going to die. I don't have this totally formed, but let me say this. Sometimes it is a little too easy to focus on hospice. I think it is sort of like, okay, let's let the chaplains come in at the end of life. That is sort of the experience.

Let me just continue. What about in the middle of life? What about early in life? The question is for me, I could say the same thing about care of chronic illness, and I could say the same thing about work I have done with adolescent substance abusers, is that everything comes together in a way that fits.

I think what we need to do is to use hospice as one model, but essentially to say that there are all

these models, all these different stages, all these different times, all these different occasions in which the model comes alive.

Then the question comes up of what we then recommend. So that is kind of where I am. I think we are circling around something, but I don't think it should just be hospice.

MS. LARSON: I would like to speak to that.

DR. FINS: Please.

MS. LARSON: It is a category issue, and it is also an issue about adding on more recommendations that are much more direct for given populations.

The model of hospice is one model, but the model also is very, very inclusive of every kind of discipline. There may be mechanisms of delivery that are not as explicit about, we are going to be inclusive of all of these different professions for adolescents, say, or for chronic illness. There is specificity there. I just wanted to make that clear.

Having worked in a hospice and knowing the phenomena of, yes, we are all very nice here; we all do this work; we are dying; et cetera, I know what you are

speaking to. So, you are asking for two things, to expand it, to recognize in background material that this is not simply the only model, and then to say, these kinds of services do apply and have been given to other age groups.

DR. GORDON: Thank you, Linnea. Then there is just one additional thing, and what do we want to have done. I think that needs to be clear, clearer than it is in Nos. 47 and 48.

DR. FINS: The other point that is important, I think, is that most communities have a hospice. Of all the integrative modalities, it is probably the most utilized, and many families are affected by that. So, in a way, to understand and to disseminate the integrative approach that is holistic, this is a good place to start.

DR. JONAS: I just want to echo, I guess, and agree with Jim's point that we need to expand it beyond that, because when the hospice individuals were here, I think I asked them specifically how many CAM modalities are incorporated into the practice, and what I thought I heard was actually not that many, that the opportunity was there, but they didn't actually use many CAM

modalities in an official way.

So, it was an opportunity, it was a place where it could certainly have a lot of payoff and benefit, but it wasn't any particularly greater percentage in hospice than it was in many other places in regular care. I think it is useful, but I don't know if it is actually a model that we could point to and say, aha, here is where integrative care is actually going on in the way we would like to see it.

MS. LARSON: I am of two minds here, and I do need to speak to that. It is actually true, having been in a hospice, but the specific requests were to expand the CHMB, to have more particulars in the naming of certain disciplines within that model for CAM practice.

DR. JONAS: What I heard was not that they were asking to expand it into CAM practices, they were asking to expand the hospice approach to non end-of-life care. In other words, to do it earlier and this type of thing.

So, it wasn't particular to complementary medicine, per se. That is what I heard about it: start it earlier; this is great care; we really talk about holistic care; we are really trying to nurture and care;

we talk about care rather than cure; let's start doing that earlier than by the time people are ready to die.

That is what I understood they were asking for, primarily.

DR. GORDON: We actually can give you some more time. So, let's take 15 more minutes at this point now, if you would like some more time. Are we addressing both Nos. 47 and 48? I feel we are.

So, please continue for the next 15 minutes, whether you want to talk more about this, or talk about No. 49. How you would like to use the time?

DR. FINS: I think that another way of really addressing this is that people who are at the end of their life, and there is sort of an artificial categorization, there is a six-month Medicare hospice benefit, but people could be dying for longer periods of time if they have, say, a progressive dementia or something of that sort. People have said that that Medicare hospice benefit -- we heard testimony -- should be changed.

It is beyond the scope of our work here, but I think this is a vulnerable population that does make use

of CAM modalities, has a tremendous amount of hopefulness that may lend itself to utilization of CAM modalities.

It is an entity that is dispersed throughout the country, and there has been a lot of progress in end-of-life care. I think that we are talking about collaboration and piggybacking onto reports. There may be a synergism of piggybacking onto another movement, because I think the ethos of the hospice movement and the palliative care movement is constant with many of the elements of the CAM movement.

I think that there are real synergisms here, and maybe we need to flesh out, in a more discrete way, how those things could be leveraged together. We may not have it right in Nos. 47 and 48, but I would like to get a sense of whether or not the group thinks it is a productive vehicle to explore further, perhaps with some editorial, substantive revisions.

DR. BRESLER: Again, following up on Wayne's comments, it seems to me that this is another issue that can be resolved by research, and that the Commission could make recommendations of some demonstration-type projects where we do meet their request to bring CAM into

the hospice movement, take a real good look at it as a model for integration, and then see what we learn from that and be able to expand it into other models.

This is something with a little more teeth in it, again, that we can make very specific recommendations to support.

MS. LARSON: Thanks.

DR. JONAS: I would echo that. I think that would be a good approach. I would also say another way to emphasize it would be if we pull out and emphasize the whole area of vulnerable populations. Then this could be one of a few, not a huge laundry list, but of a few where you say, here are some that we think are especially ripe for looking at integration issues.

MS. LARSON: Then have the appropriate background material to substantiate the use of those populations for research.

DR. JONAS: Exactly.

DR. GORDON: I also think this is one of those places where our 10 basic principles come in. One of the reasons that we see hospice as a model is because it fulfills many of those principles, but so do other

programs.

I think that this comes back to the point that Charlotte was making earlier, that this is where we have the drama and the power. I think we need to convey what it is about hospice, what it is about some of these others, whether it is ARRE, which you all heard about, which I work with, where they are really looking at whole people, people are definitely underserved. They are HIV-positive addicts, most of whom have done time recently, but they are also empowering them, they are giving them choices, they are giving them support, and peer support, and a healing community.

I think what we need to do is to get, in a sense, more imaginative with our examples and to explain how this relates to the basic principles of CAM, and how each of these different models, of which hospice is one, but for me just one of a number, can really inform all of health care, and how each of them can be a place where CAM comes in and makes a major contribution.

MS. CHANG: I just want to add, also, I want to refer folks back to a quick review of the Report, of the Medical School Objectives Projects, because it also

identified issues around spirituality and cultural relevance in this model, and I think that that also spoke to us.

I know that we will be revisiting hospice as a model in the Wellness section, I believe, but we have brought this up a couple of times to more explicitly address issues of spirituality and culture relevance in health care. I think that was one of the things that really appealed to this workgroup about hospice.

So, just a note.

MS. LARSON: Ti?

DR. LOW DOG: It is off the track, but I just wanted to know if somewhere in there under Access, we could talk about access to products, protecting people's rights to have access to products. We need to remember that half of all the money that is spent on CAM right now is in product, and the fact that on your formulary, you may be able to get Hytrin, but you can't get saw palmetto.

When we are talking about access and delivery, if you pay $2 for your Hytrin, but you have got to go down to the health food store and pay $30 for a product

that also works, it is limiting.

I just didn't know, since most of this was on service. This is access.

MS. LARSON: Ti, can we put that for Saturday to continue and have that on the table?

DR. LOW DOG: Okay.

DR. GORDON: Since Ken is going to the board, this must be a new issue, and this is one of the ones that we can come back to a bit on Saturday morning. It is a huge one.

I have one more new issue I wanted to bring up. We are going to go to No. 49 first. The new issue is something that was mentioned under Education and Training, but I think it fits better here, which is the whole issue of navigators, of educators, of people in the community who help community members find the right path for access, help them make the decisions that they need to make.

I don't think we heard it here. Harold Freeman had a very interesting example at Harlem Hospital of navigators to help women with breast cancer to make decisions. I have done a lot of work in this area. I

just want to put this up as a new area that I think could be important. I bring it up here under Access because it is designed to help people find better access. I think it fits here better than under Education and Training.

MS. LARSON: Joe.

DR. PIZZORNO: I am going to do something I am a little uncomfortable with, but I have to do it because I feel strongly. At our last meeting, unfortunately, I had to leave an hour early, and I didn't realize there was such a dramatic difference between what I thought was the committee report and what ended up in this folder. So I am just going to bring it up, because I think important things were left out.

In our committee report, Nos. 42, 43, 44 and 45 were cut out, and I don't understand why. No. 42 was the recommendation that we have: "The Commission recommends the Secretary of Health and Human Services fund model community-based initiatives through the appropriate regional offices to integrate CAM and conventional health services, especially in underserved and vulnerable communities.

"The Commission supports demonstration projects

and strategic planning to integrate CAM and conventional health services with emphasis on public and community health," et cetera.

What happened to the demonstration project?

MS. CHANG: I don't know.

DR. PIZZORNO: This is the last committee report that I had, and there are four recommendations that are just gone.

MS. CHANG: I am trying to remember, and I don't, unfortunately, have that report with me with my notes on it. We did go through staff and internal review to try to reduce the redundancy in some of the recommendations, and I think that was part of the problem that we had.

Also, I believe that we thought that the integrated service networks, one was a more useful way to incorporate some of the CAM services into the public health systems, I believe. I would have to go back and check my notes.

DR. FINS: But, Joe, given what we heard about No. 44, and how it was a little too vague, it might be better to go back to what we originally did, which was

more specific.

DR. PIZZORNO: Okay.

DR. FINS: Maybe could we just take a moment to read through them real quickly, so that people could hear about it but not discuss it, and we will get e-mail comments or something. Is that okay?

DR. PIZZORNO: So you want me to just read them. Is that what you are saying?

DR. FINS: Yes.

DR. GORDON: Let me just say, we can take a moment, but I think the full discussion is going to have to go back to your committee, because there is just no time to do it justice.

DR. PIZZORNO: I think that is a good point, because I think a lot of these things are examples of how to do this, that I think certain people, particularly like Julia that want us to do this, for example, the demonstration in community health centers was something I thought we had really clear.

DR. FINS: There was no disagreement on the subcommittee about that.

DR. PIZZORNO: I think it got lost somehow.

DR. FINS: Yes, it got lost.

DR. PIZZORNO: Quickly, the four, I will just summarize them. The second one was an interdisciplinary workgroup: "The Commission recommends the Secretary of Health and Human Service establish an interdisciplinary workgroup for decisions, assessment, implementation of CAM integration in a manner consistent with and in collaboration with Health People 2010 goals."

The next one is: "The Commission strongly supports the inclusion of appropriate CAM services in military treatment centers, public health clinics and facilities, and in state and local community health centers."

The next one is: "The Commission recommends that HCFA examine a proposal to enable services for qualified CAM practitioners in all states to be paid under its programs. For example, Medicare/Medicaid Wellness Act and the Medicare Medical Nutrition Act provide the sole right to have nutrition services reimbursed by registered dieticians."

MS. CHANG: That is actually in here. We were referring that one to the next committee. The first one

you read, I believe we took it out because it was redundant of one that appears in Wellness. When the staff went through the entire thing, we tried to reduce redundancy in recommendations in separate sections. So I believe that one will appear in Wellness.

The military institutions, I believe we had an internal staff discussion, which I will refer back to the committee on this issue, but there were some concerns regarding needing to talk to the Department of Defense before we made a recommendation that directed their service delivery.

DR. PIZZORNO: Thank you for the explanation. So I guess the recourse I have is, when we have our committee conference call, if you could tell us how these were dispersed into other areas, I would feel much better about that.

MS. CHANG: I think we can.

DR. FINS: I think for the future, it would be very helpful just to list them and know that they were referred, so that we know that they are being taken care of. Ultimately, we don't care where they are, but just so we can keep track of their dispersal.

MR. CHAPPELL: Did the committee discuss any way in which this would relate to private enterprises, experiments, entrepreneurial experiences of setting up integrated service networks?

We have had people present. Whether it was a region that was doing it, or whether it was a privately funded model, any discussion of whether our policies ought to be making suggestions to lower risk so that people are more willing to try these models?

MS. LARSON: We did have discussion around models and using them in the text, such as on a continuum. So we have well space, we have all of those different service delivery models, but I do not believe that we had major discussion of making a recommendation that would include a private --

MR. CHAPPELL: Would you give thought to that for me? I would appreciate it. I mean, they are taking the same risk, but they are doing it all on their own.

MS. LARSON: I believe that that came, as we did not know how much we could go in making a suggestion to private groups, rather than, maybe, a public/private partnership, and we were basically looking at our

recommendations at the federal level.

We have one left. I am going to read it quickly. No. 49: "The Commission recommends that the Secretary of Health and Human Services report within three years on the use of indigenous healing traditions in the United States to identify common use, best practices and challenges, and potential areas for collaborative learning between such traditions and conventional care.

"The Commission urges the Secretary's report to include recommendations for the future as regards appropriate protection of such traditions, as well as research and development of such practices as part of community-based health care."

DR. GORDON: I like it. It looks like a really good, interesting recommendation. The only thing is, just that whatever the review is, that it include members of those traditions in the process, which I am sure it would. I just think we have to make that point strongly.

DR. FINS: So, I think we are ready, Jim, for your summary, or not.

DR. GORDON: Don.

DR. WARREN: Are we trying, in this section, to link licensure, or the potential licensure, with access and delivery. By saying that licensure would increase access and delivery, which I don't believe it will, what are we trying to do with that?

MS. LARSON: I think that in my framing, and this isn't just me, this is what we struggled with, is the notion of regulation, regulation and legal authority, which then leads to licensure. So that is why I put it front and center for discussion.

I do not know if licensure necessarily will always create better access, but that is our working hypothesis, and we actually did that to have further exploration within coverage and reimbursement, because we have been told over and over again in testimony we want coverage for these services. There is increasing coverage and the payers or the companies will not pay, reimburse, unless people have the right credentials and licenses.

DR. WARREN: You gave us varying degrees of certification or approvals.

DR. FINS: George can speak to this.

MR. DEVRIES: May I make a comment, real quickly? I think there are two issues here regarding licensure. One is, it is an issue of reimbursement and payer requirements related to licensure, or the appropriate legal authority to practice their profession. Payers tend to tie reimbursement to licensure, but that should really be uncoupled from the access and delivery issue, the access and delivery issue being a different issue.

I think that this group has done a nice job. I think stratifying the different types of practitioners and the potential, shall we say, types of providers, types of regulatory requirements that they may have, or licensure or certification or registration requirements that they might have, in order to be able to practice within their scope of practice, because, again, some scope of practices, whether you are reimbursed or cash pay, if you are examining a patient, if you are making a diagnosis, if you are treating a condition, you are practicing a certain level of health care that does require legal authority to do that. It doesn't matter whether you are being reimbursed under a third-party

system, or if it is self-pay by an individual patient.

So, there probably are slightly different issues for access and delivery, but it lies around scope of practice, the legal authority to practice their profession and be able to operate within their education and their scope of practice. Again, there are some provider groups where licensure is not necessary to practice their profession.

Does that make sense?

DR. WARREN: But it is necessary for reimbursement.

MR. DEVRIES: Yes. For the most part, yes.

DR. WARREN: So, basically licensure is so that we can have our own little handshakes and our own little language that nobody else can understand. Therefore, the patient suffers because this group won't refer to the next group because they don't understand what they provide, and that group won't be referred to the next group because of professional prejudices.

MR. DEVRIES: Well, I think that that assumes there are barriers that can't be overcome through education of the different provider groups.

I believe, ultimately, licensure provides credibility to a provider group, and therefore enhances the opportunity for the referral process to work between providers.

DR. WARREN: Certification.

MR. DEVRIES: Well, certification or registration or licensure, whatever is the appropriate.

Part of it is competency, but part of it is the legal authority to practice within that state. There are several overlapping issues here, but the bottom line is legal authority to do what they are doing.

DR. GORDON: This is interesting and an important issue, and I think this is revealing something that is still unresolved in terms of this whole area.

What I would like to do is to go through what we have here, and maybe, Don, this means that you need to interact where licensure is being used as the criteria. Maybe more discussion needs to go on between you and George, as well as Linnea and Joe, and the other members of the committee, about how this needs to work. I think we still have not resolved all the issues of certification, licensure, registration, that that is very

much in the background here. The more clarity we can get, the better, I think.

DR. FINS: It is in the background. It is not our decision to come down on one side or the other, really. One state might decide to be more libertarian than another, and what we just simply tried to do is provide a set of parameters that they would take under consideration, because I don't think we can resolve this question. It is not our prerogative to resolve it at the federal level.

DR. GORDON: No, I understand. Whether or not we resolve it, there needs to be some statement and clarification of the issues, and what some of the concerns are on all sides.

Do you understand what I am saying?

MS. LARSON: I understand, but I do believe that that was addressed in this actual document. I will go over it once again, but I do not believe it was the intent to stifle people.

DR. GORDON: No, Linnea, that is not what I was saying, and that is not what I feel. I think there is an issue that people have in terms of understanding