In addition, applicants must certify that they have two years of medical acupuncture experience subsequent to the basic 200 hours training, and a case history of no fewer than 500 medical acupuncture treatments. They must also provide three physician references as to their character, professionalism, and adherence to standard clinical practice.

In effect, the ABMA has designed a program that brings medical acupuncture into the spectrum of the Western medicine specialties, and by so doing, will raise the awareness and the reputation that complementary medicine in the minds of the American public.

The requirements and oversight of the certification program will continue to raise the bar for all practitioners of acupuncture. We ask your support in recognizing that medical acupuncture is a practice and approach unto itself whose standards are in keeping with the most advanced health care system in the world, and whose guardians are committed to its success.

Thank you very much.

DR. GORDON: Thank you all very much. Questions from commissioners? Charlotte, you had one

earlier?

SISTER KERR: How much time do we have for questions? All right, I have three questions.

Now, this is Dr. Frye, correct? What was the outcome on the offering to assist in the bioterrorism? Basically, they kept referring you back to NCCAM to get money?

DR. FRYE: You have the two letters at place, I think, that we received back.

SISTER KERR: I have, yes.

DR. FRYE: Basically, they gave us pat information about what was going on, and said thank you very much, we can do this.

SISTER KERR: And you feel you have something more to offer in that area, specifically?

DR. FRYE: We think we have a great deal.

SISTER KERR: You are, at this point, at a dead end, right?

DR. FRYE: Right.

SISTER KERR: Thank you.

Boyd, thank you for being loyal to your people and all of us. I was concerned, at the end of your

report you said that you couldn't review because it is not given to you. I thought everything was on the computer.

MR. LANDRY: No, that's not true. We are only given the recommendations and the action items.

SISTER KERR: So you are given the recommendations.

MR. LANDRY: Right, because what appears to be the case, is the text is somewhat different. Although it is supposed to be in conjunction with the recommendations and action items, we are not able to review that information until its final form.

SISTER KERR: Thank you.

Dr. Nakazawa, thank you very much for your presentation. I am around the corner from you in Columbia. May I have some clarification? This new board that was formed, it is a separate entity. So you are not in any formal relationship with the American Academy of Medical Acupuncture?

If that is so, I am interested in the board certification. Would you be separate or considered to have much higher requirements than being just a member of

the American Medical Acupuncture?

DR. NAKAZAWA: About two years ago, the ABMA group has been actually established within, as I mentioned, AAMA. So that, at this moment, we are at the beginning stage, we are not completely separated yet. We have, now, at least a separate entity, at least nothing to -- what do you call it -- interfere by the AAMA.

However, financially, we are not anything. We just started off. We are still in the embryo stage, I should say, for that matter.

DR. GORDON: Other questions? Effie.

DR. CHOW: Thank you all for your input.

Dr. Nakazawa, can you explain why was the ABMA established within the AAMA? What is the purpose of having the two?

DR. NAKAZAWA: This has been, as you know, 1987 when AAMA was established. The physicians of the group, I understand, they all some day would like to have one separate board for a medical specialty like a board certified surgery and so forth. At that same time, we should have to elevate our standards to certify the physician, certify the acupuncturist.

So in a way, they tried to establish a little higher, let's say, level, because if you just become a graduate from a bona fide acupuncture school -- as you know, we have so many in the United States -- as long as you apply to AAMA, you can be a member, but it is not necessary that everybody has upgraded education and that they have to take so many courses and so forth. And so, they decided to have some, perhaps, higher standards which needed some kind of certification.

As you know, AAMA has the same thing. Someone can be an internist, graduate from a bona fide training school, but he or she may not be board certified. To have board certification, he or she has to go take an examination, which can be quite difficult. They have to go through so many hours of training, et cetera. So this kind of, a little bit, distinguishes the physician, so to speak.

DR. CHOW: I guess I am not quite clear. I guess the AAMA and the ABMA, you have the same number of hours of training, and then the ABMA requires continued education, and AAMA does not require continued education? How do you get that extra status?

DR. NAKAZAWA: Well, we have bylaws which are set by the so-called membership in AAMA, but the highest is a fellow, and the next to the regular members and so forth, we have to have at a minimum, to qualify, 75 hours education in three years to be in a fellowship.

ABMA, however, you have to not only finish school, college, you have take an examination, a board certification examination. Once you pass that examination, he or she has to prove that this person has two years in addition to that, has a minimum of medical training in acupuncture, and also, as I said, no fewer than 500 medical treatments. This has to be proven with an affidavit.

DR. GORDON: Thank you. Wayne, or Charlotte, or both of you.

SISTER KERR: Just one quick question. Dr. Nakazawa, one of the things that I value, both in this work and in my own professional work, is collaboration and partnership. My own experience has been -- and I have such respect, in my own background in teaching nursing, for the medical community -- that we would partner and collaborate in our continuing education. I

have often seen many good workshops from the doctors.

I am wondering if you have ever considered any leadership in working to bring us all together, the non-physician acupuncturist and the doctors, because the bottom line is we work together; there is so much we share. It seems like we are still having trouble coming together.

Would you comment on that?

DR. NAKAZAWA: I appreciate very much your concern, and I am so glad to inform you that we now, at the AAMA and the ABMA, we have, as you know, an annual symposium. We have about 400 to 500 physicians get together every year. This year, we are open to everybody. So anyone who wants to come -- you mentioned something, licensed practitioners -- anyone who would like to come in, that's fine.

As a matter of fact, we are going to have a speaker. It's not necessary to be a physician.

SISTER KERR: I really commend you on that, and I cannot thank you enough for that offering to the community. Thank you.

DR. GORDON: Any other questions or comments?

Wayne, please.

DR. JONAS: I want to thank the panel and I want to thank, Jim, for making sure that we did this, and I think some others who suggested that we do this, because we saw this huge list of public testimony over the past two years. Somehow, as we get involved in the discussions, it seems to rapidly fade. I am speaking for myself here, it seems to rapidly fade.

So doing this on a regular basis just flips off those neurons again and reminds me that this is in fact a massive effort of individuals calling out and saying, we want something different in health care and we are doing something different in health care; pay attention.

I would like to ask Dr. Frye if she would elaborate a bit on her organizational analogy around homeopathy. If complementary medicine is the disease and we are trying to select a remedy for this, would you suggest that a constitutional approach would be more effective, in which we pick a single remedy infrequently given and focus on a very particular core issue, the essence, if you will: time; compassion; healing interactions; and healing function?

Or, should we take a more clinical diagnostic, mixed approach in which we make sure we have covered all of the symptoms, a head remedy for CAM Central, an ear remedy for the information, a feet remedy for payment, and give it more frequency at a lower potency?

And the second question, what is the potency? My understanding is that if you more precisely select the remedy, you can often get a very high potency at a very minimum dose, in which case, are we giving too much too often?

DR. FRYE: Can you do that again, one at a time?

DR. JONAS: Yes. What is the approach? Is it constitutional, where we need to prioritize all these massive recommendations we are making in saying, this is the one we need to do now? Or, is a more mixed approach, in which we need to cover all bases and give more?

DR. FRYE: Well, I think it is an approach that looks at all of the symptoms and understands that all of those ultimately need to be healed, but there are some priorities about in what order that will happen.

I certainly can't tell you what priority that

should be. I haven't been sitting here for two years giving thought to that, but I am sure that that could be done. Some of it, again, addressing the issue of mandating this kind of thing is allowing each part of the organism, each structure to figure out for itself what it means to heal, and just simply giving it the mandate that this is what has to be done, and figure out how to do it.

A similar example might be in the City of Philadelphia, where I am from, there is a mandate that when you erect a new structure of any significant size, it has to have an art component to it. Nobody tells them what that art has to look like. It might be a particular garden or a particular fence, or a particular sculpture, but as long as it is something that is generally considered to be art, they can figure out for themselves how to prioritize that.

So I think if you tell NIH that a certain percentage of its budget has to go to CAM, you can let them figure out how they want to do that, but that the mandate has to be there across the board.

DR. JONAS: So it sounds like a constitutional approach to me, then.

DR. FRYE: I think so.

DR. JONAS: Okay.

DR. GORDON: Thank you all very much. I especially want to thank Boyd Landry for his coming again and again, and presenting his point of view to us.

[Applause.]

DR. GORDON: We have one more panel, Riva Touger-Decker and Cassandra Wimbs.

Riva, would you like to begin, please.

Riva Touger-Decker, PhD, University of Medicine and Dentistry of New Jersey

DR. TOUGER-DECKER: Good afternoon. I Riva Touger-Decker, and I come as acting director of the Center for the Study of Alternative and Complementary Medicine at the University of Medicine and Dentistry of New Jersey. I don't think anyone can say that 10 times fast.

The need for allied health, medical, nursing, and dental education programs to prepare students with the knowledge and skills they need for good patient care is driven, in part, by increases in CAM use by consumers.

These health providers must be able to

understand the spectrum of practices known as CAM, efficiently question their patients, understand and evaluate their individual reasons for use of CAM, be familiar with the potential harm of these therapies, whether they are used independently or in combination with conventional medicine, and the potential benefits, and advise consumers accordingly about the use of such therapies to provide the best possible care.

They must be able to understand and adapt to changes in health practices, collaborate across disciplines, and develop referral systems among those disciplines.

Education of traditionally trained health professionals just has not kept pace with consumer usage patterns of CAM. All health professionals need to be able to provide consumer with scientifically sound, credible guidance about CAM. Although several allied health and medical associations have formed special interest groups, their efforts continue to remain inadequate to meet the needs of students in these disciplines.

The Society of Teachers of Family Medicine has

published guidelines for CAM education of medical students. No such guidelines exist for teaching students in allied health or dentistry. Although U.S. medical schools have formed a consortium of academic health centers for integrative medicine, there is no organized effort to integrate CAM in allied health and dental schools.

This past July, our dean, Dr. David Gibson, the dean of UMDNJ - School of Health Related Professions, conducted an Email survey I designed to look at allied health profession schools in the U.S. who are members of the Association of Schools of Allied Health Professions. Less than one-third of the schools responding had elective courses, and none of them had required courses on CAM.

It is imperative that all health professionals have a detailed understanding of scientifically sound CAM practices. Such professionals must be able to apply rigorous scientific standards when examining CAM modalities to promote comprehensive care, reduce risk of interactions and potential harm, and enhance benefits. The ability to differentiate between practices supported

by sound research and those that have no scientific basis is important for public safety.

The establishment of core competencies and curriculum guidelines for CAM education is critical for integrative and safe patient care. Such guidelines should be available for adoption by educational programs for allied health professional, and all health professionals with direct patient care responsibilities.

The collaboration of key professional associations in developing these guidelines in competencies would be invaluable to help to establish and broadcast them to their constituents.

DR. GORDON: Thank you very much.

Questions from the Commissioners?

[No response.]

DR. GORDON: I just want to raise a question, which I don't know if you were for earlier discussion, when Tom Chappell was asking about schools of dentistry, and we have a discussion with some staff input.

What do you think the issue is with schools of dentistry? Why is there what seems like a lack of interest in these approaches?

DR. TOUGER-DECKER: I don't know that it is a lack of interest. As a nutritionist by discipline, with a doctorate in nutrition and oral health -- I work in a school of dentistry, as well as with our allied health school -- I think, in part, part of what has affected medical education is they don't see the direct link. In many ways, dental education, like some others, is almost bulimic in its approach, in that there is so much to absorb, and how much do they have to spit back. It is just a practical example.

I sit in the American Association of Dental Research in their Nutrition Section. As a research group, we are trying to approach it. The ADEA, The American Dental Education Association, hasn't embraced it as a competency priority.

One of our goals at UMDNJ -- and I was here earlier, and pleased that we broadened it to all health professions -- is that we are center that represents our three medical schools: nursing; allied health; dental; and biomedical science schools, but we are housed in an allied health school.

Our goal is to come up, unless others come up

sooner, with curriculum guidelines and competencies, because there is an interest in some dental schools. Our feeling is if we do take the beginning approach, others will start to adopt and collaborate.

So I don't think it is a lack of interest, I don't think it has become a priority on their radar screen.

DR. GORDON: Thank you. Don.

DR. WARREN: On the dental school front, there is so much information to be taken in just to pass the boards. If we put in a CAM course, I get the indication from Tennessee, possibly, that that might affect their accreditation for the school, because the American Dental Association doesn't really approve of any CAM.

Is that a potential possibility?

DR. TOUGER-DECKER: I don't know that ADA, ADEA, doesn't approve of any CAM, it is not a competency. I am not sure that they need a specific course. In other words, it may need to be that those competencies in CAM are integrated throughout the curriculum in courses like clinical medicine, like preventive care, that it is not a course, that it becomes part of the other competencies

that have. That may be a more effective approach, rather than to keep starting new courses.

DR. WARREN: But to do something like that, you have to have the faculty educated in CAM before you ever start that integration into the courses.

DR. TOUGER-DECKER: Exactly. It has to be something that the academic deans embrace, and then get their faculty to embrace it. We have taken the approach of trying to embrace faculty, because if we don't, students won't get to implement it or learn it. I agree with you.

DR. GORDON: Any other questions?

[No response.]

DR. GORDON: Thank you very much. I would be curious, Riva, as this develops, if you would at least keep me informed about what is happening with dental schools and allied health professions.

DR. TOUGER-DECKER: I will. I will be out at their meeting in two weeks, so we will let you know.

DR. GORDON: Great. Thank you.

Public testimony, the time has concluded, and we are going to return to our deliberations on Access and

Delivery.

Do you need a two-minute break? Let's have a five-minute break -- do you want 10 minutes? Does everybody want 10 minutes here? Okay, let's take 10 minutes, and then let's come prepared to move through Access and Delivery to the end.

[Break.]

DR. GORDON: Let me remind everyone that what we are going to be doing is we are going to moving through Access and Delivery, then we are going to go to Reimbursement, and at the end we are just going to remind everyone who is still standing, or sitting, what the procedures are going to be for the next couple of weeks.

MR. DeVRIES: In terms of a time check, Chair, what is the time frame, given it is 4:00 now, to get these things completed?

DR. GORDON: My hope is that within the next hour to hour and 15 minutes, we will be able to finish Access and Delivery. I think Reimbursement is in pretty good shape, is my estimate, and I am hoping we can do that all together in 45 minutes to an hour. So I am hoping we will finish shortly after 6:00, or by 6:00.

MR. DeVRIES: I need to leave at 6:15. Obviously, if you all want to continue until 9:00 or 10:00 tonight.

DR. GORDON: You're not staying for the pajama party?

My hope is that by 6:15, we will all have completed our work and will happily go home.

Charlotte, you raised a question at the end of the discussion that I wanted to come back to. We are currently discussing Recommendation Nos. 1 and 2, and then we are going to move into action items, discussion both of the ones that are present, and also of other ones that commissioners feel are needed.

We were in the process of discussing the recommendations, and Charlotte had a concern, which I would like to come back to. The recommendations are behind me, Recommendation No. 1, and then for Recommendation No. 2 there are two options for some of the wording that Wayne worked with with Don, I believe. Right?

So everyone cam look at those to refresh their memories. Can you read them? No? Let me read.

Recommendation No. 1: "Federal government should evaluate current barriers to consumer access to safe and effective CAM practices and qualified practitioners, and develop guidelines to remove those barriers and increase access."

Then, the notation here is that Action Item Nos. 6, 7, and 8 would change tone, and perhaps additional ones would go under that.

Recommendation No. 2: "The federal government should assist states and professional organizations in developing guidelines for practitioner accountability and confidence in CAM delivery, including either standards of practice, scope of practice, education and training, registration, licensure or exemption," which is spelling out the different categories that were present in the action item, "or just regulate the practice," and end there.

DR. JONAS: There is one item missing, which is professional oversight, which is peer review from the organizations itself. That would have to be in there in any case.

DR. WARREN: Is that where we were talking about assessments?

DR. JONAS: Professional oversight.

DR. GORDON: Where would that go?

DR. JONAS: It would go in one or the other. My feeling is that that should be in it, regardless of whether we use A or B. "B" was the suggestion to summarize all of A to make it less cumbersome. "A" spells out more specifically some of the items, but in any case, professional oversight should be on there because that is what the professions would be responsible for, and the guidelines should include that. That is different than, simply, regulation. The professional organizations provide that, not the states.

DR. GORDON: Charlotte, let's come back to your issue, and then we can move ahead.

SISTER KERR: I want Boyd to listen to this, too. He is not a commissioner, but a brother.

Anyway, my concern that I need to talk out is, I tried to image this, and I'm trying to think if I were president of the Maryland Acupuncture Society, for example, and I got a phone call, and we have worked on this for years, and the government wanted to help us develop new guidelines for our practice accountability, I

suppose, depending on who I was, I would either say, "Well, that's good and creative," or, depending on how they were going to proceed, maybe I would say, "Well, how come they're coming in now and it's all this work."

Now, it could be that the intention of this is that the federal government says, "Look, every discipline has disparity and diversity. We would like to hold a convocation where you bring all your folks together, and we would like to help facilitate a partnership of us, you, and state representatives, if we are all on track, are we serving the people the best we can, and let's talk about it."

I really need some feedback here, because my sense is, when I read this -- particularly when I read that article that somebody brought on yoga and I was realizing how people are perceiving, maybe, things we are doing -- that I thought, "Gee whiz, everybody is getting scared that we are going to tell the yoga people what to do." I thought, "Oh my gosh." I have felt, actually, pretty comfortable thinking we are not doing any of these things.

So this sounds a little bit more back to what I

have tried to express. This is probably important to me, to feel comfortable about it before we leave.

DR. GORDON: So, what are asking for?

SISTER KERR: The concern is, are we saying the federal government is going to call everybody in and say, "Well, how are you all doing," and "What did you all do," write it down, tell us," or are we going to say, "Let's get together and talk about, are we up to speed, can we be of service to you."

I mean, say there is a state that has no law. For example, I can't practice in -- or, maybe we just changed the law, but I think South Carolina, even, which is my home state, you can be a dentist, you can work under a doctor.

My point is that that state, for example, might benefit from some national regulations, and we are trying to get it together in acupuncture. Maybe the federal government is the person to convene this, I don't know.

DR. GORDON: Charlotte, you are asking for feedback from other commissioners? Okay.

Joe and Joe, to begin, and Linnea.

DR. PIZZORNO: Well, I think this conversation

has been really quite good because it has helped me to understand the multiplicity of factors that seem to be getting a little confused here. It seems like there are three things here. One is the recommendation of licensure, certification or exemption as appropriate to promote public safety and differentiate amongst practitioner types.

The second is, the government providing assistance to the states, and to try to figure out how to do it, because this is a huge challenge for the states.

The third part, which is something that has come up that's new, that Wayne brought up, which I thought was really good was, some kind of evaluative process. Because we do have licensing right now, we do have certification, and we now have this experiment in Minnesota, it would be nice if the federal government could provide some kind of evaluative process as this goes on. So five years from now, we take a look and say, well, what actually happened.

In at least the limited numbers of states where naturopathic doctors are licensed, we look at malpractice data, and we look at court decisions, and things like

that, that the safety is actually pretty good, but that is something that has got to be studied for everything that is going on to see what the situation is.

So I think, by looking at what Wayne has here, that looks to me more like an action item, because it doesn't embrace all these ideas. So I would like to have one idea which says what we want to accomplish, and then a series of action items.

DR. GORDON: Joe Fins.

DR. FINS: I want to respond to Charlotte, and then also to Joe.

I think using a phrase like "offer assistance," was never ever meant that we could impose guidelines upon the professional societies. The acupuncturists and the TCM folks didn't agree to get along at public meetings here, they couldn't get it together.

I think this is one of the functions that the central office might be able to facilitate. So I think offering assistance versus requiring compliance with a federally mandate. So offering assistance.

The other thing is, I would add I totally agree with Joe said, that when there is a change in the law or

a new guideline, there should be an evaluative piece. The professions, HRSA, AHRQ, are all the kinds of agencies that could help with that evaluative process.

Then the other thing is that the federal central office can help disseminate and share information between states, although there was something in our earlier draft. There is an entity -- I forget the name of it -- where state legislatures communicate with each other. I think that is something that needs to be re-excavated from the December draft as well, as a clearinghouse function.

DR. GORDON: Joe, how do you respond to Joe P's thoughts about, these should be action items rather than recommendations?

DR. FINS: I think they are action items. I mean, I think the recommendation is that we should offer assistance, and these specific things could be delineated as action items.

DR. GORDON: Linnea? No? Anyone else?

[No response.]

DR. GORDON: We have two recommendations here.

Wayne?

DR. JONAS: I just liked the idea that Joe suggested about evaluation. If we do anything with that, I would suggest it should be a third thing.

DR. GORDON: A third recommendation, or an action item?

DR. JONAS: A third recommendation, yes, because that is a role the federal government could supply, is evaluating what these various types of models of access and integration are.

DR. GORDON: I think that is a great idea. I would like to get some decision on these two recommendations that are here.

So let's talk about Recommendation No. 1. Are we in agreement with Recommendation No. 1? Yes? Can we have heads, hands, hearts?

[Show of hands.]

DR. GORDON: Recommendation No. 2, are we in agreement? Are we with this one? Yes? Okay.

SISTER KERR: No. No.

DR. GORDON: No. Charlotte, okay. Charlotte is not on for No. 2.

SISTER KERR: I feel unheard, except for what

Joe said, to say that we would offer to assist states and professional organizations.

DR. GORDON: What would you like to have happen?

SISTER KERR: Well, I want you all to respond to my concern, do you think anybody might feel like this? I am delighted to think there would be a federal office that would say -- I said it a few minutes ago -- "We would like to offer to help you all organize."

DR. GORDON: So you would like to hear if other people share your concerns.

SISTER KERR: Or tell me why I should not be concerned.

DR. GORDON: Effie.

DR. CHOW: You know, we have had this discussion many times. Also, many people have testified that they don't want the government coming in and telling them what to do. Joe said it is "offer," but I think we need to be very clear about that, and perhaps No. 2 isn't quite clear about that.

I thought that was the decision of the group, too, before, that we would not regulate but we would

assist associations, relevant associations and organizations, to help them make their own decisions.

DR. GORDON: How about "offer assistance to interested state," et cetera, et cetera, as a way of modifying that?

DR. CHOW: It is still state regulated. If you are offering to states, it has to be the state with the associations, the relevant associations, that are making the decisions.

DR. FINS: Can I just clarify? There are two things that are conflated here. There are the professional bodies, which is one kind of assistance, and then there are states that are writing laws and regulations.

So we might want to write two proposals or recommendations that look identical to each other, and distinguish a state one, and then a professional society one, because it is a little different.

DR. CHOW: I think a simple way is to have consultants with the relevant profession, because in setting up the California law, we were consultants to Duffey and Musconi, et cetera, to design the laws.

DR. GORDON: How would you rewrite this recommendation, then, Effie?

DR. CHOW: I don't know how exactly it is stated, but add in there, "with the states and the pertinent CAM professional associations," or "licensing associations," add it right into there.

DR. GORDON: I thought it said "offer," but it doesn't say "offer," and I think maybe that is an important item to have in here.

MS. MILLER: No, that has to be added.

DR. FINS: It has to be added.

DR. CHOW: Okay, sorry.

DR. GORDON: No, I don't see "offer" in Recommendation No. 2.

DR. FINS: "Should offer assistance to."

DR. GORDON: That is different from "should assist."

DR. FINS: Right.

DR. GORDON: So, could we put that in, please, "offer assistance"? We obviously need some more discussion.

Charlotte, you have evoked more discussion. So

let's continue with this. Joe.

DR. PIZZORNO: I would like to make two recommendations. I am kind of splitting what is up there in half. So let say them both, because I think it is addressing the issues.

DR. GORDON: Can we respond to Charlotte's concern first. Is this a direct response?

DR. PIZZORNO: I think I am directly responding to her concerns.

DR. GORDON: Okay.

DR. PIZZORNO: So let me read both these recommendations in total before people respond.

Recommendation No. 2 should be very similar to what is currently in the book, with one major change. That is, "Practitioners who provide CAM services, and products should be regulated by the states using" -- cross out "standard" -- "in an understandable framework that assures accountability to the public, and that contains provisions for regulation, licensure, and exemptions."

Recommendation No. 3: "The federal government should offer assistance to states and professional

organizations in developing guidelines for practitioner accountability and competence in CAM delivery, including periodic review of the impact of these regulations."

DR. GORDON: Other responses? I just want to make sure we have the responses to Charlotte's concerns. Effie raised one. Other people have any concerns about intrusion?

SISTER KERR: My own suggestion to myself is, look at No. 2 as it is. Just for the moment, let me just say the "Federal government should assist states and professional organizations," "should assist to evaluate existing guidelines for practitioner accountability."

Now, we could include, also, "offered to assist them to evaluate." My concern, which is why I am still interested in input, is, when you put in "offer assistance," which I feel better about, my sense was you all really wanted to say something else, that we fundamentally may disagree. I don't want to remove whatever the concept was.

Did you all really feel the federal government should be setting these guidelines?

DR. FINS: I really feel that was never, ever,

ever the intention. I think that the text will reflect this. I think it is simply that there are certain things that the states may not be able to do because they do not have the expertise that resides in the federal government. It is really to offer technical assistance and things like that.

With respect to the states, we can't mandate what the states do, because it's a constitutional issue. If the language reflects that, I think we can move on.

DR. GORDON: Steve has a comment he would like to make on this, too.

DR. GROFT: Probably about six or eight months ago -- I am not even sure -- we received a letter from the National Association of Governors that said they are looking forward to our recommendations. So they are aware of what is going on. I think it was talking with the various people outside, they are ready. They want to see it.

Some states, as Joe mentioned, don't have the capability to work alone. They want to get things together that make sense for all practitioners. I think we identified the problems of going from state to state,

and many states want to avoid this complication.

SISTER KERR: Well, I don't disagree that they aren't ready for our help from their perspective, and that is good to hear. My balancing to that is that we do it in a collaborative way and that we are partnering. So if we offer the assistance, then I think that's great.

DR. GORDON: Charlotte, does this respond to your concerns, what you've heard, or is there something missing?

SISTER KERR: Yes, unless, again, we wanted to add in that the federal government should offer assistance to states and professional organizations in evaluating guidelines for practitioners.

DR. GORDON: How about that, in evaluating and developing? Is that fine? Let's add that, then, okay.

Are we okay with this one now?

SISTER KERR: Wayne had something.

DR. GORDON: Let's have agreement about this.

DR. JONAS: I actually --

SISTER KERR: He disagrees.

DR. JONAS: I disagree with this direction. If anything, I think maybe the federal government should

just go ahead and do it, because guidelines are guidelines, and then those are taken by states and professional societies to develop their actual regulation standards.

So, if anything, I would say that the federal government should go ahead and develop their own guidelines, work, of course, with the states and the professional organizations in doing those so that there are some standards.

The reasons for that is, I don't think you can have your cake and eat it too. If you are going to say, we need more access; we want to have more practice evaluations, then you also have to have accountability. This is the accountability side of it. The federal government cannot dictate that, but this is not about dictating that.

DR. GORDON: Wayne, now, is this your second personality? Didn't you put this recommendation up here?

DR. JONAS: Yes, I did, but now it is being weakened and softened, and my feeling is that the force of it will be undermined, I think, if it becomes, "Well, we would like to try to help the states out. For those

that want to, we are going to have a little meeting, and then the states can come and we can talk about this," and this type of thing. I think that, then, becomes very useless.

DR. GORDON: How would you like to reword it?

DR. JONAS: Well, I like the wording. I mean, I will accept the wording that is in there, with some of the issues there as it is, but I don't think we should weaken it.

In fact, if anything, we should say the government should facilitate the development of guidelines for practitioner accountability and competency with states and professional organizations.

SISTER KERR: That's not taking over. That's not bad.

DR. GORDON: Now, Charlotte, does that make you more nervous, or less?

SISTER KERR: Well, first of all, you still haven't written in what we just said about evaluating, so put that in there. So, just to back up on that, Ken, can you put what we put, and we may take it away, "in developing and evaluating guidelines."

DR. FISHER: Where?

SISTER KERR: On No. 2.

MS. SCOTT: Developing and evaluating guidelines.

SISTER KERR: Now, I wanted to hear what Wayne has to say, which is why I was saying what I was saying. If we are going to put "should offer assistance," it isn't what Wayne thinks. We may all disagree with Wayne, but what Wayne just said to me sounded more participatory.

So if you want to restate that, Brother Wayne.

DR. JONAS: All right, just to make it clear, it is that, "The federal government should develop," and you can say "evaluate and develop guidelines for practitioner accountability and competence in CAM delivery for use by states and professional organizations in developing their practice regulations."

DR. GORDON: How does that sound to you?

SISTER KERR: Well, we still have the issue that they are developing for.

DR. JONAS: Yes.

SISTER KERR: I don't get it, Wayne. Why do

you think they should develop it?

DR. CHOW: Wayne, you said it different from this last time. The last time was really perfect, but this time --

DR. JONAS: Okay. I don't mind the way it's currently written up there, and the evaluation aspect the way it's written up there. I mean, I'm happy with that.

DR. CHOW: It wasn't the way it was written up there.

DR. GORDON: I would like to get agreement very quickly on one version or another, and then move on.

DR. JONAS: I don't mind the way it's up there like that. I think that that is adequate for the way it is, as far as I am concerned.

DR. GORDON: Could you read it aloud so everyone can hear it, so we know what we are talking about? Because some people can't see it.

DR. FISHER: Which word there? This, you agreed to.

DR. JONAS: I would rather put "facilitate." I would say that, "The federal government should facilitate the development of guidelines for practitioner

accountability and competence in CAM delivery with states and professional societies."

DR. CHOW: Yes.

DR. GORDON: Without those modifiers. You have Column A and Column B, too.

DR. JONAS: You could add that on top, "including."

DR. GORDON: Veronica.

DR. GUTIERREZ: In the text, or maybe in a phrase at the end of that, I would like to see how this affects consumer access. I think we need to wrap that up by saying that somehow, as a result of that, there will be portability, if there is that much federal involvement, to allow providers to move between the states. Otherwise, how can it affect access?

DR. GORDON: That may be a consequence, but I don't think that can be part of the recommendation.

DR. GUTIERREZ: Okay. So we will address that separately.

DR. FINS: We have a whole other section to do. What I would suggest, Veronica, is that for letter D under this evaluation piece, we can look at its impact on

consumer access, and leave it at that.

The way it was originally written, with "offer assistance," I think we could have a preamble. Maybe we can say, "Recognizing the need for accountability, the federal government should offer assistance to states and organizations."

DR. GORDON: I don't think it is because of the accountability.

DR. FINS: I mean, we have recognized the need to some extent, but we are not in a position to impose it. So that's why we are having this rhetorical problem.

DR. GORDON: I think we are okay with this recommendation, rather than get into a preamble, which is going to confuse things a little more.

Are we okay with this one as stated?

SISTER KERR: If I read it to be "The federal government should facilitate the development" -- Ken, could you help us? -- "and evaluation of guidelines for practitioner accountability and competence in CAM."

So we want them to just facilitate the --

DR. GORDON: You have left out the collaborative piece with states and professional

organizations.

DR. FINS: This is not making sense, just editorially. I don't think this makes sense. I think you are actually arguing against your original point.

SISTER KERR: I'm just trying to receive what Wayne said first.

DR. FINS: But the federal government now is actually doing this, and it seems to impose it. Whereas, I think the original "and offer assistance" --

SISTER KERR: They can offer to assist in the facilitation of the development.

Do you all think I'm over-concerned?

DR. GORDON: I think Joe is right, it is getting more confused. I think the way it was stated earlier was more collaborative and less of an imposition. That seemed to be what the general agreement had come to, and now we are complicating it again.

DR. CHOW: Wayne, why don't you write what you said, instead of editing all the others.

DR. GORDON: Don.

DR. WARREN: I leave to go to the bathroom, and I come back to this. I think we need to leave "assist"

up there, not the other part. We need to have "facilitate the development," yes, and we need "evaluation" in there. I think we need to add B part to it, and forget the rest of it. That simplifies the wording.

The states are going to regulate how they darn well want to.I

DR. PIZZORNO: I think it's fine to put B in there, if we then go back and use a modified version of Recommendation No. 2 as Recommendation No. 3 for what is in the text on page 9.

DR. GORDON: I think it is a question of whether we need to decide if we still want the Recommendation No. 2 that is in the text. I think we have to establish whether we want this or not.

DR. PIZZORNO: I think we want both.

DR. GORDON: Okay, but we are proceeding one at a time here. So I would like to get a decision on this one, and then we can go back and look at the other. Otherwise, we are just jumping around.

Would somebody read the final text, somebody whose brain is not overly compounded with extranei?

Anybody got it? Wayne, go ahead.

DR. JONAS: It needs to be rewritten, but I will read it as I think it says: "The federal government should assist states and professional organizations in developing and evaluating guidelines for practitioner accountability and competence in CAM delivery."

DR. FINS: I think, grammatically it doesn't work.

DR. JONAS: "In delivery of CAM services."

DR. FINS: "Guidelines for."

DR. JONAS: "In guidelines for practitioner accountability."

DR. FINS: "Guidelines to promote."

DR. JONAS: "Guidelines for practitioner accountability and competence."

DR. FINS: Maybe "to promote practitioner accountability." Again, Sister Charlotte's comment about the sensibilities out there, now I want to know if Sister Charlotte with this declarative.

DR. GORDON: I much prefer "offer assistance." "Assist" is a little too Big Brotherish for me. I think it really will offend people, that people will feel they

have to accept it.

DR. JONAS: Who will it offend?

DR. GORDON: I think it may offend people who feel the state is going to impinge on them in some way. I think if we are offering assistance, then it has a gentler feel to it.

DR. JONAS: They will impinge.

DR. FINS: I mean, if I look at professional societies in conventional medicine, as an evolved profession, they set their own professional guidelines about certification and all those various things. So I think if the American Board of Internal Medicine needed the assistance of ARHC, they would appreciate the assistance, but they would not want the imposition of guidelines or standards.

I think "offer assistance" is very collegial and you are more likely to have more progress that way. So I would have a hard time with "should," but rather say "should offer assistance" to promulgate whatever we are talking about.

DR. GORDON: Can we agree to this, "offer assistance" and the rest of it the way it is? Yes? Yes?

DR. WARREN: With which modifier?

DR. GORDON: Are we agreed, then, on this one, with B, the simplified ending? Okay.

Have you got that? Maureen, do you have this down? Is it perfectly clear?

Let's go on. Joe Pizzorno wanted to discuss the present Recommendation No. 2. It's on page 9.

DR. PIZZORNO: So on page 9, Recommendation No. 2 would now be Recommendation No. 3, and would be, "Practitioners who provide CAM services and products should be regulated by their states using" -- cross out "standard" -- "in an understandable framework that ensures accountability to the public, and that contains provisions for registration, licensure, and exemptions."

DR. GORDON: What I would like to hear from you is a little bit about why you feel this is necessary, and then let's have some discussion, and then let's vote up or down.

DR. PIZZORNO: Because I think we have heard quite a bit of testimony that there are important reasons to differentiate the CAM practitioners out in the field. One of the big challenges, I think, facing the Commission

has been that there is a huge variation in who these people are. Those who have proper training, standards, some research, some track record of safety, need to be differentiated from those who don't. Right now, it is, in so many places, a free-for-all.

I think it is very clear that to facilitate that public safety, those practitioners with proper credentials need to be recognized so they can practice what they have been trained to practice.

DR. GORDON: Let me ask you a question. Would the Minnesota law come under this recommendation as an understandable framework, as one of the possible frameworks? It would? Okay.

DR. FINS: Can I make a modification that avoids that very simply?

DR. GORDON: Yes.

DR. FINS: Joe, I agree with you, and I would rewrite this with a very modest change: "Practitioners who provide CAM services and products should be regulated using an understandable framework that ensures accountability to the public and that contains provisions for registration, licensure, and exemptions, as

determined by their respective state."

DR. PIZZORNO: Perfect.

DR. GORDON: Don.

DR. WARREN: I personally think we ought to leave off "and that contains provisions for registration, licensure, and exemptions." I think that is redundant because you've already got regulations up there: "using an understandable framework that ensures accountability."

DR. FINS: What I think we are trying to capture here is range of options that exist that each state will choose from. The state has a range of options for their own point of view, and also relative to each individual practitioner.

You might want to have licensure for a naturopathic physician, and you might want to have registration for someone whose scope of practice is less intrusive, less dangerous, whatever. So this is simply to lay out there in the recommendation the possibilities, and then say, "as determined by their respective state," which gives due deference to the constitutional issue that the states regulate health care.

DR. GORDON: Let's hear some other thoughts

about this. Effie, please.

DR. CHOW: I have a question. We are assuming in this that all CAM services will be regulated and have an understandable framework, not licensing. Is that right?

DR. GORDON: It says, "licensing, registration, or exemptions." The way I read this, and please interpolate for me if I'm wrong, is that we are asking the state to set some kind of rational framework for dealing with the CAM professions, and that framework is going to vary from state to state. We are presenting licensure, registration, and exemptions as one set of criteria, although not exclusive.

Is that correct?

DR. FINS: Yes, just a range of options.

DR. GORDON: Don, you are shaking your head. Do you want to speak?

DR. WARREN: States have a system to determine that.

DR. FINS: No, they don't.

DR. WARREN: They don't have a clue?

DR. FINS: Sorry?

DR. WARREN: Are you telling me they don't have a clue?

DR. FINS: I mean, Joe is saying, and we have heard testimony, that there are some states that don't have any mechanism to provide a practice base for a range of practitioners, which leaves the practitioner unable to practice, and it leaves patients or consumers vulnerable to unregulated practitioners.

DR. GORDON: I would like to do two things. Don, I would like you to articulate what your concern is, and then George will be next.

DR. WARREN: I don't feel that licensure ensures public safety. I don't think that licensure ensures consumer protection, and I think we are assuming that it does. If the professions want to be regulated through licensure, they need to get that. They need to lobby their legislature and get it, but I don't think we should tell them that they have to be licensed, or suggest to the state that they just run out and license everybody.

DR. GORDON: I want to develop the question. Do you think there is anything in this recommendation

that makes sense?

DR. WARREN: Yes.

DR. GORDON: Do you think there should be regulation?

DR. WARREN: Yes.

DR. GORDON: So, what is your concern? Just with the licensure?

DR. WARREN: If I take it and I say, "Practitioners providing CAM services and products should be regulated using a standard understandable framework that ensures accountability to the public," period, I'll take that.

DR. GORDON: That's another possibility.

George, did you want to speak to it?

Thank you, Don.

MR. DeVRIES: First of all, the Minnesota Practice Act, I think we need to be really clear, when we were in Minnesota and we had our Town Hall Meeting, the director of the office that oversees the Minnesota Practice Act in Minnesota said that providers operating under that act were not able to diagnose a medical condition, were not able to treat a condition.

So we have talked about, previously, one of the action steps, and it may be what Joe has proposed, another form of saying this is, "The Commission recommends the states require the licensure, certification, registration, or exemption consistent with the provider's education and scope of practice."

If you consider that, if the scope of practice says they don't diagnose and they don't treat, well then, an exemption could potentially be the legislative solution. If they are a naturopathic physician who diagnoses a medial condition and treats a medical condition, they have to be licensed or they practice medicine without a license.

I think what I am coming back to is, the Minnesota Practice Act is not a cure-all for the provider. It does not help them practice their profession.

I believe, we need to recommend to the states that they enact the proper licensure, certification, and registration consistent with the provider's scope of practice and education. That, I believe, will address the whole spectrum of issues regarding exemption, all the

way up to licensure.

DR. GORDON: I would like to go back to Joe.

Don, do you want to respond directly to that? Please.

DR. WARREN: I like that, because it ties it to their level of expertise. But to say that the states are going to go in and license every CAM practitioner, I think that is a fallacy, and that is what I read into this.

DR. GORDON: Joe, but then I want to come back and see which of these makes most sense. Don made an alternative proposition, you just made yet another alternative, Joe made the first one. We have three on the floor. I would like to focus on one, if we could.

Joe.

DR. FINS: I have, maybe, compromise language that accommodates, I think, everything that has been said. The one thing that I am taking out, just at the outset is "standard," because there will be no standard from state to state. That is a separate question, and it is beyond our ken.

DR. WARREN: You mean no uniform standard

across the board? They vary state to state.

DR. FINS: That's right. So let me try this here: "Practitioners who provide CAM services and products should be regulated using an understandable framework that ensures accountability to the public, and that contains provisions for registration, licensure, and exemptions as determined by the respective states and consistent with their scope of practice," or "appropriate to their scope of practice."

The point here is that every state can say, okay, the scope of practice is A, and A is A in New York or Seattle, but Washington State might just decide to make it a licensure thing, and New York might decide registration. So it is trying to accommodate both of those issues.

DR. GORDON: Joe, are we addressing Joe's? Okay. Because we have one compromise proposition on the floor. Let's see if we can deal with it.

DR. PIZZORNO: I accept the friendly amendment from George and Joe to what I originally said.

But, Joe, I would like to emphasize one part, which I don't think you said, and that was, I think it

should be "education and scope of practice," not just "scope of practice."

DR. FINS: Okay. I agree with that. How about "education, training, and scope of practice"?

DR. GORDON: Is that okay, George?

MR. DeVRIES: My only concern is it is just too long. I mean, I'm okay with it, but I think we could just simplify down to one simple statement: "We recommend the states require licensure, certification, registration, or exemption based on the provider's education, scope of practice and training."

DR. GORDON: We spoke of regulation first, rather than licensure. We are really addressing regulation, and then we are offering different ways that regulation might take, rather than offering specific forms of regulation. So that's a slight distinction.

DR. FINS: One way of addressing George's concern about the length of this thing would be to say, "Practitioners who provide CAM services and products should be regulated to ensure accountability to the public" -- I guess it doesn't quite work, and we have to rewrite the whole thing, but the notion of understandable

framework was something that was intrinsic. We heard about that in the New York meetings and the Federation of State Medical Boards. So people understood and there was transparency.

DR. GORDON: I would rather have a long statement that we can agree on right now and be finished with it, then a short statement.

MR. DeVRIES: Can you reread it, Joe? Can you reread it?

DR. GORDON: Read it again.

DR. FINS: Okay, I think I've got what we said: "Practitioners who provide CAM services and products should be regulated using an understandable framework that ensures accountability to the public, and that contains provisions for registration, licensure, and exemptions as determined by their respective states and appropriate to their education, training, and scope of practice."

DR. GORDON: "Practitioner's education, training, and scope of practice."

DR. FINS: Right, "to their practitioner's."

DR. GORDON: Well, it is long.

DR. FINS: But it captures, I think, everybody's stuff.

DR. GORDON: Julia.

MS. SCOTT: It is long, but I thought we were going to try to get as complete as we could in terms of the intent of the commissioners, and then the writers were going to work with it.

I think if we try to put every little word in here and every comma, we are going to be here until midnight. So I would just urge us to trust. I think they got it, and if they didn't, they need to tell us.

DR. GORDON: Don.

MR. DeVRIES: Joe, I think we're okay with that. So, is everybody okay with that?

DR. WARREN: Don is okay with it.

MR. DeVRIES: Don is okay with it?

DR. GORDON: Great.

MR. DeVRIES: All right, we're done.

DR. GORDON: Good. Let's move on to the action items. Thank you.

There are a couple of different kinds of concerns here. We can start with any action item that

anyone would like. What I would prefer is, we can either relate to the ones we have here, or create new action items that better fulfill our evolving consciousness.

Buford, do you want to start with the one that you were focusing on so we can deal with that?

MR. ROLIN: I have spoken to Steve, and what we are going to do is we are going to back to the December language, which I think we all accepted, and we will go from there on No. 8.

DR. GORDON: Is that acceptable to everybody regarding indigenous healing practices and practitioners? I remember we had absolute unanimity in December. Okay, thank you.

What else here?

DR. BERNIER: Jim? Jim? George.

DR. GORDON: Yes, George.

DR. BERNIER: We are talking about the five items that are listed?

DR. GORDON: We are actually talking about all eight of the items.

DR. BERNIER: All eight.

DR. GORDON: Yes. Well, let's start with one:

"The Secretary of Health and Human Services should convene a National Policy Advisory Committee to address issues related to the regulation of CAM practitioners, provide guidance to the states, and provide a forum for dialogue on other issues related to maximizing access."

Joe.

DR. PIZZORNO: I think it is all consistent, up until that last clause of "maximizing access." I think it should be "maximizing public safety and health."

Others on No. 1? My feeling about this is, this is where we have to begin redressing the imbalance between regulation and access, and I feel the most important part of the advisory committee is ensuring something like access to safe and effective practices and qualified practitioners. I would start with that, and then move into the regulatory.

I really feel we need to indicate clearly that we are concerned about access as well as regulation, but let's have discussion. This is not fiat.

[No response.]

DR. GORDON: Is that okay with everyone? Yes.

DR. PIZZORNO: Jim, I think what is here

already written is pretty good. I am willing to live with it. I don't know about anybody else. I mean, I can modify a couple of words here and there, but it looks pretty good.

DR. GORDON: What is written in what?

DR. PIZZORNO: Page 11.

DR. GORDON: No. 1.

DR. GORDON: You're feeling all five are okay.

If we go to Nos. 6, 7, and 8, and understand the issues related to access have to be dealt with in that second part, and we understand that these are dealing with regulation, and that the order may be different and they may fall under different recommendations.

Where is Joe Fins?

DR. GROFT: He's okay.

[Laughter.]

DR. GORDON: He's okay with it, too? Steve is in constant telepathic communication.

[Laughter.]

DR. GROFT: I've got his proxy.

DR. KACZMARCZYK: One Joe is as good as

another.

[Laughter.]

DR. GORDON: Are we okay, then, with those first five, understanding that those are the ones that refer specifically to regulation, rather than to access and consumers? Okay.

Effie has a point, and then Linnea.

DR. CHOW: I'm okay with them, except in the very first there, "should convene a National Policy Advisory Committee, including CAM professionals," that we have been dealing in other issues, "to address issues related to regulation."

DR. GORDON: So you would say "CAM and conventional professionals."

DR. CHOW: Yes.

DR. GORDON: Health professionals.

DR. CHOW: Yes.

DR. GORDON: Is everyone okay with that addition? Yes? Please shake your heads, or any moving part. Good. Thank you.

Linnea.

MS. LARSON: This is simply a clarification

point. About an hour or so ago, Julia suggested that taking those last Nos. 6, 7, 8, and putting them under, I believe it was the No. 1 recommendation, and then adding on one or two more. So that's all I am saying.

DR. GORDON: We are okay Nos. 1 through 5, understanding that those go with regulation.

DR. GROFT: Joe does have a few words here underlined, so we may have to wait until he comes back in.

DR. GORDON: Veronica.

DR. GUTIERREZ: Where are we going to address the portability?

DR. GORDON: That is a whole other recommendation, or whole other action step, or it is something for the text. We need to discuss it.

MR. DeVRIES: Portability, is it in our charge?

DR. GORDON: If I can interpolate, the way I think we might address portability is to say that one of the reasons that national guidelines might be helpful is to encourage portability.

I was on the Pew Commission that talked about this at great length, so I think that that might be a

way, in the text.

So let's come back to, now, the action items relating, more particularly, to access, Nos. 6 and 7. We have already discussed No. 8. Can we have some discussion of these action items and any other action items that need to be put in here under consumer access?

Who would like to begin?

[No response.]

DR. GORDON: Should I read No. 6?

"The Department of Health and Human Services and other appropriate federal agencies should use health care workforce data, data from national surveys on CAM, and regional public health reports on CAM activities to identify current and future health care needs that qualified CAM practitioners may help address."

How is that one?

MR. DeVRIES: Good.

DR. GORDON: Okay?

MS. MILLER: Excuse me.

DR. GORDON: Maureen, please.

MS. MILLER: Only because of the tone of the report up to now, I am not sure we know what the needs

are for these services. So I am just wondering if we need a little rewording here, again, in the spirit of evaluation, et cetera.

DR. GORDON: How would you reword it, then?

MS. MILLER: Well, I think, at the current time, until we understand some of this, another thing we could document is the geographic distribution of these practitioners, because I think it will become clear that that is an issue.

DR. GORDON: That would be included in workforce data, right?

MS. MILLER: I'll have to look at the text.

DR. GORDON: The intent is fairly clear: "The current and future health care needs that qualified CAM practitioners may help address." This brings in the evaluation content here, because we are not saying that they are going to address all the health care needs, it is just a question of, is there anywhere they might be helpful. I think that is the intent here.

Max, do you want to address that?

DR. HEIRICH: I am wondering if we simply change the word "may" to "might" it might help.

DR. GORDON: That's fine.

Maureen, are we okay with this, then?

MS. MILLER: I am just still a little uncomfortable here.

DR. GORDON: With what? I can't tell.

MS. MILLER: It is what the health care needs actually are. I am just not sure that the government knows enough about this.

DR. GORDON: We don't know what their needs. If we knew the needs, we wouldn't have to do the surveys. The surveys are to determine what the needs are.

MS. MILLER: Well, let me tell you where I come from, in my experience at least, from HCFA, in the context of access, which is, we have actual ratios, numbers of physicians to the population, say, one general practitioner per 2,000 people or something.

That is what I am thinking about. When I read this, that is what I think, in the context of some people from my background, would read into this, is, we are making some statement about how many massage therapists or acupuncturists.

DR. GORDON: I don't know that we are.

Wayne, thank you very much.

DR. JONAS: Goodbye. I have to leave. I'm sorry.

MS. MILLER: If that is not what is needed, then --

DR. GORDON: I don't know that that is what is implied here. I don't read it that way, but maybe there is a way you can word it. I think what we are looking for here is, what is going on, what are the needs, and are there ways in which CAM professionals can help. It is more of an open question then saying there has to be one massage per 5,000 people, or for 50 people. So if it needs a little tinkering.

Is that okay with everyone? The intention is not that we are saying there has to be a massage therapist for every 100 people, but simply to find out what the health care needs are, and then to begin to think about ways that CAM practitioners might help.

Conchita, and then you, Joe.

MR. PAZ: Well, one of the things that Tieraona was saying, is to do some of these feasibility studies. I think this would be a really good area that might

benefit from some of these studies to see what the needs are.

DR. GORDON: I thought that is what it said.

Joe, go ahead.

DR. FINS: I think there are two issues here. One is what Conchita just said, what are the health care needs above and beyond the primary care kind of needs that we have been talking about.

What I would like to do is have 6(a) Action Item, to simply collate and get a sense of what the CAM health care workforce is, its characteristics, its demography, how many people are pure CAM providers, how many people are cross-trained.

If indeed the kinds of categories that are listed on pages 2 to 3 or 4 in this report, just to get a sense of who is out there, the distribution. So that's one question.

The other question, which I think Maureen is absolutely right about, is that we don't have a real way of matching up that data which we don't have to the identified needs yet, because we don't know what the need is for this.

So I think that is where a demonstration project would really make sense in a small catchment area, to do a survey to get a sense of the utilization of massage and herbal therapy and chiropractic, and get a sense of, what is a small, little area doing. Then to match the workforce to the need.

MS. LARSON: I actually do agree with that concept. I think that the use of the term "distribution," which addresses your issue about geographic distribution, too, and distribution of discreet CAM professionals is very important.

Then adding on, maybe a feasibility study and a demonstration project. I actually think we do have an opportunity here. There is already a place to do some analysis of data that is in the State of Washington.

DR. GORDON: My concern is that doing that doesn't tell us what we need to know. What would be interesting is to see what is going on, not just in the State of Washington where it may be much more advanced, but the issue is, are there needs out there that could be met, or that are being met by CAM professionals. What are the health care needs.

That is the fundamental question that is embedded here: Are there health care needs -- and I'm not sure how to get at it; I'm not trying to be prescriptive -- are there health care needs that CAM professionals could help to meet.

DR. FINS: I think that is a really complicated question. I think it would just simpler and it would be really additive to the process if we simply tried to just characterize the CAM workforce as a cornerstone for future policy work. Whether they meet the needs or not, you wouldn't know if you didn't know who they were.

So I think we could say in the text, this would be a first step to utilizing this workforce to meet as yet undefinable or undescribed needs. I think it is a more modest proposal at this late hour and it might be a way to go, and I would suggest that for consideration.

DR. GORDON: What do people think about this? Effie.

DR. CHOW: Using the data that is existing doesn't necessarily help us identify current and future health care needs, so I wonder if we could insert three ideas there: analysis of the data that is secured from

the health care workforce, et cetera, et cetera, and if necessary establish a feasibility study or demonstration project to identify current and future health care needs.

DR. FINS: It is also kind of vague, in a sense. Health care needs, you would specify for health promotion or rehabilitation or substance abuse. There are so many categories. I just think that we have a whole other section, and we have an hour to do it. Then there are a few other dangling participles that are left that we need to address.

DR. GORDON: I agree, obviously, that we need to move ahead.

Max, do you have a thought?

DR. HEIRICH: It seems to me that what would be most useful would be, what health care practitioners are prepared to work on particular kinds of health care needs, for example, substance abuse. We name the needs and say, who does that kind of work now.

DR. GORDON: That gets closer to bringing the two parts together, the survey of practitioners and the survey of needs.

Are we okay with Max fashioning some action

statement that will take account of those two?

Conchita.

MR. PAZ: Well, I do want to emphasize what Effie was saying, though, to try and make sure that we have that access to the needs part brought in.

DR. GORDON: I think it is important in these last recommendations not to lose the access piece, because I feel it tends to get subsumed again under the practitioners, and that is not the only issue here.

Joe.

DR. PIZZORNO: I want to finish this thought, and then I want to go on to a new thought.

DR. GORDON: You want to finish this thought, okay.

Are we finished with this thought? Are we okay with Max fashioning something that will take account of the possible responsiveness of CAM practitioners to a variety of health needs? Yes? Okay.

Let's go on to a new thought.

Joe.

DR. PIZZORNO: I am concerned that Julia's concerns are not being adequately met, because we still

have the problem of underserved populations who are wanting these services and don't have access to them. I am thinking about the community health centers as a good example. We have not addressed that.

MS. SCOTT: Well, quite frankly, I don't think my concerns can be addressed at this meeting, unless we are prepared to stay here a lot longer. What I am suggesting is that, as a result of all of this discussion, staff has a sense of what is missing here. Referring back to some of the earlier drafts, there were definitely recommendations in there that addressed consumers.

MS. LARSON: It was community health centers, we had a demonstration.

MS. SCOTT: I mean, it wasn't just consumers who were low-income, or minority consumers, but definitely those groups should be included in any recommendations that we come up with.

If staff feels like they want us to talk about it a little more, then we can do that, but I think it's there. It was there, and I think it can be resurrected and probably made better.

DR. GORDON: Joe, do you feel comfortable? Where are you with that?

DR. FINS: Yes. It is sort of related to what didn't get in here, the fact that it is practitioner-focused and all that.

It is just an editorial point, that a lot of what is on those action items on page 11 that we agreed to, don't necessarily fall in that part of the chapter, that we have things about accreditation of practitioners after we have accreditation of organizations. I think we should have some sort of logical sweep.

So on page 11, for Nos. 4 and 5, it sort of relates to JACO-kind of things. I think we should just make sure we have the order correct. I think if we adopt that sort of strategy of micro-to-macro, some of Julia's concerns, which are beyond individual practitioners but relate to community health centers, and then health care systems, will not fail to get dropped out of the picture. It is also good for the logical evolution of the chapter.

DR. GORDON: Effie.

DR. CHOW: I know I made the comment before about the special population. In order to meet that, in

this No. 6, we can add in there, "activities to identify current and future health care needs of all populations, especially underserved and special populations."

DR. GORDON: Yes. I think that is what Max was thinking of doing.

Are we okay with that?

The recommendation that I would like to make, or the action step is -- and I don't have to spell it out, but I need to get general agreement on this -- I would like a variety of assessments of potential model programs, not just integration of CAM into conventional medical settings, but in a variety of settings, including pure CAM settings, conventional medical settings, integrative settings, hospices, community-based programs, community health clinics.

I think this is where we can begin to respond to Julia's concerns, and I think we need to articulate it, we need to state it clearly, that we feel that there are a number of settings where we need to understand how CAM is being used, and that this would be at least preparatory to developing larger-scale demonstration programs, that we need to study what people are actually

doing out there.

Joe.

DR. FINS: We were all at the Joint Commission with Michele and Steve. I mean, there is a real crying need to determine best practices. Just think about supplements in a hospital and formulary committees as an example. The Joint Commission is looking for collaboration and guidance, and we need their input, and demonstration projects.

Every step above the practitioner, which I think we have done a pretty good job at, we have additional questions. It is in earlier drafts, and we will talk more in the next days about that.

DR. GORDON: Linnea.

MS. LARSON: He just said what I was going to say. We have done this.

DR. GORDON: I understand it has been in earlier drafts. What I am looking for now is agreement that we are going to be looking at what is actually happening in a number of different kinds of settings, what the benefits are, what the barriers are, what the problems are, with a view toward using this information,

potentially, as the basis for developing demonstration programs.

George.

DR. BERNIER: Could we accept Nos. 6 and 7 at this point?

DR. GORDON: We have accepted No. 6. No. 7, I would like to enlarge to include these other issues. That is, that it won't just be on integrating into conventional settings. I want the information from all of these different projects to be available.

DR. FINS: I think that is a really important point. I'm looking where Tom used to sit; the ghost of Tom Chappell past.

What I want to say here is that, in this section it is about integration because there is a health care delivery system. So there are going to be access issues that are independent. This is the hierarchy again.

So you have individual practitioners who may or may not want to affiliate with a hospital or with a health care system, and they are on their own, but as you go further up in levels of complexity, inevitably you are

getting into health care systems where inevitably you have to integrate, or you are separate, you are not integrated into that.

These are truly issues of safe and effective integration, and you bring in issues of coverage and reimbursement and funding streams and the like.

DR. GORDON: I would agree with you as long as we have a parallel. You are talking about convening conferences. As long as we have parallel conferences on some of the other models that are also out there.

DR. FINS: I think that having a conference model is kind of a weak action item, and it doesn't really say much. I think there are real step-by-step operational complexity issues that need to be addressed, as you bring practitioners into hospitals and you bring CAM clinics into health care systems, into managed care plans, and on, and on, and on.

DR. GORDON: I am saying I agree with you completely as long as we are also paying the same attention to other experiments that are taking place outside of that system.

DR. FINS: Right, which would not be

integrated.

DR. GORDON: Okay. Perfect.

Anything else on this section? Do you have still another thought, Joe, or are you okay? Julia was your other thought. Okay.

Julia.

MS. SCOTT: And I failed to thank you, Joe. I was so busy into the response, I didn't thank you for bringing it up, and all of you for remembering those issues. Thanks.

DR. GORDON: Don.

DR. WARREN: We were talking about Nos. 6 and 7. On No. 7, I would like to change one word. I don't know, maybe you've knocked it out already, but it says, "conventional medical settings." Let's say "health settings" instead of "conventional medical."

DR. GORDON: Is that okay? "Health care settings," fine.

I think that, having given a good deal of work to Max and the staff, and having taken on a lot of responsibility for reviewing this as it comes back to us, we are in agreement on the points we made here. Yes?

Thank you all.

Max, go ahead.

DR. HEIRICH: I just want to make one comment. I will do my best, we will do our best, to honor the spirit of what is said here. We are going to do it fast, so know that that may affect the quality of what comes out, but we will try to make it as high as we can.

DR. GORDON: But, Max, you are also saying that if you are doing fast, you are going to need fast attention from all of us here.

DR. HEIRICH: Absolutely.

DR. GORDON: So that's on us.

Maureen, do you want to say something?

MS. MILLER: Yes. Can I have a bathroom break before the next session?

[Laughter.]

DR. GORDON: Yes. Why don't you take your break. I think we all need a five-minute break, and then let's come back.

[Break.]

DR. GORDON: We want to begin with No. 2 that was left over, related to National Health Service Corps,

scholarships, et cetera, that we asked Joe Fins and Joe Pizzorno to work on.

Where is Joe K.?

MR. DeVRIES: Chair, I am wondering if we should at least get through Coverage and Reimbursement.

DR. GORDON: This is going to take a few minutes, but since Joe K. is not here, we will move ahead with Coverage and Reimbursement, and then we will come back to this issue at the end.

One thing I want to say, Maureen, is, I think this is an indication of the great faith and trust we all have in you to have left the issue, and in what you have done with this section, to have left this issue until the end.

Coverage and Reimbursement of CAM

DR. GORDON: Let's take a look at Coverage and Reimbursement. Again, we will go through it, I will read the recommendation, and we will look at the action items, and then we will go back and look at the text.

I know it's a lot, but I appreciate everybody hanging in. This is wonderful.

Recommendation No. 1 is on page 13: "Evidence

should be developed and disseminated as to the cost effectiveness of CAM interventions as well as optimum models for complementary and integrated care."

I would ask everyone to read the eight action items under that, and then we will go through it and discuss.

[Pause.]

DR. GORDON: Let's begin with the recommendation: "Evidence should be developed and disseminated as to the cost effectiveness of CAM interventions as well as optimum models for complementary and integrated care."

Are we okay with this general recommendation?

Joe.

DR. FINS: I think I would make one little change here. I was really looking to hear the economic dimension, the cost effectiveness dimension. I would just say, "of safe and effective CAM interventions."

Again, the distinction I would make is that it is effective for an individual, but there are a lot of things that are effective that may not be cost beneficial. So with that caveat, I am comfortable with

it. It would read, "Evidence should be developed and disseminated as to the cost effectiveness of safe and effective CAM interventions," blah-blah-blah.

DR. GORDON: The assumption being they wouldn't get to this stage unless they were safe and effective. Is that right?

DR. FINS: There are also things that are safe and effective, but they may not be cost effective.

DR. GORDON: No, no, I understand that.

DR. FINS: Correct.

DR. GORDON: But the other as well.

DR. FINS: Yes.

DR. GORDON: And that's why you're inserting "safe and effective."

DR. FINS: Yes.

DR. GORDON: Okay. Everybody with this?

MS. MILLER: Actually, in some comments we had gotten from Max earlier, there is a difference between the benefit aspect, cost benefit and cost effectiveness.

DR. GORDON: Why don't you explain the difference between cost effectiveness and cost benefits, and then we can make up our mind which we want to focus

on.

DR. HEIRICH: Businesses usually use cost benefit because they are simpler. That is, for how much you put in terms of specific benefits, how much do you get back; what does it cost you to achieve the benefit.

Cost effectiveness, you tend to take into account over many years. For example, the argument about the cost effectiveness of smoking cessation programs is, if people live longer, does it cost more health care coverage in the meantime; have you really saved any money in the long run, and all that sort of thing.

MS. MILLER: So actually, I think we need both because there is the limited benefit issue, but I think the implication of some of the health services research is that it looks at this more broadly.

In fact, on another issue, are these CAM services additive, or do they replace conventional; are we saving money or is this going to end up with higher health care costs. So I think we need both.

DR. GORDON: You are saying it should be both cost benefits and cost effectiveness. Okay, that's your recommendation.

Joe K.

DR. KACZMARCZYK: There is another usage of cost benefit. Thank you for mentioning health services research, because in that context health benefit means one or another service. It's a choice, it's either/or.

DR. GORDON: So, are we comfortable with having both cost benefit and cost effectiveness? Okay. Let's move on. Thank you for that addition.

Action Item No. 1: "The Secretary, should convene a joint public and private taskforce to identify and set priorities for studying health services issues related to CAM, and to help purchasers and health plans make prudent decisions regarding coverage of and access to CAM."

Joe.

DR. FINS: I am just wondering if CMS might not be a good place to locate this because the major payer is going to be the government for almost everything.

DR. GORDON: Maureen, what do you think?

MS. MILLER: Well, since employers are moving out ahead on this, for Medicare it could be another ASBE or AHRQ or something.

DR. GORDON: So HHS is better, from your point of view.

MS. MILLER: Yes.

DR. GORDON: Are we okay with this, then? Fine. Let's move on.

No. 2: "Federal agencies, states, and private organizations should increase funding for health services research, demonstrations, and evaluations related to CAM, including outcomes of CAM; interventions, coverage, and access; effective sequencing and integration with conventional therapies; effective models for service delivery; and the use of CAM in underserved, vulnerable, and special populations."

Veronica.

DR. GUTIERREZ: Only, after "integration" I would add "when appropriate."

DR. GORDON: Okay, "When appropriate." Any other emendations, questions, reservations?

DR. FINS: We are studying the integration. We are not saying it is always appropriate. We are saying we are studying integration. So here, "when appropriate" is not the issue.

DR. GORDON: Because we are saying we are also studying CAM interventions separately, and then we are studying integration as another category.

Is that right, Joe?

DR. FINS: Yes. It doesn't mean that we are integrating all the time, just that when we do integrate, we are studying it.

DR. GORDON: Do you see that, Veronica? "Including outcomes of CAM interventions."

DR. FINS: Which could be in isolation.

DR. GORDON: Exactly. Could be in isolation, so it doesn't always have to be integration.

Thank you, Joe, for clarifying that.

Are we okay with that one? Let's move on.

No. 1.3: "Federal, state, and private entities should fund health services research on the costs and cost effectiveness of CAM interventions and wellness programs."

MR. DeVRIES: "Cost benefits and cost effectiveness."

DR. GORDON: Adding "cost benefits"? Everyone okay with this one? Okay.