THE CORSELLO NEWSLETTER

Volume 1, Issue 1 November 2000

Welcome

By Paula M. Moerland

Co-chair, Dr. Corsello's Patient Coalition

Welcome to the first regular issue of *The Corsello Newsletter*. I would like to say that it brings good news, but I cannot. The objective of this newsletter is to bring awareness to an unjust tragedy. For the past thirteen years, the Office of Professional Medical Conduct (OPMC) has targeted and harassed Dr. Serafina Corsello for one primary reason: she is a successful Alternative physician, and people like her have become a threat to the survival of mainstream medicine. Each time the OPMC called her in for "questioning", Dr. Corsello has quietly stood before them and justified and proven her cause. Each time she has done this, she has had to hire lawyers to assist in her protection. Until now, her patients have not known of her persecution, because she did not want to concern them she wanted to heal them. Now, the OPMC is actively trying to take her license to practice medicine away from her. Now, she has a team of lawyers. Now, she wants the world to know what is

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IN THIS ISSUE

What's Really Happening

By Dr. Serafina Corsello

Two years ago, Christopher Caracciola, a handsome 25-year-old young man with his whole life ahead of him, died in a Long Island hospital as the result of the incompetence of physicians who are entrenched in the medical orthodoxy. Yet these doctors were not reprimanded by the Office of Professional Medical Conduct (OPMC) and therefore are still free to continue to kill other patients. Mr. Caracciola was admitted to the hospital with delusions that were immediately deemed to be purely psychological in nature, while the real underlying cause, encephalitis, was never properly evaluated. The young man died nine days later.

While the Bureau of Hospital Services ruled that *the doctors had made substantial errors*, the OPMC - responsible for sanctioning physicians – determined that they had not erred. They stated, "*we have concluded that the physician care did not deviate from accepted medical standards*". "Accepted medical standard" is based on dangerously little testing and a lot of pharmaceutical drugs. Death at the hands of mainstream physicians or as a result of medication, is the third leading cause of death in the United States, according to the JAMA report published six years ago.

Death at the hands of mainstream physicians or as a result of medication, is the third leading cause of death in the United States

While this goes on in mainstream medicine, good and reputable alternative medicine physicians are being ferociously persecuted in New York State and all over the country.

The Office of Professional Medical Conduct (OPMC) is on a rampage in New York State to revoke the licenses of alternative physicians for doing "too much testing", while they exonerate doctors who, by doing minimalist testing, kill people. New York State is determined to lift the licenses of physicians such as myself, Dr. Charles Gant of Syracuse and Dr. Joseph Burrascano of East Hampton.

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happening. For if the OPMC succeeds, they have also succeeded in taking away the patients right to choose their own physician and their own medical methodology. You see it is not just Dr. Corsello that they are after; it is Alternative physicians nation-wide that they are trying to defeat. Until practitioners of Alternative Medicine can practice openly and breathe freely, this newsletter will be advising you on the politics that are attempting to force Alternative Medicine down the proverbial drain. ∂

For reasons that you will see, this newsletter will be political in nature until we can go back to the business of healing patients instead of saving licenses.

You Are Losing Your Rights

The confrontation between the OPMC and innovative physicians such as Dr. Corsello and Dr. Burrascano has reached its peak, this first week of November.

The OPMC has been challenged by Dr. Burrascano's patients who do not want to lose the services of their brilliant physician, who is the best in correctly diagnosing and treating Lyme disease (see Newsweek for the first week in November).

The Corsello Patients' Coalition is taking the same stand. We want to know why there is a heightened persecution of complementary-alternative physicians in New York State and all over the country. We want answers and will enlist the assistance of a special detective to find the link between the various departments of health and special interest groups that stand to lose billions of dollars if alternative medicine continues to take hold. We have already found the link between the FDA and the pharmaceutical industry. "USA Today" just reported that "more than half of the experts hired to advise the U.S. Government on the safety and effectiveness of medicine have financial ties to the drug companies." The same scandalous relationships exist in other branches of government, such as the Department of Health.

Over the years, we consumers have seen our freedom of choice challenged by the threat of FDA control of nutrients. We fought and won, but the FDA still puts unfair restrictions on the ability of health food stores and distributors to explain to the public the benefits of certain nutrients. Even the names of beneficial compounds have to be obscure and not suggest its use to the consumer. For instance, the FDA wants Dr. Corsello's splendid combination of nutrients that, for years, has kept untold numbers of people free of colds, flu and other infections, to change the name from "Infection Nutrients Pack" to "immune pack". This is just a small example of the FDA's harassment of the competition to their patrons of the pharmaceutical industry. For more information, go to AOL Health News - "US FDA advisors said tied to industry". Given this war-like climate, we The Corsello Patients' Coalition, need to move fast to save our doctor's ability to continue to take care of us. She has been harassed for thirteen years and fought this battle, never letting it interfere with the care of us, her patients. This time, the stakes are even higher and the fight fiercer because they (the OPMC) want her out, and with her the thousands of consumers that rely on her treatment. Dr. Corsello is not only fighting for herself, but for the field of Alternative medicine at-large. Her attorneys are insisting that Alternative physicians be appointed to the medical board and be allowed to review the charges against Alternative physicians. This is per the provision of the New York State 1994 health care bill, which was enacted to prevent the harassment of Alternative physicians. The OPMC, however, tries to circumvent this law by presenting bogus charges (see my review of the charges in this newsletter titled "The Charges"). We consumers are aware of these maneuvers and are not easily blinded by the OPMC's strategies.

I ask that we all join together in this effort. Time is of the essence. As soon as you get this newsletter, get out your pen and paper or sit down at your computer and write to your NYS political representative about your discontent. Brief letters are sufficient, but they need to be STRONG. Since we know that approximately 70% of the patients at the Manhattan office of the Corsello Centers are from out of town, we advise you to include the fact that out-of-towners represent a significant tax revenue for New York City and New York State, coming so far to seek out the skills of Dr. Corsello. ∂

Letters are needed NOW!

Our lawyer **highly** recommends that patients and advocates send a letter demanding redress with copies to the appropriate persons. Below are the names and addresses that you will need. Following, is a sample letter you are welcome to use. It is also very important for you to keep a copy, and to send one to Dr. Corsello.
Send letters to:

Brian Murphy, Chief Counsel
Bureau for Professional Medical Conduct
New York State Department of Health
Room 2509, Corning Tower
Empire State Plaza
Albany, New York 12237

Dear Chief Counsel Murphy:

Send a copy to:

Antonia Novello, MD
New York State Commissioner of Health
New York State Department of Health
Corning Tower
Empire State Plaza, 14th Floor
Albany, NY 12237

And a copy to:

Kemp Hannon
Chairman, Senate Health Committee
Legislative Office Building
Albany, NY 12247

And a copy to:

Richard Gottfried
Chairman, Assembly Health Committee
Legislative Office Building
Albany, NY 12247

And a copy to:

Either your New York State Senator and Assemblyman **or** the Senator and Assemblyman representing Dr. Corsello's NYC office location:

Senator Roy M. Goodman
270 Broadway, Suite 2400
New York, NY 10007

And

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Four out of six alternative physician licenses in Syracuse have already been lifted and harassment continues for the other two.

The "accepted medical standards" set by the governmental agencies are the *"minimalist testing protocols"* that doctors are forced to follow, both in their offices and in hospitals. Doctors are "scared to death" of being sanctioned for doing "too many tests" and, in fact, both Dr. Gant and myself have been accused of doing exactly that, while we *save lives*. Dr. Gant has taken on the pharmaceutical industry by using a non-pharmaceutical approach for attention deficit disorder. I, by doing Chelation therapy. New York State cannot *openly* declare that these are the reasons, because of the legislation passed in 1994 that allows physicians to practice alternative medicine.

Let's look at the courses of this dangerous trend:

In the United States, and especially in the State of New York, the insurance industry (particularly HMOs) is afraid to have their minimalist and ineffective standards compared to the *open market good standards of innovative physicians*. Among the most innovative physicians are those who study so-called "functional medicine". This is a branch of medicine where physicians study very subtle blood changes to arrive at possible enzymatic shifts that are the hallmarks of pre-disease states. Discovery of early subtle biochemical changes leads to further "medical detective work" that saves lives.

If any physician who was free to think solely about patients' care had seen Christopher Caracciola, this tragedy would have never happened. The truth of the matter is doctors are constantly admonished to do "less and less testing" to "save money" to the point where they have slipped into a path of indolence, typical of abused people. Simple viral testing and a more astute observation of this young man would have saved his life. Instead, all they thought of was a "psychiatric illness". It would have been much better to err on the side of caution, rather than assume his hallucinations were the result of psychological derangement. This error killed the young man.

"Official" medicine does not demand efficiency, only cost control. In the end, this policy leads to cost escalation and last minute expensive hospitalizations, as statistics prove. Doctors today are walking around with what I call "the red book of Mao Tse Tung", where they are given specific guidelines of what they can and cannot do. They are not only rewarded for not doing "excessive" testing, they are actually scared into

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Assemblyman John Ravitz
251 E. 77th Street
New York, NY 10021

TO LOCATE YOUR SENATOR/ASSEMBLYMAN:
New York City Board of Elections, 212-487-5300
New York County Board of Elections, 212-868-3692

A Sample Letter

Dear Chief Counsel Murphy:

I am a patient of Dr. Serafina Corsello, an integrative physician in New York City. It has come to my attention that the Office of Professional Medical Conduct (OPMC) has brought charges against Dr. Corsello and has boldly stated that she should just turn her license in! I also understand that the OPMC's primary issue is that Dr. Corsello practices Alternative Medicine. I thought practitioners of Alternative Medicine were supposed to be protected from persecution. Apparently not in this case, for the OPMC has repeatedly harassed her for the last ten years, and not one single patient has been harmed! They did the same thing to Dr. Warren Levin – for twenty years – until they realized that they had no choice but to dismiss the case. Please don't let this happen again! Patients come to Dr. Corsello **because** she is an alternative/integrative physician and **because** she is one of the best!

I wish to state here, adamantly, that **Dr. Corsello is one of the finest and most caring and most reputable physicians I have ever come to know.** She has one of the finest reputations in the field of complementary and alternative medicine in the country. She is well known and well renowned for her abilities as both a physician and a person. She was also a member of the ad hoc committee of the National Institutes of Health for the formation of the Office of Alternative Medicine.

Since hearing about what the Medical Board is trying to do, I have vowed to do my part in protecting practitioners of alternative and integrative medicine. Already the word is spreading as this appears to be persecution at a national level. Has the Medical Board forgotten that patients have a right to choose? Is that not our Constitutional Right? If the Medical Board gets their way, that means my choice of physician has been taken away. I, personally, will not stand for it, and will

"What's Really Happening" Continued from page 3

submission in order to force them not to do tests that are actually necessary. Unless this situation is properly understood and reversed, the persecution of doctors, such as myself, will multiply and the trend will lead to more casualties of innocent consumers

I have single-handedly vowed to fight this downward spiral of your medical care. While the overall cost of medicine has not been reduced, the care that Americans receive is pitifully inadequate. Who is benefiting from all this? Obviously not doctors. The insurance industry and the pharmaceutical based medicine are the victors, not the consumers.∂

The Charges

I have had the opportunity to read the actual charges as written up by the OPMC. I will share with you my actual thoughts as I reviewed these charges.

There are 8 case histories that encompass all of the charges: The earliest case stems from 1987. In none of the cases was a patient ever harmed. Okay, maybe I misunderstand, but in 13 years, the OPMC has only found 8 cases with which to take issue and no patients were harmed? I was under the impression the entire objective of the OPMC was to protect patients from harm! So, just what are they doing anyway? I have heard that their primary objective is to persecute doctors who practice certain kinds of Alternative Medicine: and that means the kind of medicine that works and therefore takes money out of the pockets of mainstream medicine --and insurance companies...?

Each of the 8 cases is about one thing: Dr. Corsello "deviated from accepted standards of medical practice".

The following deviations were the same amongst the 8 cases:

- Excessive testing was number one
- The use of Vitamin infusions, Vitamin supplements and Chelation therapy
- Making diagnoses that are against the rules, like informing a patient of Lead Toxicity

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I am writing to you in good faith that you will acknowledge my concern for Dr. Corsello and my right as a citizen of the State of New York and the United States of America to access the medicine and physicians of my choice.

Respectfully,

Ways You Can Help

One of the objectives of the OPMC when they have decided to go after alternative physicians, is to hound them repeatedly with legal proceedings. Dr. Corsello's legal expenses have now become overwhelming. To help Dr. Corsello handle her overwhelming legal expenses, you can do one or more of the following:

- Purchase a **Holiday Gift Basket** which will make a fantastic gift for friends and family
- Give her book **"The Ageless Woman"** as a holiday gift
- Make a **tax-deductible** donation to her defense fund. Make checks payable to: **Phelps-Stokes Fund: Health Research P/S**, and send to:

  The Corsello Center

  200 West 57th Street, Suite 1202

  New York, NY 10019

  The Corsello Center will forward checks to P/S, who will send you a receipt for income tax purposes.
- **Write Letters!** (See Page 3)

The Medicine Corner

Here Comes the Flu!

Television and newspapers are bombarding us with the news that this year's flu is going to be a very virulent one. Yet, medical facilities don't have enough vaccines available and there is already a "black market." I have no intention of tapping into this black market, and I hope you don't either.

At our Center we know how to keep ourselves out of trouble. At the first sign of a cold we use the appropriate remedies (call us for the Infection Protocol). Our patients know they can come in for a special antioxidant injection and the small homeopathic (DC-4) infusion three to four times a week, if necessary, and abort any cold. It all takes no more than 30 to 40 minutes, and patients often come in on their lunch hour. Most alternative physicians have their own version of a rapid infection remedy, so ask your practitioner about theirs.

Most importantly, you can reduce your chances of infection by following these pointers:

- **Avoid shopping at the busiest times. Start your shopping now by catalogue or Internet.**
- **Avoid sugar and all the empty calories in holiday foods that lower your resistance. Drink plenty of clean water.**
- **Keep Oscillococcinum in your mouth when exposed to viruses.**
- **Ask about our infection immune pack.**
- **Do not cheat yourself of good sleep. Quality is more important than quantity. Use Melatonin, GABA Plus, Valerian, Chamomile, a relaxation tape, or whatever works for you.**

"The Medicine Corner" continued on page 6

"The Charges" continued from page 4

- Inaccurate and false record keeping. (You see, if they disagree with her diagnoses and treatment, then by default, the records are invalid!)

Now, as far as I can tell, we merely have a disagreement in the approach to the practice of medicine. But, when you get to the end of the description of each of the 8 cases (which takes up 17 pages and is titled "factual allegations"), the OPMC gets really serious, and this is where I get really mad. The "factual allegations" are then boiled down to "specifications of charges". How do you like these terms: Gross Negligence and Gross Incompetence. These are the two main charges against Dr. Corsello. She's grossly negligent and incompetent because she does thorough testing and locates her patient's real and underlying health problems and then heals them with a therapy that works?! Let us not forget how well she keeps her patients' charts and how well she and her entire staff stays on top of their progress! Gross negligence indeed! I say, medicine needs a lot more of it!

Gross Negligence and Gross Incompetence make nice newspaper headlines, but they most certainly do not reflect the truth! ∂

Mercury Removal

Mercury is one of the most toxic substances, most often right in our mouth. DMPS (the substance that removes primarily mercury from the body) has finally been approved by the FDA for testing and treatment.

The Corsello Centers has now begun dealing with this issue. You can call us for our internal protocol regarding DMPS, or ask your complementary physician.

The Dilemma over Infusion Costs

Although alternative physicians all *seem* to come from similar backgrounds and training, like any good creative scientist, they must modify their infusions to suit their patient population and standards of care.

At the Corsello Centers, we put large amounts of top quality vitamins and minerals in our infusions. Most of our vitamins come from a specialized pharmacy and are made to order, without preservatives. They are more costly, but they are safer for our patients. We also add glutathione and/or taurine without charging extra.

Every doctor has his or her own little modifications, and sometimes this accounts for the difference in cost. All **reputable** physicians will aim at a high level of proficiency and efficacy.

If you have any questions regarding this subject, please discuss it with your physician, but beware of so-called "cheap" versions.

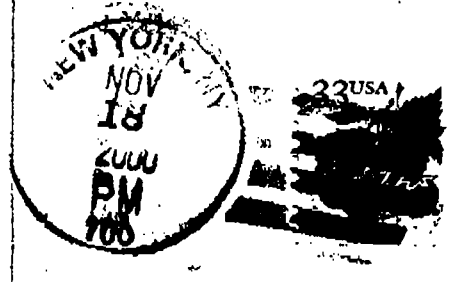
Dr. Serafina Corsello, MD

Contact Information

If you would like to help, please call:

Paula M. Moerland **212-663-8366**

The Corsello Centers
200 West 57th Street, Suite 1202
New York, NY 10019



Ms. Gail Harris
300 Kent Street
Brookline, MA 02146

Question - Non-Commissioner member - 0 response

no patients - costs / access / Hawaii / CA
- Infrastructure - ~~1 to 0 patients~~
= 50 not adequate
- Town Hall

Groft, Stephen (NCCAM)

From: Chang, Michele (NCCAM)
Sent: Thursday, November 16, 2000 10:02 AM
To: 'Troy Petenbrink'; Groft, Stephen (NCCAM)
Cc: Helen Szablya
Subject: RE: draft Dec agenda

I realize only now that I've been holding my breath ever since Josh suggested the site! I am thrilled! The website doesn't quite picture the auditorium, but I trust that Josh has seen the site and found it appropriate?

Are we pencilled in, pending meeting their contractual requirements? I look forward to talking with you on Friday.

-----Original Message-----
From: Troy Petenbrink [mailto:troy@fenton.com]
Sent: Wednesday, November 15, 2000 7:13 PM
To: Chang, Michele (NCCAM)
Cc: Helen Szablya
Subject: RE: draft Dec agenda

Michele -

I think we have found an ideal space for the meeting - the Lighthouse International Conference Center and Auditorium.

The space is located at 111 East 59th Street in midtown Manhattan. The auditorium can hold 240 people. The base price is $1300, plus additional cost for catering and A/V equipment. They require that you demonstrate that you are a non-profit organization and have a certificate of insurance.

The following is a link to their Web site, which includes pictures and detailed layout of the space:
http://www.lighthouse.org/conference_center_main.htm

I am out of the office tomorrow but let's plan to talk on Friday morning if possible. We will need to move quickly to secure the space if you believe it meets your needs.

Troy Petenbrink
Fenton Communications
1320 18th Street, NW
Washington, DC 20036
202/822-5200
202/822-4787 fax
www.fenton.com

-----Original Message-----
From: Chang, Michele (NCCAM) [mailto:changm@mail.nih.gov]
Sent: Tuesday, November 14, 2000 4:30 PM
To: Troy Petenbrink (E-mail)
Subject: draft Dec agenda

<<rtfagenda3.rtf>>

Michele M. Chang, CMT, MPH
Executive Secretary
White House Commission on
Complementary and Alternative Medicine Policy
tel: 301-435-7592
fax: 301-480-1691

Debbie Harry

MSFT

CAM

Jane Seymour

Model

Jay
Peter
Jeff Bruno
Nancy
Neil

Jan 22 – Mark
23

Recommended Sites

Reception

Am Cancer Society
Chaplaincy

Location – Site
Format + Schedule
NYC – Contacts to begin outreach

Josh@Fenton.com

Possible Media Outreach

Programs + Themes

N.Y. – Part + Parcel of academic medicine
Beth Israel, Cornell, Columbia
N.Y. Academy of Sciences

500
450
500

CEO # TIA Craft 46th + 3rd

Josh

212 584 5005

Time Out / Craft magazine
newspaper / calendar
Scenic / NY Times
Section

Courtney
Laurence Rutkin

Jim
Joe
Bill
Tom

David
Bresley
Hansen

Julia
Charlotte
~~Simone~~
Concetta

Brief Summary of Major Themes from Seattle Meeting

Tie into the goals of Healthy People 2010, the Federal blueprint for public health.

Facilitate collaboration
(1) between conventional and CAM practitioners;
(2) among local, regional, state, and Federal government agencies (including regulators, licensing boards, public health officials, and community-based primary care facilities); and
(3) with 3rd party payers.

Identify obstacles slowing the incorporation of evidence-based CAM practices into mainstream practice. Address, through collaboration, lack of familiarity with CAM research and researchers, suspicion of CAM therapies, and mistrust of CAM practitioners and researchers. This is often difficult and a challenge for both communities.

Strengthen accountability and develop uniform, high quality standards; consistent licensing procedures; and practice guidelines as the basis for the inclusion of CAM practitioners in Federal, state, and regional/local programs, to ensure uniformity of services for reimbursement, and to allow patients freedom of choice.

Develop public or private quality assurance programs to increase provider and public trust in CAM products.

Support with local, state, and Federal funds primary health care clinics that can serve as incubators for improving communication, cross training, integrating multiple-practice approaches, and other collaborative and relationship building activities. Integrate CAM into community health center networks nationally.

Eliminate arbitrary exclusions, avoid mandates, and focus benefits on scientific outcomes in state health programs.

Reduce the disparity in funding for research on conventional medical modalities and CAM practices and products; increase funding to CAM professional schools for research and research training. Fund planning grants to CAM academic centers to develop research agendas, etc. Issue an RFA to support research infrastructure at CAM institutions. Establish collaborative relationships with universities/hospitals that have needed facilities.

Increase funding for education and training at CAM institutions and at traditional universities, including schools of medicine, nursing, dentistry, pharmacy, public health, and veterinary science. Train CAM professionals in public health.

Develop methodologies to study emerging unconventional healing practices. Find methodologies that accommodate the cultural context and patient-centered, unique questions posed by some CAM therapies. When placebo-controlled trials are not feasible or appropriate, employ practice-based outcomes research, best case series, clinical audits, cohort analysis, pattern recognition, statistical evaluation, multi-varied or cluster analysis, and other known or new methods. Start with practical health services trials to develop data and the basis for further study.

Include CAM professionals on research advisory councils, regulatory boards, review committees, and policy groups.

Educate IRBs to provide more informed oversight of CAM clinical research.

Study wellness, the effect of social context on health, quality of life measures, and cost effectiveness of CAM.

Increase research support to provide valid chiropractic clinical outcomes data. Support researchers and infrastructure at colleges of chiropractic. Integrate chiropractic research and education programs in conventional higher education environments.

Allow for continuum of care as part of collaboration between allopathic and CAM care.

Increase research on CAM as an alternative to conventional approaches that are not successful or create adverse reaction risk, especially for chronic conditions.

Be more proactive to ensure that CAM research findings reach a broader audience.

Support National Library of Medicine indexing of CAM journals.

Determine the distinctions between incorporation of CAM procedures into conventional medical practice and integration of CAM providers into patient care pathways.

Design services for reaching and covering the underserved; evaluate utilization by the underserved.

Expand Federal laws to include loan repayment and scholarships for some CAM professions to serve in underserved areas.

Include CAM in Medicare, Medicaid, and other Federal and state health-related program coverage.

Improve collaboration among payers, the research and regulatory communities, and the professions.

Fund research on insurance company CAM databases and how CAM affects health care costs.

Evaluate insurance data from the Washington state experience.

Examine the effect of insurance coding and "medical necessity" as limitations on CAM.

Investigate reimbursement for herbal practice in states with practice standards.

Develop an herbal pharmacopoeia with standardization and regulation of manufacture, similar to the homeopathic pharmacopoeia.

Work toward insurance coverage in private, Federal, and state plans to provide access to licensed CAM providers and to cover (approved) substances prescribed and certified as part of treatment.

Strengthen Federal role as facilitator, partner, and referee.

Increase Federal agency support for local community demonstration projects to integrate CAM into conventional health services.

Conduct regional conferences on CAM integration.

Examine regulations that lead to the removal of licenses of CAM practitioners and intimidate collaborating, allopathic physicians.

December 21, 2000

Clyde Jensen, Ph.D.
President
National College of Naturopathic Medicine
049 SW Porter
Portland, OR 97201

Dear Dr. Jensen,

Thank you so much for your response to the questions we asked at the recent Town Hall in Seattle. I very much appreciate your written testimony. It would be extremely useful to us, however, if you included a much more detailed curriculum of the residency experience that addressed the following questions: What kind of didactic material is taught? How much classroom time is there and how much time in the clinic? Is there an opportunity to work in a hospital setting? What is the level of training in allopathic approaches? And, what would be your ideal training? Answers to all these questions will be helpful to us as we try to understand the kind of training that a variety of healthcare providers do and should have.

Thanks in advance for your responsiveness.

All the best,

James S. Gordon, M.D.

Cc: Steve Groft

Groft, Stephen (NCCAM)

From: Chang, Michele (NCCAM)
Sent: Saturday, December 23, 2000 2:19 PM
To: 'Bernier, George M.'; Groft, Stephen (NCCAM)
Subject: RE: WHCCAMP CONFERENCE CALL 12/21

Thanks, George. we will follow up.

-----Original Message-----
From: Bernier, George M. [mailto:gbernier@utmb.edu]
Sent: Friday, December 22, 2000 1:06 PM
To: Chang, Michele (NCCAM)
Subject: RE: WHCCAMP CONFERENCE CALL 12/21

Michele, At the Conference Call yesterday, I made a strong statement that it was extremely important that leadership of the skeptics was represented. Jordan Cohen or his delegate has to be part of the group 1. In addition, residence and Continuing Medical education from traditional Medicine should be represented. These are groups that can make or break the process
George Bernier

-----Original Message-----
From: Chang, Michele (NCCAM) [mailto:changm@mail.nih.gov]
Sent: Wednesday, December 20, 2000 4:15 PM
To: Bill Fair (E-mail); Conchita Paz (E-mail); David Bresler (E-mail); Donald Warren (E-mail); Effie Chow (E-mail); George Bernier (E-mail); George DeVries (E-mail); Jim Gordon (E-mail); Joe Pizzorno (E-mail); Linnea Larson (E-mail); Tieraona Low Dog (E-mail); Tom Chappell (E-mail); Veronica Gutierrez (E-mail); William Fair (E-mail)
Cc: Kaczmarczyk, Joseph (NCCAM); Groft, Stephen (NCCAM); Kingsbury, Doris (NCCAM); Pollen, Geraldine (NCCAM)
Subject: WHCCAMP CONFERENCE CALL 12/21

Holiday Greetings to the Training and Education WorkGroup!

We are attempting to fit in a critical planning conference call before everyone disappears for the holidays; thanks for accommodating us! If you have NOT been contacted by Doris Kingsbury or Michele Chang to be linked to this conference call, please call Doris immediately at 301-435-7592 with your phone number. If you are unable to make the call, please contact Michele Chang at your earliest convenience after January 1 to receive an update.

The call is scheduled for Thursday, December 21 from 3:30 -5:00 p.m. EST. Please be available at the phone number you provided by 3:15 p.m. to receive the operator's link up call.

Our agenda:

1) Meeting Overview

2) Meeting Format

3) Staffing and Member Input

Please review the background materials for this call, which are attached as a file, or you may scroll down to view.

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Meeting on Training, Education, Credentialing and Licensing of CAM Practice

C MEETING OVERVIEW

Plenary Session I. CAM Education and Training: Establishing Educational Foundations
[Rationale: This session will address whether, how and by whom requisite minimal levels of knowledge and understanding about CAM are established for all licensed health professionals, and whether, how and by whom national educational standards are established for CAM practices. Discussion will include the barriers to and incentives for developing and implementing such standards, and identification of the best available models.]

Plenary Session II Continuing CAM Education and Training: Building Knowledge and Skills
[Rationale: This session will address whether, how and by whom minimal levels of continuing education in CAM are established for all licensed health professionals and licensed CAM practitioners. Discussion will include the barriers to and incentives for developing and implementing such standards, and identification of the best available models.]

Plenary Session III CAM Credentialing and Licensure: Assuring Quality and Accountability in CAM Practice
[Rationale: This session will address whether, how, and by whom national standards and/or certification is established for the CAM practitioner and any licensed health professional practicing CAM. Discussion will include issues involving traditional healing, the barriers to and incentives for developing and implementing such standards, and identification of the best available models.]

C PROPOSED MEETING FORMAT

DAY ONE:
C Panel Presentations on 3 Plenary Sessions (3-4 speakers will be chosen to lay out the most prominent or emergent issues for discussion on this topic. Their 5-10-minute presentation sets the context for small group discussions.)

C Questions and Answers by Commissioners after each panel presentation.

C Public Comment Sessions (1-2 hours)

DAY TWO:
C Small discussion group breakouts: Commissioners will convene into groups of 4-5 members to review and explore the challenges and opportunities as presented in the Plenary Sessions specific to their separate reference groups. One member will serve as chair to facilitate the discussion, and will work with a staff member assigned to the group. The chair will report out preliminary findings to the full Commission by the end of the day. (Small group discussions scheduled for 4-5 hours before reconvening for full group discussion).

Discussion Group (1) proposed chair: Joe Fins
Reference group: Conventionally-trained allopathic and osteopathic physicians.

Discussion Group (2) proposed chair: Donald Warren
Reference group: Licensed health professionals, including, but not limited to, dentists, nurses, nurse practitioners, nurses-midwives, physician assistants, pharmacists, dieticians, physical therapists, social workers, and psychologists.

Discussion Group (3) proposed chair: Tieraona Low Dog
Reference group: Physicians and other licensed health professions who integrate CAM with conventional health care.

Discussion Group (4) proposed chair: Linnea Larson
Reference group: CAM practitioners (licensed and

unlicensed) such as -but not limited to--chiropractors, acupuncturists, body workers, energy healers, herbalists, homeopaths, naturopaths, traditional healers...

C MEETING PREPARATION

Once the meeting overview and format is approved, staff will begin to contact organizations and experts to collect and develop background information on each Plenary Session topic that is tailored for the four reference groups. Background information will be passed on to members of the Discussion Groups 2-3 weeks before the meeting to allow members to review the material and request clarification, etc. A limited number of conference calls may be scheduled by the Discussion Group chairs to organize the small group discussion prior to the meeting. One staff person will be assigned to each Discussion Group chair.

C SAMPLE OF TARGET CONTACTS (Joe Kaczmarczyk)

C SAMPLE OF TARGET QUESTIONS FOR CONTACTS (Joe Kaczmarczyk)

Michele M. Chang, CMT, MPH
Executive Secretary
White House Commission on
Complementary and Alternative Medicine Policy
tel: 301-435-7592
fax: 301-480-1691

9008 *Time + complexity of Issues Outline Report

12/11/08

~~4-5 Alaska~~ Publishing / Publication

Delete Remaining 3 Town Halls

Dayton NY ⇒

6 weeks Clearance

~~Contact~~ - AMA, ANA, etc.

? - Local Presence

- Key CA... list

More Policy Focused Mtg.

More Time for Public Session = No Questions from Commissioner Members

Delete all Town Hall meeting

Interim Report Draft Recommendations

Recommendations from Commission Members

~~Interact~~

- Research - Access - Delivery

any other Recommendation

Begin to think of Structure for Report

7 Subcommittee < major Institution / major organizations

{Stay-In-School}

5E[th] + Paul Av - Lighthouse

Reflexology Mtg
Certification, Licensure, Credentialing

NASA - MN - (Board Accreditation)

do
- Training + Education CAM Practitioner
- CAM Knowledge for Conventional Practitioner
- Referral Process
- Conventional Practitioner as CAM Provider

(?) General CAM Knowledge — Specialist

(?) Certification Board - How does this occur

(?) What Policies ~~Changes~~ are needed to assure
Confidence of CAM Provider
What policies are needed to improve Knowledge
+ training of CAM Provider
(3) What are barriers + obstacles to the provision
of CAM

Groft, Stephen (NCCAM)

From: Dr. Joe Pizzorno [drpizzorno@qwest.net]
Sent: Tuesday, January 02, 2001 10:07 PM
To: Chang, Michele (NCCAM); Stephen Groft (E-mail)
Subject: Recommendations for speakers for February meeting

Steve and Michelle,

VERY Important meeting. Following are my recommendations for speakers. I've ordered them in two lists based on priority.

Joe

FIRST PRIORITY

Lt. Sam Constance:
The detective involved in prosecution of the questionably credentialed practitioner in the death of the diabetic child in North Carolina
(828)250-4438

John Bear, PhD
Degree.net
Most knowledgeable about distance learning, mail order degrees, where there is credibility and where there is fraud
Closely involved with FBI investigations.
Johnbbear@aol.com 510-528-4274

Tom Shepherd, PhD
President Bastyr University
Provide Bastyr University's 20+ years experience in proving modality and practice training for MDs
(425)602-3003

Lou Orzak, PhD
National academic leader on emerging professions
Rutgers University
lhorzack@andromeda.rutgers, (617)969-9468

Washington Health Casualty
Comprehensive data on CAM provider malpractice
Sharon Hall, Vice President
(425)641-1335, ext. 213

Juries Verdicts Northwest
Comprehensive data on CAM provider malpractice
Donna @ 1/425/774-0530

Sally Ringdahl, ND
Academic Dean, Naturopathic Medicine
ND education and practice standards
(425)602-3003

Stephen Myers, ND, MD, PhD
Dean Naturopathic Medicine, Southern Cross University, Australia
World leader in CAM education
Hard data on CAM modality safety issues and education

SECOND PRIORITY

Dort Bigg, JD
Executive Director Accreditation Commission for Acupuncture and Oriental

Medicine
National Accrediting agency for acupuncture schools and programs
acaom1@compuserve.com

Sheila Quinn
Institute for Functional Medicine
Substantial experience in educating MDs and other health care professionals in CAM, especially nutrition, practices
(253) 853-7260

Steve Barrie, ND
President Great Smokies Diagnostic Laboratories
Alternative medicine laboratory credentialing
sb@gsdl.com, (800) 522-4762

Lee Philips, DC, PhD
Cleveland Chiropractic
Attended the Macy Foundation conf (as did I--very interesting experience!) and seemed knowledgeable and broad in his perspective

Alan Tracktenberg, MD, MPH
Medical Director, SAMHSA
Public health and safety, practitioner credentialing
atrachte@samhsa.gov, (301) 443-1281

Dick Lyons, MD
Regional Administrator, U.S. Public Health Region X
Substantial experience with CAM public safety issues
RLyons@hrsa.gov, (206)615-2469

John Weeks
Editor, The Integrator
Considerable experience with CAM provider credentialing
Pihcp@aol.com, (206) 933-7983

Mark Bloomenthal
President, American Botanic Council
Extremely knowledgeable about botanical medicine education for both CAM and conventional providers
(512) 306-8677

John Castellia, MD
Chief Medical Officer, Premera Blue Cross
CAM credentialing issues from an insurance perspective
john.castiglia@premera.com, (425)670-4662

Summary of Suggested 22 Feb 01 Plenary Speakers

Plenary Session I. CAM Education and Training: Establishing Educational Foundations

Joe Fins:
- Mike Woodcome (sp?), AAMC
- Jordan Cohen, AAMC
- Dean, UCSF Med School
- Dr. Andy Weil
- Linda Blanck, VP Education ABIM
- ACP, ACOG, American Colleges of Peds, Psychiatry, AAFP
- American Palliative Care Association (new Board exam)
- Dr. Charles Van Goodin (sp?)

David Bressler:
- Marty Rossman, American Academy of Guided Imagery
- Dr. David Sobel, Mind-Body Medicine

Veronica Gutierrez:
- Dr. McAulay, Sherman College of Chiropractic
- Dr. Guy Riekeman, Palmer College of Chiropractic

Effie Chow:
- Chairman, NCCAOM (Christina Herlihy, PhD, CEO)

Linnea Larson:
- Elizabeth Card (sp?), Energy Healers
- Micha Krastner (sp?), Body Workers

Joe Pizzorno:
- Tom Shepherd, PhD, President Bastyr University
- Pamela Snider, ND, Bastyr University (white paper)
- Lou Orzak, PhD, emerging professions
- Paul Levendusky (sp?), Harvard sociologist, emerging professions
- Sally Ringdahl, ND, ND education/practice standards
- Stephen Myers, ND, MD, PhD, Dean Naturopathic Medicine, Southern Cross University, Australia, World leader in CAM education, Hard data on CAM modality safety issues and education
- Lee Philips, DC, PhD, Cleveland Chiropractic, Attended the Macy Foundation conf (as did I--very interesting experience!) and seemed knowledgeable and broad in his perspective

Plenary Session II. Continuing CAM Education and Training: Building Knowledge and Skills

Donald Warren:
- Academy of General Dentistry

Linnea Larson:
- Barbara Brannan, Energy Healers
- Steve Farcy (sp?)
- Pat Norris
- Dr. Joe Helms and a LAc. (e.g., Bob Duggan)

Veronica Gutierrez:
- Dr. Fabrizzio Mancine, Parker College of Chiropractic
  - [Also endorsed by Donald Warren]
- Ms. Connie Glasgow, Washington State Chiropractic QA Commission
- Dr. Bill Decken
- Dr. David Brotman

Joe Pizzorno:
- Sheila Quinn, Institute for Functional Medicine, Substantial experience in educating MDs and other health care professionals in CAM, especially nutrition, practices
- Mark Bloomenthal, President, American Botanic Council, Extremely knowledgeable about botanical medicine education for both CAM and conventional providers

Plenary III. CAM Credentailing and Licensure: Assuring Quality and Accountability in CAM Practitioner Education

Jim Gordon:

Michael Cohen, JD

Veronica Gutierrez:

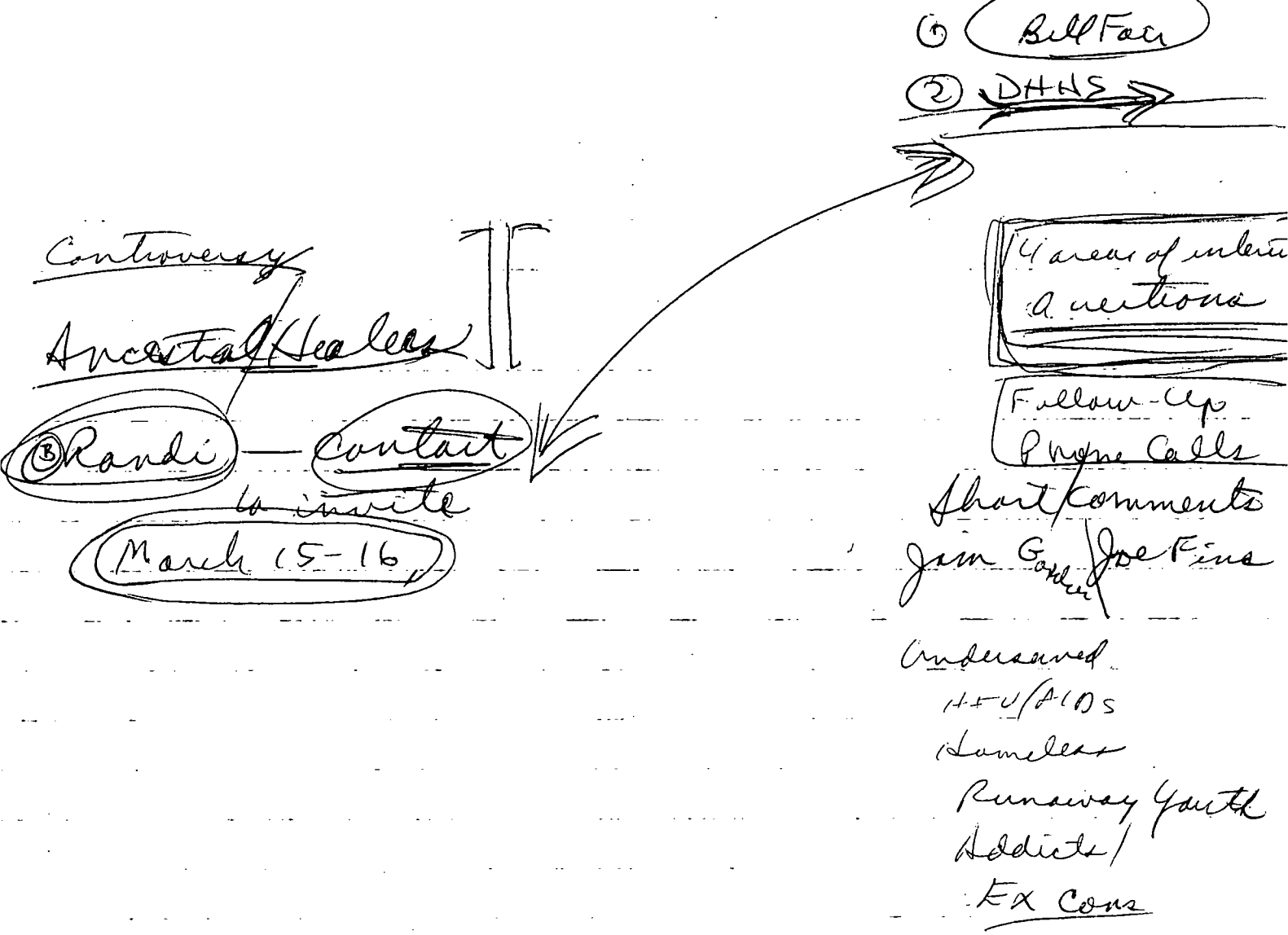
Mr. Timothy Feuhling, Chiropractic Benefit Services Malpractice Program
Dr. Christopher Kent, Council on Chiropractic Practice
Mr. Scott Blair, Malpractice Defense Attorney

Joe Pizzorno:

Lt. Sam Constance, Detective involved in prosecution of the questionably credentialed practitioner in the death of the diabetic child in NC
John Bear, PhD Most knowledgeable about distance learning, mail order degrees, credibility/fraud;closely involved with FBI investigations
Sharon Hall, VP Washington Health Casualty, Comprehensive data on CAM provider malpractice
Juries Verdicts Northwest, Comprehensive data on CAM provider malpractice
SECOND PRIORITY…

Dort Bigg, JD, Executive Director Accreditation Commission for Acupuncture and Oriental Medicine
Steve Barrie, ND, President Great Smokies Diagnostic Laboratories, Alternative medicine laboratory credentialing
Alan Trachtenberg, MD, MPH, SAMHSA, Public health and safety, practitioner credentialing
Dick Lyons, MD, Regional Administrator, USPHS, Region X, Substantial experience with CAM public safety issues
John Weeks, Editor, The Integrator, Considerable experience with CAM provider credentialing
John Castellia, MD, Chief Medical Officer, Premera Blue Cross CAM credentialing issues from an insurance perspective

Clem Bezold, AHP
Consumer Community
John Weeks
Sharon Hall
Juries Pulled


Bill Fox
DHHS
Controversy
Ancestral Healers
Randi
Contact
to invite
March 15-16
4 areas of interest
questions
Follow-up
Phone calls
Short comments
Jim Gordon
Joe Pine
Underserved
HIV/AIDS
Homeless
Runaway Youth
Addicts/
Ex Cons

Kaczmarczyk, Joseph (NCCAM)

From: Kingsbury, Doris (NCCAM)
Sent: Thursday, January 04, 2001 3:52 PM
To: Kaczmarczyk, Joseph (NCCAM); Kingsbury, Doris (NCCAM)
Subject: FW: February 22-23, 2001 WHCCAMP Meeting

DATE: January 4, 2001

TO: Commissioners

FROM: Joseph M. Kaczmarczyk, DO, MPH
Senior Medical Advisor
White House Commission on Complementary and Alternative Medicine Policy

SUBJECT: February 22 - 23, 2001 WHCCAMP Meeting

The purpose of this e-mail message is describe the format for the second day of the February 22-23, 2001 meeting which was developed by the Education and Training Workgroup and distribute materials to catalyze the small Discussion Group process.

While the format of the first day will be largely plenary sessions, the format of the second day will consist of breakout sessions for small Discussion Groups followed with a plenary discussion of the output of each of the four Discussion Groups. Each Discussion Group will be chaired by a Commissioner who will be assisted by a member of the WHCCAMP Staff. Prior to the meeting, Discussion Groups will have conference calls and other communications; and WHCCAMP staff will be contacting organizations and collecting information. So at the meeting, each Discussion Group will be able to consider issues involving target populations and produce draft policy recommendations for the report.

To" jump-start" the process, information is attached as a separate rich text format file for each of the four Discussion Groups, including the target populations, target organizations, questions for the target organizations, and questions to be answered by the Discussion Groups in the form of draft policy recommendations for the report. Please note that the attached material is intended to facilitate the process and can be modified by the Discussion Group by, for example, adding or deleting target organizations or modifying questions for target organizations.

Please open and print the rich text file below which corresponds to your Discussion Group number. To obtain a copy of all of the material, open, print, and collate the files sequentially.

I would like to thank the members of the Education and Training Workgroup for their insight and creativity that shaped this new meeting format. In addition, I want to thank all of the Commissioners in advance for embracing this new format and moving the Commission closer to a report.

If anyone has any questions, please call me at 301.435.6197.

Discussion Group #1
1. Joe Fins (chair), Gerry Pollen (staff)
2. George Bernier
3. Effie Chow
4. Veronica Gutierrez
5. Joe Pizzorno

Discussion Group #2
1. Donald Warren (chair), Corinne Alexrod (staff)
2. David Bresler
3. Julia Scott
4. Charlotte Kerr

Discussion Group #3
1. Tieraona Low Dog (chair), Michele Chang (staff)
2. George DeVries
3. Wayne Jonas

4. Dean Ornish
5. Xiaoming Tian

Discussion Group #4
1. Linnea Larson (chair), Joe Kaczmarczyk (staff)
2. Tom Chappell
3. Bill Fair
4. Conchita Paz
5. Buford Rolin


Discussion Group #1 Questions ...


Discussion Group #2 Questions ...


Discussion Group #3 Questions ...


Discussion Group #4 Questions ...

Discussion Group Questions for
22-23 Feb 01 Meeting
CAM: Education, Training, Quality, and Accountability

Breakout Session One: Education and Training
Discussion Group #1
Chair, Joe Fins
Staff, Gerry Pollen
George Bernier
Effie Chow
Veronica Gutierrez
Joe Pizzorno

Target Population: Undergraduate and graduate medical education (allopathic and osteopathic)

Target organizations:
- National Conventional Medical Organizations
  - American Board of Medical Specialties (ABMS)
  - American Association of Medical Colleges (AAMC)
  - American Association of College of Osteopathic Medicine (AACOM)
  - National Board of Medical Examiners
  - National Board of Osteopathic Medical Examiners
  - American Medical Student Association (AMSA)
  - Student Osteopathic Medical Association (SOMA)
- Foundations
  - Macy
    - Report from the Josiah Macy, Jr. Foundation Conference on *Education of Health Professionals in Complementary/Alternative Medicine* 2-5 Nov 00
  - Pew
- HRSA, Bureau of Health Professions

Questions for target organizations:
AMSA, SOMA, AAMC, AACOM, and ABMS:

1. What is the state/status of CAM in undergraduate and graduate medical education (residency/fellowship)? To what extent is CAM included in curricula? What systems of care, modalities, and therapies are addressed? When, where, how, and by whom is CAM addressed? To what extent should CAM be included in curricula?
2. What are the barriers to inclusion of CAM in curricula? Conversely, what are the incentives for inclusion of CAM in curricula?
3. What policy recommendations can you make to facilitate the inclusion or expansion of CAM in curricula?
4. What should every medical student, resident, and fellow—irrespective of specialty—know about CAM? How should that level of knowledge be determined?

NBME and NBOME:

1. What is the status of CAM in National Board examinations?
2. What are the barriers to and incentives for inclusion of CAM in National Board examinations?
3. What policy recommendations can you make about the inclusion of CAM on National Board examinations?

Macy Foundation, Pew Foundation, ACGME, ABMS, AAMC, AACOM, AMSA, and SOMA:

1. How and by whom should the inclusion or expansion of CAM in medical education be funded?
2. N.B., the above question could be asked of HRSA, Bureau of Health Professions

Specific question for the Macy Foundation:

1. What were the findings of the 2-5 Nov 00 Conference on *Education of Health Professionals in Complementary/Alternative Medicine*?

HRSA, Bureau of Health Professions:

1. Should the future health care workforce be structured differently in view of the effects of CAM and emerging professions on medical education and training and health care delivery?
2. If so, how should the future health care workforce be structured and why?

Questions for Discussion Group #1 to answer in the form of recommendations for Breakout Session One:

1. Should every medical student, resident, and fellow be expected to have a minimal level of knowledge and understanding of CAM? If so, how and by whom should that be determined? Of what should that basic knowledge and understanding consist and how and by whom should that be determined?
2. Should CAM be included on National Board examinations? If so, why?
3. How could the inclusion and expansion of CAM in curricula be funded?
4. What should the future physician workforce look like to reflect the effects of CAM and emerging professions?

Breakout Session Two: Continuing Education
Discussion Group #1
Chair, Joe Fins
Staff, Gerry Pollen
George Bernier
Effie Chow
Veronica Gutierrez
Joe Pizzorno

Target Population: Practicing Physicians (allopathic and osteopathic)

Target organizations:
National Conventional Medical Organizations
American Council of Graduate Medical Education (ACGME)
American Medical Association (AMA)
American Osteopathic Association (AOA)

Questions for target organizations:
ACGME, AMA, and AOA:

1. What is the state/status of CAM in continuing medical education (CME)? To what extent is CAM included in CME curricula? What systems of care, modalities, and therapies are addressed? When, where, how, and by whom is CAM addressed? To what extent should CAM be included in CME curricula?
2. What are the barriers to inclusion of CAM in CME curricula? Conversely, what are the incentives for inclusion of CAM in CME curricula?
3. What policy recommendations can you make to facilitate the inclusion or expansion of CAM in CME curricula?
4. What should every practicing physician--irrespective of specialty—know about CAM? How and by whom should that level of knowledge be determined?
5. What should physicians know about referring to CAM practitioners? How and by whom should that level of knowledge be determined?

Questions for Discussion Group #1 to answer in the form of recommendations for Breakout Session Two:

1. Should every practicing physician—irrespective of specialty--be expected to have a minimal level of knowledge and understanding of CAM? If so, how and by whom should that be determined? Of what should that basic knowledge and understanding consist and how and by whom should that be determined?
2. What is the role of CAM in CME?
3. What should physicians know about referring to CAM practitioners? How and by whom should that level of knowledge be determined?

Breakout Session Three:
Licensure, certification, credentialing, and accountability: Quality in CAM
Discussion Group #1
Chair, Joe Fins
Staff, Gerry Pollen
George Bernier
Effie Chow
Veronica Gutierrez
Joe Pizzorno

Target Population: Practicing Physicians (allopathic and osteopathic)

Target organizations:

American Medical Association (AMA), American Osteopathic Association (AOA), American Board of Medical Specialties (ABMS), Federation of State Medical Boards

Questions for target organizations:

1. Should there be national standards or certification to provide CAM practices and products and why or why not? If so, how and by whom should national standards or certification be established, to whom should they apply, and how should they be implemented?
2. Should there be condition-specific or modality specific practice guidelines and why or why not? If so, how and by whom should these guidelines be developed, to whom should they apply, and how should they be implemented?
3. In terms of malpractice, what are the malpractice implications of **not** discussing, offering, or referring a patient for CAM practices and products; what is the liability of referring a patient to a CAM practitioner who then has an adverse outcome; and what policy changes should be made to reduce malpractice liability associated with referral for CAM practices and products?
4. What information should conventional physicians communicate to a CAM practitioner? What information should a conventional physician expect to receive from a CAM practitioner?
5. In terms of quality of CAM practices and products:
    a. How and by whom should "quality" be defined?
    b. How and by whom should quality be measured?
    c. What should consumers be told about costs, safety, effectiveness, and time for effectiveness to be evident?
6. How can conventional physicians minimize the risks of dietary supplement-drug, dietary supplement-dietary supplement, and dietary supplement-food interactions?
7. If a consumer has a concern or grievance about the quality of CAM practices or products, what mechanism is available to address the consumer's concern or grievance? If none exists, what should be established for consumers of CAM practices and products?

Questions for Discussion Group #1 to answer in the form of recommendations for Breakout Session Three:

1. Should there be national standards or certification to provide CAM practices and products? If so, how and by whom should national standards or certification be established, to whom should they apply, and how should they be implemented?
2. Should there be condition-specific or modality specific practice guidelines and why or why not? If so, how and by whom should these guidelines be developed, to whom should they apply, and how should they be implemented?
3. What policy changes should be made to reduce malpractice liability associated with referral for CAM practices and products?
4. What information should conventional physicians communicate to a CAM practitioner? What information should a conventional physician expect to receive from a CAM practitioner?
5. In terms of quality of CAM practices and products:
    a. How and by whom should "quality" be defined?
    b. How and by whom should quality be measured?
    c. What should consumers be told about
6. How can conventional physicians minimize the risks of dietary supplement-drug, dietary supplement-dietary supplement, and dietary supplement-food interactions?
7. What mechanism should be available to address consumer concerns or grievances about the quality of CAM practices or products, what mechanism is available to address the consumer's concern or grievance?

Discussion Group Questions for
22-23 Feb 01 Meeting
CAM: Education, Training, Quality, and Accountability

Breakout Session One: Education and Training
Discussion Group #2
Chair, Donald Warren
Staff, Corinne Alexrod
David Bresler
Julia Scott
Charlotte Kerr

Target Population: Licensed Health Professionals including—but not limited to—dentists, nurses, nurse practitioners, nurses-midwives, physician assistants, pharmacists, dieticians, physical therapists, social workers, psychologists, chaplains, and...

Target organizations:

> National organizations representing licensed health professionals such as, but not limited, to American Dental Association (ADA), Academy of General Dentistry (AGD), American Nurses Association (ANA), American Academy of Nurse Practitioners (AANP), American College of Nurse Practitioners (ACNP), American College of Nurse Midwives, American Academy of Physician Assistants (AAPA), American Pharmaceutical Association (APhA), American Society of Health-System Pharmacists (ASHP), American Dietetics Association (ADA), American Physical Therapy Association (APTA), National Association of Social Workers (NASW), American Psychological Society (APS), Association of Professional Chaplains, etc.

Questions for target organizations:

1. What is the state/status of CAM in your undergraduate and graduate education? To what extent is CAM included in curricula? What systems of care, modalities, and therapies are addressed? When, where, how, and by whom is CAM addressed? To what extent should CAM be included in curricula?
2. What are the barriers to inclusion of CAM in curricula? Conversely, what are the incentives for inclusion of CAM in curricula?
3. What policy recommendations can you make to facilitate the inclusion or expansion of CAM in curricula?
4. What should every member of your profession know about CAM? How should that level of knowledge be determined?

Questions for Discussion Group #2 to answer in the form of recommendations for Breakout Session One:

1. Should every licensed health professional be expected to have a minimal level of knowledge and understanding of CAM? If so, how and by whom should that be determined? Of what should that basic knowledge and understanding consist and how and by whom should that be determined?

2. Should CAM be included on National Board examinations (if such examinations exists)? If so, why?
3. How could the inclusion and expansion of CAM in licensed health professions curricula be funded?
4. What should the future licensed health professions workforce look like to reflect the effects of CAM and emerging professions?

Breakout Session Two: Continuing Education
Discussion Group #2
Chair, Donald Warren
Staff, Corinne Alexrod
David Bresler
Julia Scott
Charlotte Kerr

Target Population: Licensed Health Professionals including—but not limited to—dentists, nurses, nurse practitioners, nurses-midwives, physician assistants, pharmacists, dieticians, physical therapists, social workers, psychologists, chaplains, and...

Target organizations:

National organizations representing licensed health professionals such as--but not limited to--American Dental Association (ADA), Academy of General Dentistry (AGD), American Nurses Association (ANA), American Academy of Nurse Practitioners (AANP), American College of Nurse Practitioners (ACNP), American College of Nurse Midwives, American Academy of Physician Assistants (AAPA), American Pharmaceutical Association (APhA), American Society of Health-System Pharmacists (ASHP), American Dietetics Association (ADA), American Physical Therapy Association (APTA), National Association of Social Workers (NASW), American Psychological Society (APS), Association of Professional Chaplains, etc.

Questions for target organizations:

1. What is the state/status of CAM in your continuing education (CE)? To what extent is CAM included in CE curricula? What systems of care, modalities, and therapies are addressed? When, where, how, and by whom is CAM addressed? To what extent should CAM be included in CE curricula?

2. What are the barriers to inclusion of CAM in CE curricula? Conversely, what are the incentives for inclusion of CAM in CE curricula?

3. What policy recommendations can you make to facilitate the inclusion or expansion of CAM in CE curricula?

4. What should every licensed health professional know about CAM? How and by whom should that level of knowledge be determined?

5. What should licensed health professionals know about referring to CAM practitioners? How and by whom should that level of knowledge be determined?

Questions for Discussion Group #2 to answer in the form of recommendations for Breakout Session Two:

1. Should every licensed health professional be expected to have a minimal level of knowledge and understanding of CAM? If so, how and by whom should that be determined? Of what should that basic knowledge and understanding consist and how and by whom should that be determined?
2. What is the role of CAM in continuing education (CE) for licensed health professionals?
3. What should every licensed health professional know about referring to CAM practitioners? How and by whom should that level of knowledge be determined?

Breakout Session Three:
Licensure, certification, credentialing, and accountability: Quality in CAM
Discussion Group #2
Chair, Donald Warren
Staff, Corinne Alexrod
David Bresler
Julia Scott
Charlotte Kerr

Target Population: Licensed Health Professionals including—but not limited to—dentists, nurses, nurse practitioners, nurses-midwives, physician assistants, pharmacists, dieticians, physical therapists, social workers, psychologists, chaplains, and...

Target organizations:

National organizations representing licensed health professionals such as but not limited to American Dental Association (ADA), Academy of General Dentistry (AGD), American Nurses Association (ANA), American Academy of Nurse Practitioners (AANP), American College of Nurse Practitioners (ACNP), American College of Nurse Midwives, American Academy of Physician Assistants (AAPA), American Pharmaceutical Association (APhA), American Society of Health-System Pharmacists (ASHP), American Dietetics Association (ADA), American Physical Therapy Association (APTA), National Association of Social Workers (NASW), American Psychological Society (APS), Association of Professional Chaplains, etc.

Questions for target organizations:

1. Should there be national standards or certification to provide CAM practices and products and why or why not? If so, how and by whom should national standards or certification be established, to whom should they apply, and how should they be implemented?
2. Should there be condition-specific or modality specific practice guidelines and why or why not? If so, how and by whom should these guidelines be developed, to whom should they apply, and how should they be implemented?
3. In terms of malpractice, what are the malpractice implications of **not** discussing, offering, or referring a patient for CAM practices and products; what is the liability of referring a patient to a CAM practitioner who then has an adverse outcome; and what policy changes should be made to reduce malpractice liability associated with referral for CAM practices and products?
4. What information should a licensed health care professional communicate to a CAM practitioner? What information should a licensed health care professional expect to receive from a CAM practitioner?
5. In terms of quality of CAM practices and products:
    a. How and by whom should "quality" be defined?
    b. How and by whom should quality be measured?
    c. What should consumers be told about costs, safety, effectiveness, and time for effectiveness to be evident?

6. How can licensed health care professionals minimize the risks of dietary supplement-drug, dietary supplement-dietary supplement, and dietary supplement-food interactions?
7. If a consumer has a concern or grievance about the quality of CAM practices or products, what mechanism is available to address the consumer's concern or grievance? If none exists, what should be established for consumers of CAM practices and products?

Questions for Discussion Group #2 to answer in the form of recommendations for Breakout Session Three:

1. Should there be national standards or certification to provide CAM practices and products? If so, how and by whom should national standards or certification be established, to whom should they apply, and how should they be implemented?
2. Should there be condition-specific or modality specific practice guidelines and why or why not? If so, how and by whom should these guidelines be developed, to whom should they apply, and how should they be implemented?
3. What policy changes should be made to reduce malpractice liability associated with referral for CAM practices and products?
4. What information should conventional licensed health care professionals communicate to a CAM practitioner? What information should a conventional licensed health care professionals expect to receive from a CAM practitioner?
5. In terms of quality of CAM practices and products:
    a. How and by whom should "quality" be defined?
    b. How and by whom should quality be measured?
    c. What should consumers be told about
6. How can conventional licensed health care professionals minimize the risks of dietary supplement-drug, dietary supplement-dietary supplement, and dietary supplement-food interactions?
7. What mechanism should be available to address consumer concerns or grievances about the quality of CAM practices or products, what mechanism is available to address the consumer's concern or grievance

Discussion Group Questions for
22-23 Feb 01 Meeting
CAM: Education, Training, Quality, and Accountability

Breakout Session One: Education and Training
Discussion Group #3
Chair, Tierarona Low Dog
Staff, Michele Chang
George DeVries
Wayne Jonas
Dean Ornish
Xiaoming Tian

Target Population: Physicians and other licensed health professions who integrate CAM with conventional health care

Target organizations:

> American Holistic Medical Association (AHMA), American Holistic Nurses Association (AHNA), American Holistic Dental Association, American Holistic Health Association (AHHA), other similar organizations, and ...

Questions for target organizations:

1. Should there be postgraduate training programs such as residencies and fellowships in integrative medicine or integrative health and why or why not?
2. Should those programs be residential, distance learning, or a combination of both and why?
3. Should those programs be designed to produce providers who can function in a "gatekeeper" capacity or can deliver some CAM practices and products and why?
4. How should those postgraduate training programs be funded and why?

Questions for Discussion Group #3 to answer in the form of recommendations for Breakout Session One:

1. Should there be postgraduate training programs such as residencies and fellowships in integrative medicine or integrative health? If so, how and by whom should these programs be designed and developed?
2. Should those programs be residential, distance learning, or a combination of both?
3. Should those programs be designed to produce providers who can function in a "gatekeeper" capacity, deliver some CAM practices and products, or provide a combination of both roles?
4. How should those postgraduate training programs be funded?

Breakout Session Two: Continuing Education
Discussion Group #3
Chair, Tierarona Low Dog
Staff, Michele Chang
George DeVries
Wayne Jonas
Dean Ornish
Xiaoming Tian

Target Population: Physicians and other licensed health professions who integrate CAM with conventional health care

Target organizations:

> American Board of Medical Specialties (ABMS), American Holistic Medical Association (AHMA), American Holistic Nurses Association (AHNA), American Holistic Dental Association, American Holistic Health Association (AHHA), American Association of Medical Acupuncture, and other similar organizations.

Questions for target organizations:

1. What is the state/status of CAM in your organization's continuing educational activities? To what extent is CAM included in your continuing education curricula? What systems of care, modalities, and therapies are addressed? When, where, how, and by whom is CAM addressed? To what extent should CAM be included in continuing education curricula?
2. What are the barriers to inclusion of CAM in continuing education curricula? Conversely, what are the incentives for inclusion of CAM in continuing education curricula?
3. What should every member of your organization know about CAM? How should and by whom that level of knowledge be determined?
4. What policy recommendations can you make to facilitate the inclusion or expansion of CAM in continuing education curricula?

Questions for Discussion Group #3 to answer in the form of recommendations for Breakout Session Two:

1. Should every holistic or integrative health care professional be expected to have a minimal level of knowledge and understanding of CAM? If so, how and by whom should that be determined? Of what should that basic knowledge and understanding consist and how and by whom should that be determined?
2. What is the role of CAM in continuing education (CE) for holistic or integrative health care professionals?
3. What should every holistic or integrative health professional know about referring to CAM practitioners? How and by whom should that level of knowledge be determined?

Breakout Session Three:
Licensure, certification, credentialing, and accountability; Quality in CAM
Discussion Group #3
Chair, Tierarona Low Dog
Staff, Michele Chang
George DeVries
Wayne Jonas
Dean Ornish
Xiaoming Tian

Target Population: Physicians and other licensed health professions who integrate CAM with conventional health care

Target organizations:

American Holistic Medical Association (AHMA), American Holistic Nurses Association (AHNA), American Holistic Dental Association, American Holistic Health Association (AHHA), other similar organizations, American Board of Medical Acupuncture (ABMA), and Federal Trade Commission (FTC), and Agency for Healthcare Research and Quality (AHRQ).

Questions for target organizations:

1. Should there be national standards or certification to provide CAM practices and products and why or why not? If so, how and by whom should national standards or certification be established, to whom should they apply, and how should they be implemented?
2. Should there be condition-specific or modality specific practice guidelines and why or why not? If so, how and by whom should these guidelines be developed, to whom should they apply, and how should they be implemented?
3. In terms of malpractice, what are the malpractice implications of providing CAM practices and products? What policy changes should be made to reduce malpractice liability associated with providing CAM practices and products?
4. In terms of quality of CAM practices and products:
    a. How and by whom should "quality" be defined?
    b. How and by whom should quality be measured?
    c. What should consumers be told about costs, safety, effectiveness, and time for effectiveness to be evident?
5. How can licensed health care professionals minimize the risks of dietary supplement-drug, dietary supplement-dietary supplement, and dietary supplement-food interactions?
6. If a consumer has a concern or grievance about the quality of CAM practices or products, what mechanism is available to address the consumer's concern or grievance? If none exists, what should be established for consumers of CAM practices and products?
7. Should all health care professionals providing CAM practices and products be included in the National Practitioner Data Bank and why or why not? If so, how should this be accomplished?

Specific questions for the American Holistic Medical Association (AHMA), American Board of Medical Acupuncture (ABMA), and other organization offering certification:

1. What is the current status of your certification?
2. Why, how, and by whom was the certification process and examination developed and administered?
3. Who is eligible to participate in your certification? How much does it cost? Is the certification life-long or time-limited?
4. What does your certification mean for patients and for providers?
5. How does your certification relate to the assuring the public access to safe, effective CAM practices and products?
6. What lessons did your as a result of embarking on certification?
7. What policy recommendation would you like to make to the Commission?

Specific questions for Federal Trade Commission:

1. What should consumers be told about the safety, effectiveness, costs, and time necessary for effectiveness to be evident of CAM practices and products?
2. What should be done to minimize the risks of dietary supplement-drug, dietary supplement-dietary supplement, and dietary supplement-food interactions whether the dietary supplements are prescribed, recommended, or provided by a practitioner or used as self-care?
3. If a consumer has a concern or grievance about the quality of CAM practices and products, what mechanism is available to address the consumer's concern or grievance? If none exists, what mechanism should be established for consumers of CAM practices and products?
4. What policy recommendations should be made to assure the quality of CAM practices and products whether they are provided by a practitioner or used as self-care?

Specific questions for the Agency for Healthcare Research and Quality (AHRQ):

1. How should "quality" in terms of CAM practices and products be defined? Who should define it? How do cost, safety, and effectiveness fit in that definition?
2. Should the quality of CAM practices and products be measured? If so, how and by whom?
3. To assure quality of CAM practices and products, who should provide CAM practices and products?
4. What credentials should providers of CAM practices and products possess to assure quality?
5. What should consumers be told about costs, safety, effectiveness, and time for effectiveness to be evident of CAM practices and products?
6. What should be done to minimize the risks of dietary supplement-drug, dietary supplement-dietary supplement, and dietary supplement-food interactions whether the dietary supplements are prescribed, recommended, or provided by a practitioner or used as self-care?
7. What information should a conventional health care provider communicate to a CAM practitioner? What information should a CAM practitioner communicate to a

conventional provider either with a referral or without a referral as when a consumer self-refers?

8. If a consumer has a concern or grievance about the quality of CAM practices and products, what mechanism is available to address the consumer's concern or grievance? If none exists, what mechanism should be established for consumers of CAM practices and products?
9. What policy recommendations should be made to assure the quality of CAM practices and products whether they are provided by a practitioner or used as self-care?

Questions for Discussion Group #3 to answer in the form of recommendations for Breakout Session Three:

1. Should there be national standards or certification to provide CAM practices and products? If so, how and by whom should national standards or certification be established, to whom should they apply, and how should they be implemented?
2. Should there be condition-specific or modality specific practice guidelines and why or why not? If so, how and by whom should these guidelines be developed, to whom should they apply, and how should they be implemented?
3. What policy changes should be made to reduce malpractice liability associated with providing CAM practices and products?
4. In terms of quality of CAM practices and products:
    a. How and by whom should "quality" be defined?
    b. How and by whom should quality be measured?
    c. What should consumers be told about
5. How can holistic or integrative health care professionals minimize the risks of dietary supplement-drug, dietary supplement-dietary supplement, and dietary supplement-food interactions?
6. What mechanism should be available to address consumer concerns or grievances about the quality of CAM practices or products, what mechanism is available to address the consumer's concern or grievance?
7. Should all health care professionals providing CAM practices and products be included in the National Practitioner Data Bank?

Discussion Group Questions for
22-23 Feb 01 Meeting
CAM: Education, Training, Quality, and Accountability

Breakout Session One: Education and Training
Discussion Group #4
Chair, Linnea Larson
Staff, Joe Kaczmarczyk
Tom Chappell
Bill Fair
Conchita Paz
Buford Rolin

Target Population: CAM practitioners (licensed and unlicensed) such as--but not limited to--chiropractors, acupuncturists, body workers, energy healers, herbalists, homeopaths, naturopaths, traditional healers, and ....

Target organizations:

American Chiropractic Association (ACA), American Association of Oriental Medicine (AAOM), Council of Colleges of Acupuncture and Oriental Medicine (CCAOM), American Massage Therapy Association (AMTA), American Herbalists Guild (AHG), American Institute of Homeopathy (AIH), American Association of Naturopathic Physicians (AANP), American Reiki Masters Association (ARMA), American Organization of Bodywork Therapies of Asia (AOBTA), The Rolf Institute of Structural Integration, American Polarity Therapy Association (APTA), Hellerwork International, Nurse Healers-Professional Associates International (NH-PAI), Reflexology Association of American (RAA), The Feldenkrais Guild, HRSA/Bureau of Health Professions (BHPr), and HRSA/ National Health Service Corps (NHSC), and ...

Questions for target organizations:

1. Should there be national educational standardization for your modality/therapy? If so, why; and what is being done to achieve national educational standardization?
2. What are the barriers to national educational standardization for your modality/therapy? What are the incentives for national educational standardization?
3. In your modality/therapy educational programs, should there be exposure to other CAM modalities and therapies and why or why not? If so, to which modalities and therapies should there be exposure?
4. In your modality/therapy educational programs, should there be exposure to conventional or western medicine and why or why not? If so, to which aspects of conventional medicine should there be exposure?
5. What is the status of "postgraduate" training in your modality/therapy? Should there be a required minimum level of postgraduate training for non-allopathic and

non-osteopathic physicians such as naturopathic physicians? If so, why or why not? How should this postgraduate training be created, structured, and funded?
6. What other policy recommendations would you like to make?

Specific questions for Bureau of Health Professions (BHPr):

1. Should there be a required minimum level of postgraduate training for non-allopathic and non-osteopathic physicians such as naturopathic physicians and other unconventional physicians? If so, why or why not? How should this postgraduate training be created, structured, and funded?
2. Are there scholarship and/or loan repayment programs available for students of CAM or emerging professions particularly for those who wish to provide services for underserved populations? If not, why not?

Specific questions for National Health Service Corps (NHSC):

1. Are there scholarship and/or loan repayment programs available for students of CAM or emerging professions particularly for those who wish to provide services for underserved populations? If not, why not?
2. If these programs do not exist, how can such scholarship and loan repayment programs be established?

Question for Traditional healer organization(s) [e.g., Papa Ola Lokahi and Navajo Medicine Man Society] and representative Traditional healers;

1. Who should be allowed to use the "Traditional Healer" designation? How and by whom should "Traditional Healer" status or designation be determined?
2. How should Traditional healing be preserved and perpetuated?
3. How should preservation and perpetuation of Traditional healing be funded?

Questions for Discussion Group #4 to answer in the form of recommendations for Breakout Session One:

1. Should there be national educational standards for CAM modalities and therapies? If so, how and by whom should they be developed? Should those national educational standards for a given modality/therapy include exposure to other CAM modalities/therapies? If so, how and by whom should that be determined? Should those standards also include exposure to conventional or western medicine? If so, how and by whom should that be determined?
2. Should there be scholarship and/or loan repayment programs for CAM students or students of emerging professions?
3. Should there be a minimum level of postgraduate training (i.e., residency) for non-allopathic and non-osteopathic physicians such as naturopathic physicians and other unconventional physicians? If so, how and by whom should that be determined as well as how and by whom should this postgraduate training be created, structured, and funded?

4. Should there be use of the designation "Traditional Healer?" If so, how and by whom should "Traditional Healer" status or designation be determined?
5. Should Traditional healing be preserved and perpetuated? If so, how and by whom should that be done and funded?

Breakout Session Two: Continuing Education
Discussion Group #4
Chair, Linnea Larson
Staff, Joe Kaczmarczyk
Tom Chappell
Bill Fair
Conchita Paz
Buford Rolin

Target Population: CAM practitioners (licensed and unlicensed) such as –but not limited to--chiropractors, acupuncturists, body workers, energy healers, herbalists, homeopaths, naturopaths, traditional healers, and…

Target organizations:

American Chiropractic Association (ACA), American Association of Oriental Medicine (AAOM), American Massage Therapy Association (AMTA), American Herbalists Guild (AHG), American Institute of Homeopathy (AIH), American Association of Naturopathic Physicians (AANP), American Reiki Masters Association (ARMA), American Organization of Bodywork Therapies of Asia (AOBTA), The Rolf Institute of Structural Integration, American Polarity Therapy Association (APTA), Hellerwork International, Nurse Healers-Professional Associates International (NH-PAI), Reflexology Association of American (RAA), The Feldenkrais Guild, and …

Questions for target organizations:

1. What is the state/status of continuing education for your modality/therapy? Apart from your primary modality or therapy, what other systems of care, modalities, and therapies are addressed in your continuing education activities? When, where, how, and by whom are these other modalities and therapies addressed? To what extent should conventional medicine be included in your continuing education curricula?
2. What are the barriers to conducting continuing education for your modality/therapy? Conversely, what are the incentives for providing continuing education for your modality/therapy?
3. What policy recommendations can you make to facilitate initiation or expansion of continuing education for your modality/therapy?
4. Should organizations representing a given modality or therapy come together to form "a community" and why or why not?
5. What barriers are there to forming this type of "community?" What incentives are there for forming this type of "community?" How should such a "community" be formed?
6. What other policy recommendations would you like to make?

Questions for Discussion Group #4 to answer in the form of recommendations for Breakout Session Two:

1. Should every CAM practitioner be expected to have a minimal level of knowledge and understanding of other CAM systems of care, modalities, and therapies? If so, how and by whom should that be determined? Of what should that basic knowledge and understanding consist and how and by whom should that be determined?
2. Should every CAM practitioner be expected to have a minimal level of knowledge and understanding of conventional or western medicine and referring to conventional physicians or conventional health care providers? How and by whom should that level of knowledge be determined?
3. What is the role of continuing education (CE) for CAM practitioners?
4. Should organizations representing a given modality or therapy come together to form "a community?" If so, how and by whom should that "community" be formed?

Breakout Session Three:
Licensure, certification, credentialing, and accountability: Quality in CAM
Discussion Group #4
Chair, Linnea Larson
Staff, Joe Kaczmarczyk
Tom Chappell
Bill Fair
Conchita Paz
Buford Rolin

Target Population: CAM practitioners (licensed and unlicensed) such as –but not limited to--chiropractors, acupuncturists, body workers, energy healers, herbalists, homeopaths, naturopaths, traditional healers, and…

Target organizations:

American Chiropractic Association (ACA), American Association of Oriental Medicine (AAOM), National Certification Commission on Acupuncture an Oriental Medicine (NCCAOM), National Guild of Acupuncture and Oriental Medicine (NGAOM), American Massage Therapy Association (AMTA), American Herbalists Guild (AHG), American Institute of Homeopathy (AIH), American Association of Naturopathic Physicians (AANP), American Reiki Masters Association (ARMA), American Organization of Bodywork Therapies of Asia (AOBTA), The Rolf Institute of Structural Integration, American Polarity Therapy Association (APTA), Hellerwork International, Nurse Healers-Professional Associates International (NH-PAI), Reflexology Association of American (RAA), The Feldenkrais Guild, and …

Questions for target organizations:

1. Should there be national standards or certification to provide CAM practices and products and why or why not? If so, how and by whom should national standards or certification be established, to whom should they apply, and how should they be implemented?
2. Should there be condition-specific or modality specific practice guidelines and why or why not? If so, how and by whom should these guidelines be developed, to whom should they apply, and how should they be implemented?
3. In terms of malpractice, what are the malpractice implications of providing CAM practices and products? What policy changes should be made to reduce malpractice liability associated with providing CAM practices and products?
4. In terms of quality of CAM practices and products:
    a. How and by whom should "quality" be defined?
    b. How and by whom should quality be measured?
    c. What should consumers be told about costs, safety, effectiveness, and time for effectiveness to be evident?
5. How can licensed and unlicensed CAM practitioners minimize the risks of dietary supplement-drug, dietary supplement-dietary supplement, and dietary supplement-food interactions?

6. What information should a CAM practitioner communicate to a conventional physician or a conventional health care provider either with a referral or without a referral?
7. If a consumer has a concern or grievance about the quality of CAM practices or products, what mechanism is available to address the consumer's concern or grievance? If none exists, what should be established for consumers of CAM practices and products?
8. Should all CAM practitioners be included in the National Practitioner Data Bank and why or why not? If so, how should this be accomplished?

Specific questions for the American Herbalist Guild (AHG) and other organizations offering certification:

1. What is the current status of your certification?
2. Why, how, and by whom was the certification process and examination developed and administered?
3. Who is eligible to participate in your certification? How much does it cost? Is the certification life-long or time-limited?
4. What does your certification mean for patients and for providers?
5. How does your certification relate to the assuring the public access to safe, effective CAM practices and products?
6. What lessons did you learn as a result of embarking on certification?
7. What policy recommendation would you like to make to the Commission?

Specific questions for Papa Ola Lokahi, Navajo Medicine Man Society, and selected Traditional Healers:

1. For unlicensed practitioners such as Traditional Healers, energy healers, and others for whom licensure is unlikely, should uniform standards of education, training, and certification be developed and applied to these practitioners and why or why not? If so, how and by whom should those standards be developed and applied?
2. What should be done to assure public access to safe and effective CAM practices and products provided by these practitioners?

Specific questions for practitioners licensed in some but not all states such as—but not limited to—naturopathic physicians and acupuncturists:

1. In the absence of licensure, should uniform standards of education, training, and certification be developed for these practitioners and why or why not? If so, how and by whom should those standards be developed?
2. What should be done to assure public access to safe and effective CAM practices and products provided by these practitioners?

Specific questions for Federal Trade Commission:

1. What should consumers be told about the safety, effectiveness, costs, and time necessary for effectiveness to be evident of CAM practices and products?
2. What should be done to minimize the risks of dietary supplement-drug, dietary supplement-dietary supplement, and dietary supplement-food interactions whether the dietary supplements are prescribed, recommended, or provided by a practitioner or used as self-care?
3. If a consumer has a concern or grievance about the quality of CAM practices and products, what mechanism is available to address the consumer's concern or grievance? If none exists, what mechanism should be established for consumers of CAM practices and products?
4. What policy recommendations should be made to assure the quality of CAM practices and products whether they are provided by a practitioner or used as self-care?

Specific questions for the Agency for Healthcare Research and Quality (AHRQ):

1. How should "quality" in terms of CAM practices and products be defined? Who should define it? How do cost, safety, and effectiveness fit in that definition?
2. Should the quality of CAM practices and products be measured? If so, how and by whom?
3. To assure quality of CAM practices and products, who should provide CAM practices and products?
4. What credentials should providers of CAM practices and products possess to assure quality?
5. What should consumers be told about costs, safety, effectiveness, and time for effectiveness to be evident of CAM practices and products?
6. What should be done to minimize the risks of dietary supplement-drug, dietary supplement-dietary supplement, and dietary supplement-food interactions whether the dietary supplements are prescribed, recommended, or provided by a practitioner or used as self-care?
7. What information should a conventional health care provider communicate to a CAM practitioner? What information should a CAM practitioner communicate to a conventional provider either with a referral or without a referral as when a consumer self-refers?
8. If a consumer has a concern or grievance about the quality of CAM practices and products, what mechanism is available to address the consumer's concern or grievance? If none exists, what mechanism should be established for consumers of CAM practices and products?
9. What policy recommendations should be made to assure the quality of CAM practices and products whether they are provided by a practitioner or used as self-care?

Questions for Discussion Group #3 to answer in the form of recommendations for Breakout Session Three:

1. Should there be national standards or certification to provide CAM practices and products? If so, how and by whom should national standards or certification be established, to whom should they apply, and how should they be implemented?
2. Should there be condition-specific or modality specific practice guidelines and why or why not? If so, how and by whom should these guidelines be developed, to whom should they apply, and how should they be implemented?
3. What policy changes should be made to reduce malpractice liability associated with providing CAM practices and products?
4. In terms of quality of CAM practices and products:
    a. How and by whom should "quality" be defined?
    b. How and by whom should quality be measured?
    c. What should consumers be told about

1. How can CAM practitioners minimize the risks of dietary supplement-drug, dietary supplement-dietary supplement, and dietary supplement-food interactions?
2. What mechanism should be available to address consumer concerns or grievances about the quality of CAM practices or products, what mechanism is available to address the consumer's concern or grievance?
3. Should all CAM practitioners providing CAM practices and/or products be included in the National Practitioner Data Bank?

New Format (15 Dec 00) 20-21 Feb 01 Meeting
On Training, Education, Licensure, and Certification

DAY ONE
Opening Remarks
Plenary Session One
Overview of CAM and medical education and training--Andrew Weil, MD
Breakout Session One: Training and Education
Workgroup #1—Chair, Joseph J. Fins, MD
Workgroup #2—Chair, Donald W. Warren, DDS
Workgroup #3—Chair, Tierarona Low Dog, MD AHG
Workgroup #4—Chair, Linnea S. Larson, LCSW, LMFT
Plenary Session Two
Report of breakout session one workgroups
Discussion
Lunch
Public Comment
Plenary Session Two
Training and education for the practicing physician—Joseph M. Helms, MD
Breakout Session Two
Workgroup #1—Chair, Joseph J. Fins, MD
Workgroup #2—Chair, Donald W. Warren, DDS
Workgroup #3—Chair, Tierarona Low Dog, MD AHG
Workgroup #4—Chair, Linnea S. Larson, LCSW, LMFT
Plenary Session Two
Report of breakout session two workgroups
Discussion
Conclude day one
DAY TWO
Opening Remarks
Plenary Session Three
Overview of licensure, certification, credentialing, and accountability in CAM—Michael H. Cohen, JD, MBS, MFA
Breakout Session Three
Workgroup #1—Chair, Joseph J. Fins, MD
Workgroup #2—Chair, Donald W. Warren, DDS
Workgroup #3—Chair, Tierarona Low Dog, MD AHG
Workgroup #4—Chair, Linnea S. Larson, LCSW, LMFT
Plenary Session Four
Report of breakout session three workgroups
Discussion
Lunch
Public Comment
Plenary Session Five
Discussion
Adjourn

Breakout Session One: Training and Education
Workgroup #1—Chair, Joseph J. Fins, MD

Target Population: Undergraduate and graduate medical education (allopathic and osteopathic)

Target organizations:

- National Conventional Medical Organizations
  - American Association of Medical Colleges (AAMC)
  - American Association of College of Osteopathic Medicine (AACOM)
  - National Board of Medical Examiners
  - National Board of Osteopathic Medical Examiners
  - American Medical Student Association (AMSA)
- Foundations
  - Macy
    - Report from the Josiah Macy, Jr. Foundation Conference on *Education of Health Professionals in Complementary/Alternative Medicine* 2-5 Nov 00
  - Pew
- HRSA, Bureau of Health Professions

Questions for target organizations:
AMSA, AAMC, AACOM, and ABMS:

1. What is the state/status of CAM in undergraduate and graduate medical education (residency/fellowship)? To what extent is CAM included in curricula? What systems of care, modalities, and therapies are addressed? When, where, how, and by whom is CAM addressed? To what extent should CAM be included in curricula?
2. What are the barriers to inclusion of CAM in curricula? Conversely, what are the incentives for inclusion of CAM in curricula?
3. What policy recommendations can you make to facilitate the inclusion or expansion of CAM in curricula?
4. What should every medical student, resident, and fellow—irrespective of specialty—know about CAM? How should that level of knowledge be determined?

NBME and NBOME:

1. What is the status of CAM in National Board examinations?
2. What are the barriers to and incentives for inclusion of CAM in National Board examinations?
3. What policy recommendations can you make about the inclusion of CAM on National Board examinations?

Macy Foundation, Pew Foundation, ACGME, ABMS, AAMC, AACOM, and AMSA:

1. How and by whom should the inclusion or expansion of CAM in medical education be funded?
2. N.B., the above question could be asked of HRSA, Bureau of Health Professions

Macy Foundation:

1. What were the findings of the 2-5 Nov 00 Conference on *Education of Health Professionals in Complementary/Alternative Medicine*?

HRSA, Bureau of Health Professions:

1. Should the future health care workforce be structured differently in view of the effects of CAM on medical education and training an health care delivery?
2. If so, how should the future health care workforce be structured and why?

Questions for Workgroup #1 to answer in the form of recommendations for Breakout Session One:

1. Should every medical student, resident, and fellow be expected to have a minimal level of knowledge and understanding of CAM? If so, how and by whom should that be determined? Of what should that basic knowledge and understanding consist and how and by whom should that be determined?
2. Should CAM be included on National Board examinations? If so, why?
3. How could the inclusion and expansion of CAM in curricula be funded?
4. What should the future physician workforce look like?

Breakout Session One: Training and Education
Workgroup #2—Chair, Donald W. Warren, DDS

Target Population: Licensed Health Professionals including—but not limited to—dentists, nurses, nurse practitioners, nurses-midwives, physician assistants, pharmacists, dieticians, physical therapists, social workers, and psychologists

Target organizations:

National organizations representing licensed health professionals such as but not limited to American Dental Association (ADA), American Nurses Association (ANA), American Academy of Nurse Practitioners (AANP), American College of Nurse Practitioners (ACNP), American College of Nurse Midwives, American Academy of Physician Assistants (AAPA), American Pharmaceutical Association (APhA), American Society of Health-System Pharmacists (ASHP), American Dietetics Association (ADA), American Physical Therapy Association (APTA), National Association of Social Workers (NASW), American Psychological Society (APS), etc.

Questions for target organizations:

1. What is the state/status of CAM in your undergraduate and graduate education? To what extent is CAM included in curricula? What systems of care, modalities, and therapies are addressed? When, where, how, and by whom is CAM addressed? To what extent should CAM be included in curricula?
2. What are the barriers to inclusion of CAM in curricula? Conversely, what are the incentives for inclusion of CAM in curricula?
3. What policy recommendations can you make to facilitate the inclusion or expansion of CAM in curricula?
4. What should every member of your profession know about CAM? How should that level of knowledge be determined?

Questions for Workgroup #2 to answer in the form of recommendations for Breakout Session One:

1. Should every licensed health professional be expected to have a minimal level of knowledge and understanding of CAM? If so, how and by whom should that be determined? Of what should that basic knowledge and understanding consist and how and by whom should that be determined?
2. Should CAM be included on National Board examinations (if such examinations exists)? If so, why?
3. How could the inclusion and expansion of CAM in licensed health professions curricula be funded?
4. What should the future licensed health professions workforce look like?

Breakout Session One: Training and Education
Workgroup #3—Chair, Tierarona Low Dog, MD, AHG

Target Population: Physicians and other licensed health professions who integrate CAM with conventional health care

Target organizations: American Holistic Medical Association (AHMA), American Holistic Nurses Association (AHNA), American Holistic Dental Association, and other similar organizations.

Questions for target organizations:

1. What is the state/status of CAM in your organization's educational activities? To what extent is CAM included in curricula? What systems of care, modalities, and therapies are addressed? When, where, how, and by whom is CAM addressed? To what extent should CAM be included in curricula?
2. What are the barriers to inclusion of CAM in curricula? Conversely, what are the incentives for inclusion of CAM in curricula?
3. What policy recommendations can you make to facilitate the inclusion or expansion of CAM in curricula?
4. What should every member of your organization know about CAM? How should that level of knowledge be determined?

Breakout Session One: Training and Education
Workgroup #4—Chair, Linnea S. Larson, LCSW, LMFT

Target Population: CAM practitioners (licensed and unlicensed) such as –but not limited to--chiropractors, acupuncturists, body workers, energy healers, herbalists, homeopaths, naturopaths, traditional healers, and...

Target organizations: American Chiropractic Association (ACA), American Association of Oriental Medicine (AAOM), American Massage Therapy Association (AMTA), American Herbalists Guild (AHG), American Institute of Homeopathy (AIH), American Association of Naturopathic Physicians (AANP), and ...

Questions for target organizations:

1. Should there be national educational standardization in your modality/therapy? If so, why and what is being done to achieve national educational standardization?
2. What are the barriers to national educational standardization in your modality/therapy? What are the incentives for national educational standardization?
3. In your modality/therapy educational programs, should there be exposure to other CAM modalities and therapies and why or why not? If so, to which modalities and therapies should there be exposure?
4. In your modality/therapy educational programs, should there be exposure to conventional or western medicine and why or why not? If so, to which aspects of conventional medicine should there be exposure?
5. What other policy recommendations would you like to make?

Question for Traditional healer organization(s) [e.g., Papa Ola Lokahai and Navajo Medicine Man Society] and representative Traditional healers;

1. Who should be allowed to use the "Traditional Healer" designation? How and by whom should "Traditional Healer" status or designation be determined?
2. How should Traditional healing be preserved and perpetuated?
3. How should preservation and perpetuation of Traditional healing be funded?

Breakout Session Two: Training and Education
Workgroup #1—Chair, Joseph J. Fins, MD

Target Population: Practicing Physicians (allopathic and osteopathic)

Target organizations:

National Conventional Medical Organizations
American Council of Graduate Medical Education (ACGME)
American Medical Association (AMA)
American Osteopathic Association (AOA)

Questions for target organizations:
ACGME, AMA, and AOA:

1. What is the state/status of CAM in continuing medical education (CME)? To what extent is CAM included in CME curricula? What systems of care, modalities, and therapies are addressed? When, where, how, and by whom is CAM addressed? To what extent should CAM be included in CME curricula?
2. What are the barriers to inclusion of CAM in CME curricula? Conversely, what are the incentives for inclusion of CAM in CME curricula?
3. What policy recommendations can you make to facilitate the inclusion or expansion of CAM in CME curricula?
4. What should every practicing physician--irrespective of specialty—know about CAM? How and by whom should that level of knowledge be determined?
5. What should physicians know about referring to CAM practitioners? How and by whom should that level of knowledge be determined?

Questions for Workgroup #2 to answer in the form of recommendations for Breakout Session Two:

1. Should every practicing physician—irrespective of specialty--be expected to have a minimal level of knowledge and understanding of CAM? If so, how and by whom should that be determined? Of what should that basic knowledge and understanding consist and how and by whom should that be determined?
2. What is the role of CAM in CME?
3. What should physicians know about referring to CAM practitioners?

Breakout Session Two: Training and Education
Workgroup #2— Chair, Donald W. Warren, DDS

Target Population: Licensed Health Professionals including—but not limited to—dentists, nurses, nurse practitioners, nurses-midwives, physician assistants, pharmacists, dieticians, physical therapists, social workers, and psychologists

Target organizations:

National organizations representing licensed health professionals such as but not limited to American Dental Association (ADA), American Nurses Association (ANA), American Academy of Nurse Practitioners (AANP), American College of Nurse Practitioners (ACNP), American College of Nurse Midwives, American Academy of Physician Assistants (AAPA), American Pharmaceutical Association (APhA), American Society of Health-System Pharmacists (ASHP), American Dietetics Association (ADA), American Physical Therapy Association (APTA), National Association of Social Workers (NASW), American Psychological Society (APS), etc.

Questions for target organizations:

1. What is the state/status of CAM in your continuing education (CE)? To what extent is CAM included in CE curricula? What systems of care, modalities, and therapies are addressed? When, where, how, and by whom is CAM addressed? To what extent should CAM be included in CE curricula?

2. What are the barriers to inclusion of CAM in CE curricula? Conversely, what are the incentives for inclusion of CAM in CE curricula?

3. What policy recommendations can you make to facilitate the inclusion or expansion of CAM in CE curricula?

4. What should every licensed health professional know about CAM? How and by whom should that level of knowledge be determined?

5. What should licensed health professionals know about referring to CAM practitioners? How and by whom should that level of knowledge be determined?

Breakout Session Two: Training and Education
Workgroup #3— Chair, Tierarona Low Dog, MD, AHG

Target Population: Physicians and other licensed health professions who integrate CAM with conventional health care

Target organizations: American Board of Medical Specialties (ABMS), American Holistic Medical Association (AHMA), American Holistic Nurses Association (AHNA), American Holistic Dental Association, and other similar organizations.

Questions for target organizations:

1. Should there be postgraduate training programs such as residencies and fellowships in integrative medicine/health and why or why not?

2. Should those programs be residential, distance learning, or a combination of both and why?
3. Should those programs be designed to produce providers who can function in a "gatekeeper" capacity or can deliver some CAM practices and products and why?
4. How should those postgraduate training programs be funded and why?

Breakout Session Two: Training and Education
Workgroup #4—Chair, Linnea S. Larson, LCSW, LMFT

Target Population: CAM practitioners (licensed and unlicensed) such as –but not limited to--chiropractors, acupuncturists, body workers, energy healers, herbalists, homeopaths, naturopaths, traditional healers, and…

Target organizations: American Chiropractic Association (ACA), American Association of Oriental Medicine (AAOM), American Massage Therapy Association (AMTA), American Herbalists Guild (AHG), American Institute of Homeopathy (AIH), American Association of Naturopathic Physicians (AANP), and …

Questions for target organizations:
1. Should organizations representing a given modality or therapy come together to form "a community" and why or why not?
2. What barriers are there to forming this type of "community?" What incentives are there for forming this type of "community?"
3. What is the status of "postgraduate" training in your modality/therapy?
4. What other policy recommendations would you like to make?

DAY TWO
Breakout Session Three: licensure, certification, credentialing, and accountability in CAM
Workgroup #1—Chair, Joseph J. Fins, MD

Target Population: Practicing Physicians (allopathic and osteopathic)

Target organizations:

Questions for target organizations;
1. Should there be national standards or certification to provide CAM practices and products and why or why not? If so, how and by whom should national standards or certification be established?
2. Should there be condition-specific or modality specific practice guidelines and why or why not? If so, how and by whom should these guidelines be developed?
3. In terms of malpractice, what are the malpractice implications of **not** discussing, offering, or referring a patient for CAM practices and products; what is the liability of referring a patient to a CAM practitioner who then has an adverse

outcome; and what policy changes should be made to reduce malpractice liability associated with referral for CAM practices and products?

4. What policy recommendations can you make to assure the quality of CAM practices and products?

New Format (15 Dec 00)

20-21 Feb 01 Meeting on Training, Education, Licensure, and Certification

DAY ONE

Opening Remarks

Plenary Session One

Overview of CAM and medical training and education--Andrew Weil, MD

Breakout Session One: ~~Training and Education~~ Undergraduate Training

Workgroup #1—Chair, Joseph J. Fins, MD
Workgroup #2—Chair, Donald W. Warren, DDS
Workgroup #3—Chair, Tierarona Low Dog, MD AHG
Workgroup #4—Chair, Linnea S. Larson, LCSW, LMFT

Plenary Session Two

Report of breakout session one workgroups
Discussion

Lunch

Public Comment

Plenary Session Two

Training and education for the practicing physician—Joseph M. Helms, MD

Breakout Session Two Graduate Training

Workgroup #1—Chair, Joseph J. Fins, MD
Workgroup #2—Chair, Donald W. Warren, DDS
Workgroup #3—Chair, Tierarona Low Dog, MD AHG
Workgroup #4—Chair, Linnea S. Larson, LCSW, LMFT

Plenary Session Two

Report of breakout session two workgroups
Discussion
Conclude day one

DAY TWO

Opening Remarks

Plenary Session Three

Overview of licensure, certification, credentialing, and accountability in CAM--Michael H. Cohen, JD, MBS, MFA

Breakout Session Three

Workgroup #1—Chair, Joseph J. Fins, MD
Workgroup #2—Chair, Donald W. Warren, DDS
Workgroup #3—Chair, Tierarona Low Dog, MD AHG
Workgroup #4—Chair, Linnea S. Larson, LCSW, LMFT

Plenary Session Four

Report of breakout session three workgroups
Discussion

Lunch

Public Comment

Plenary Session Five

Discussion

Adjourn

20-21 Feb 01 Meeting on Training, Education, Licensure, and Certification, Credentialing

I. Structure based on combination of Stakeholders, Modalities, and Issues (licensure & certification)

II. Stakeholders:

A. Undergraduate Medical education
   1. AMSA
   2. AAMC
   3. AACOM
   4. Other possibilities
      a. Wetzel survey data
      b. Dr. Ellen Hughes

B. Graduate Education
   1. ~~U of Az (Dr. Andy Weil)~~

C. Federal Agencies (Scholarship, Loan Programs)
   1. Department of Education
   2. HRSA Bureau of Health Professions
   3. HRSA, BPHC, NHSC

D. CME
   1. ACGME (?)
   2. AHMA
   3. AAMA (Dr. Joe Helms)

E. Nurses, Pharmacists, Dentists, Psychologists, Social Workers, PTs, Body Workers, et al.
   1. AHNA
   2. AHDA

F. NDs, DCs, Lac's , ODMs.... AHG

G. Traditional Healers (and other unlicensed CAM practitioners):
   1. Papa Ola Lokahi (Traditional Native Hawaiian)
   2. Navajo Medicine Man Society

III. Modalities:

A. Acupuncture
B. Botanicals
C. Homeopathy
D. Manual Healing (Body Work)
E. Mind-Body
F. Other

IV. Licensure, Certification and Credentialing

A. Overview Michael Cohen, JD
B. Practitioners not licensed in all 50 states:
   1. NDs
   2. Lac"s
   3. Others

V. Certification

A. AAMA
B. AHMA
C. AHG
D. Others
E.

Questions - What do Medical, Conventionally Health Care Providers about CAM
- What do CAM Providers need to know about Conventional Med & other Interventions
- Who should be doing what for what condition

GUIDANCE DOCUMENT FOR DISCUSSION GROUP 3:
Integrative Physicians and other licensed integrative health professionals

This is a **guidance document** intended to assist Discussion Group 3 to develop draft policy recommendations during the February 22-23 Commission meeting on CAM Education, Training, Credentialing and Licensing.

Breakout Sessions:

Three (3) breakout sessions are scheduled for the February 22-23 meeting, during which draft recommendations on each issue will be prepared by each Discussion Group. These draft recommendations will be reported back to the full Commission for consideration and discussion at the closing session of the February meeting. The three breakout sessions are: (1) CAM Education and Training: Establishing Educational Foundations; (2) Continuing CAM Education and Training: Building Knowledge and Skills; and (3) CAM Credentialing and Licensure: Promoting Quality and Accountability in CAM Practice. A full description of the session topics, discussion points for each Discussion Group, and target organizations to be used as resources follows later in this document.

Conference Calls:

In preparation for these sessions, at least four (4) conference calls will be conducted with Discussion Group members over the next six weeks. Conference calls will focus on a specific topic and are intended to review background information and recommendations that are submitted by a number of target organizations, listed later in this document. At the discretion of the Discussion Group, experts also may be invited to participate on the calls. The conference calls are as follows:

Conference Call	Proposed Schedule	Break out Session (Topic)
#1 (1 hour)	Week of January 15	Overview and Planning
#2 (1.5-2 hrs)	Week of January 22	Education and Training
#3 (1.5-2 hrs)	Week of February 5	Continuing Education
#4 (1.5-2 hrs)	Week of February 12	Licensure, certification

Target Organizations:

For each breakout session (topic), target organizations will be identified and contacted. Preliminary lists follow under each breakout session description. These organizations will serve as expert resources for background information on each of the topics under consideration. Prior to each scheduled conference call, experts will be interviewed by staff and asked to submit written responses to questions from the Discussion Group. If appropriate, organizational representatives will be invited to participate on conference calls to help clarify or expand upon information received. A list of proposed questions to be submitted to target organizations first will be reviewed by the Discussion Group.

Overview of Breakout Sessions, Discussion Points and Target Organizations

Session 1. CAM Education and Training: Establishing Educational Foundations
All Discussion Groups will review whether, how and by whom requisite minimal levels of knowledge and understanding about CAM are established for all licensed health professionals, and whether, how and by whom national educational standards are established for CAM practices.

Specifically, Commissioners in Discussion Group 3 will review the best available model standards for integrative health care education, and programs that are successfully delivering integrative education. The barriers to, as well as the incentives for developing such standards and implementing such programs will be discussed.

- Discussion Points may include the following:

1. Should there be integrative health or medicine programs for medical students or other graduate programs for health care providers? If so, what are the Commission's recommendations on the nature and structure of such programs, and what guidance, if any, can be provided regarding how and how designs and develops the programs?

2. Should there be postgraduate training programs (such as residencies, fellowships, practitioner programs) in integrative medicine or integrative health? If so, what are the Commission's recommendations on the structure of such programs? For example, should these programs be residential, distance learning, or a combination? What guidance, if any, can be provided regarding how and who designs and develops the programs?

3. What guidance, if any, can the Commission provide as to whether such programs are designed to produce health care providers who function only as "gatekeepers" in making referrals to specific CAM providers, or who are able to deliver specific CAM services and products themselves, or providers who are qualified to do both?

4. What recommendations or other guidance can be offered regarding funding for integrative health postgraduate training programs, if supported?

- Target Organizations that may be contacted to provide background information or expertise on these issues may include (this list is NOT comprehensive. For example, organizations or experts who offer a counterpoint perspective need to be identified.):

  American Holistic Medical Association (AHMA)
  American Holistic Nurses Association (AHNA)
  American Holistic Dental Association
  American Holistic Health Association

Session 2. Continuing CAM Education and Training: Building Knowledge and Skills
All Discussion Groups will review whether, how and by whom minimal levels of continuing education in CAM are established for all licensed health professionals and licensed CAM practitioners.

Specifically, Commissioners in Discussion Group 3 will review the best available model standards for continuing or advanced integrative health care practice, and the range and scope such educational opportunities for providers who practice integrated health care, including how continuing "integrative health or medicine" education is defined. The barriers to, as well as the incentives for developing such standards and implementing such programs will be discussed.

- Discussion Points may include the following:

1. Should every holistic and integrative health care professional be expected to have a minimal level of knowledge and understanding of CAM? If so, how and by whom should this be determined? What guidance, in any, can be offered regarding what that basic knowledge or understanding should be, and by whom such levels of knowledge would be determined?

2. What, if any, recommendation or guidance can be offered regarding requirements for continuing education in CAM for holistic and/or integrative health professionals? How will continuing integrative health or medicine be defined and structured vis-a-vis extant qualifications (medical degrees, other CAM-specific education)? What, if any, guidance can be offered as to how and by whom these requirements are made and whether they should be made uniformly or be specific to different CAM practices?

3. Should the ability of holistic and/or integrative health professionals to refer to other CAM practitioners be contingent on first satisfying educational/continuing educational requirements or standards? How, and by whom, should these standards be set? What, if any, guidance can be offered to address in this area?

- Target Organizations that may be contacted to provide background information or expertise on these issues may include (this list is NOT comprehensive. For example, organizations or experts who offer a counterpoint perspective need to be identified.):

  American Board of Medical Specialties
  American Holistic Medical Association
  American Holistic Nurses Association
  American Holistic Dental Association
  American Holistic Health Association
  American Association of Medical Acupuncture

Session 3. CAM Credentialing and Licensure: Promoting Quality and Accountability in CAM Practice
All Discussion Groups will review whether, how, and by whom national standards and/or certification is established for the CAM practitioner and any licensed health professional

practicing CAM. The scope of this session includes consideration of traditional healers, and other unconventional practitioners who may not be licensed.

Specifically, Commissioners in Discussion Group 3 will review the best available model standards for the practice of integrative health care. The barriers to, as well as the incentives for developing such standards and enforcing them will be discussed.

- Discussion Points may include the following:

1. What recommendations should the Commission make regarding licensure, certification, credentialing and recredentialing for integrative health care practitioners? Should national standards to provide integrative health practices and products be established? If so, how and by whom? To whom should the standards apply? How should the standards be implemented?

2. What recommendations, if any, should the Commission make regarding integrative practice guidelines, such as condition-specific or modality-specific guidelines? If so, how and by whom should these guidelines be developed, to whom should they apply, and how should they be implemented?

3. What recommendations should the Commission make regarding professional recognition, safe and high quality CAM practice, and exposure to medical malpractice? Consider issues of state sovereignty and federal purview.

4. What recommendations does the Commission wish to make regarding defining "quality care" and quality improvement activities/initiatives for integrative health care?

5. What guidance, if any, can be offered regarding consumer information and consumer complaints about integrative health care?

6. What guidance, if any, can be offered regarding the risks associated with dietary supplement-drugs, dietary-supplement-dietary supplement, and dietary supplement-food interactions, particularly for holistic and integrative professionals?

7. What guidance, if any, can be offered as to whether CAM practitioners and products should be incorporated in the National Practitioner Data Bank?

- Target Organizations that may be contacted to provide background information or expertise on these issues may include (this list is NOT comprehensive. For example, organizations or experts who offer a counterpoint perspective need to be identified.):

  American Holistic Medical Association
  American Holistic Nurses Association
  American Holistic Dental Association
  American Holistic Health Association

American Board of Medical Acupuncture
Federal Trade Commission, Agency for Healthcare Research and Quality

Whccamp (NCCAM)

From: Jan Forsberg [info@homeopathicschool.org]
Sent: Thursday, March 15, 2001 11:31 PM
To: Whccamp (NCCAM)
Subject: MINNESOTA MODEL FOR HEALTH FREEDOM

March 15, 2001

To: White House Commission on Alternative and Complementary Medicine
From: MINNESOTA HOMEOPATHIC ASSOCIATION

The Minnesota Homeopathic Association was founded as a state-wide professional organization for homeopathic practitioners with the following mission:

to promote homeopathy as a safe and effective health care choice for Minnesotans;
to protect the public interest by upholding high standards of care by its member practitioners;
to serve and support the community of Minnesota's professional homeopaths.

We would like to share with you our dedication to the idea that health care consumers should have access to the modalities they feel are most appropriate to their individual needs. While government should protect citizens from harm, we believe it is also the government's important role to protect the citizen's right to individual choice and autonomy as regards the way in which they decide to protect and enhance their own health and well-being.

We enthusiastically support the Minnesota Model as it has supported maximum access by health care consumers to the many modalities and types of healers available while at the same time protecting the individual through a Health Department consumer hot-line for complaints and the enforcement of 24 paragraphs of practitioner prohibited conduct.

We believe that the Minnesota Model was carefully crafted after much thought and deliberation as well as the legislative give-and-take of all interested parties. We want you to know that the Minnesota Complementary and Alternative Health Care Freedom of Access Act has the full support and confidence of our professional organization. In sum, the Minnesota Model provides the opportunity for the citizens of Minnesota to maintain their health and well-being across a broad spectrum of choices while at the same time protecting Minnesota health care consumers from harm.

Best regards,
Valerie Ohanian, R.S. Hom., C.C. Hom.
President

U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration
Bureau of Health Professions

Fact Sheet

COMMUNICATIONS STAFF (301) 443-1590 JULY 2000

HRSA Bureau of Health Professions

Health Care Access: It All Starts with Quality Professionals

Overview

Nearly 3,000 communities throughout the United States do not have enough health care providers to meet basic medical, dental and general health needs. Half of these communities are located in rural areas and most of the rest, in poor, urban neighborhoods. The ***Bureau of Health Professions (BHPr)*** seeks to address these problems by creating a health care workforce that is up to the challenges of the new century: delivering quality care in underserved areas and meeting the needs of an increasingly diverse population. In doing so BHPr is laying the groundwork for access to health care for all Americans, the overriding goal of its parent Agency, the ***Health Resources and Services Administration (HRSA).***

Funded at $500 million in FY 2000, BHPr administers 40 grant programs that support 1,600 projects at academic health centers, health professions training programs and community-based programs. Charged with providing National leadership in assuring a health professions workforce that meets public needs, the Bureau has four primary goals.

- Better ***distribute*** health professionals both geographically and in terms of specialty since certain types of practitioners, including family medicine providers and nurses, are in short supply in underserved areas.
- ***Diversify*** the health professions workforce so that African Americans, Hispanics, American Indians and other racial and ethnic minorities are better represented. These groups comprise half of the 46 million Americans who are medically underserved but represent less than 10 percent of the health professions workforce.
- ***Improve quality*** of health professions practice and education with a continuous quality improvement process, generating data to ensure that change is made and that it is appropriate.
- Collect, analyze and disseminate accurate health professions workforce ***data*** so that National, state and local decision-makers can accurately assess and meet the public's health needs.

Increasing Health Professions Diversity

Minority health professionals provide more health care for the poor and uninsured and for patients in their own racial and ethnic groups than non-minority providers. African American physicians treat African American patients five times as often as other physicians; Hispanic physicians are 2.5 times more likely than others to treat Hispanic patients. However, the proportion of minority and disadvantaged students enrolling in health training programs has dropped because of changes in state affirmative action laws and financial and other barriers.

Working to reverse the trend, BHPr programs will graduate almost 16,000 health career students from minority and disadvantaged backgrounds in Fiscal Year 2001, up almost 70 percent over FY 1999. Also in FY 2001, over 7,500 BHPr supported graduates (double the number in FY 1999) are expected to practice in underserved areas, among them, physicians, dentists, advanced practice nurses, physician assistants, public health professionals and a wide variety of allied health professionals.

Promoting greater diversity and cultural competence among America's health care professionals is such a pressing National need that it is an overriding goal of six BHPr divisions, which support over 1,500 educational institutions, but it is the primary focus of programs within BHPr's ***Division of Health Professions Diversity.***

As early as high school, minority and disadvantaged students are prepared for health care training through the ***Health Careers Opportunity Program (HCOP).*** HCOP identifies and recruits promising students, gets them into training programs, provides counseling and mentoring, helps with financing and primary health care placement. Minority enrollment is 20 percent higher than the National average at HCOP funded medical schools.

The Division's ***Centers of Excellence (COE)*** enable health professions training programs to increase the number of under-represented minority students applying, enhance academic performance, improve recruitment and retention of under-represented minority faculty, and in other ways enhance the capacity of their graduates to provide health care services to medically underserved individuals. At COE funded medical schools, minority enrollment is 19 percent higher than the National average.

The Division also provides ***minority faculty fellowships,*** which help health profession training programs increase the number of under-represented racial and ethnic minorities serving on their faculties.

Assuring Access to Medical and Dental Care

To address the need for health and dental care in underserved areas, BHPr's largest division, the ***Division of Medicine and Dentistry***, offers grants to expand or enhance family and general internal medicine, general pediatrics and physician assistant training programs, as well as training in general and pediatric dentistry. These programs prepare and encourage medical and dental health professionals to serve in areas of the country where shortages exist.

Medicine: During the last 25 years, the trend in medicine has been toward specialization. This has resulted in a shortage of primary care doctors in poor and rural areas. Currently there are 1.9 specialists for every general practitioner. A ratio of one to one is considered optimal with better distribution.

The Division has helped create or expand 141 departments of family medicine in osteopathic and allopathic medical schools. All but 10 allopathic medical schools in the U.S. now have such departments, without which medical students are unlikely to become generalist physicians. Grants are made to improve and expand training of primary care practitioners from medical students to faculty and thus increase the pool of practicing family physicians. In 1999 BHPr supported 774 graduating residents in family practice, of whom 40 percent are working in shortage areas.

- ***Academic Administrative Units in Primary Care (Family Medicine, General Internal Medicine/General Pediatrics)*** assist accredited schools to establish, maintain or improve primary care academic administrative units that may be departments or divisions or other units which teach family medicine, general internal medicine and general pediatrics.
- ***Predoctoral Training in Primary Care*** helps schools develop, plan and operate predoctoral training programs in family medicine, general internal medicine and general pediatrics. Assistance may take the form of curriculum development, clerkships, preceptorships or student assistantships.
- ***Physician Assistant Training in Primary Care*** trains physician assistants and teachers of physician assistants. Programs receiving awards must encourage their graduates to work in areas where health professionals are in short supply and be able to place them there.
- ***Residency Training in Primary Care*** assists graduate training programs in the field of family medicine, general internal medicine and general pediatrics to meet the cost of planning, developing and operating a graduate medical program.
- ***Faculty Development in Primary Care*** helps eligible institutions increase the supply and expertise of faculty available to teach primary care medicine. These grants can also be used to further educate faculty already teaching family medicine, general internal medicine and pediatrics.
- ***Podiatric Residency in Primary Care*** trains podiatric physicians who plan to specialize in primary care podiatry.
- ***National Research Service Award (NRSA) Grants.*** NRSA fellows gain experience in applied research while expanding their knowledge of primary medical care research methodology and exploring areas where further research is needed.

The Division's new ***Children's Hospitals Graduate Medical Education (GME) Program*** provides $40 million in FY 2000 to freestanding children's teaching hospitals for training resident pediatricians. These 59 freestanding children's teaching hospitals train almost 30 percent of the country's pediatricians and nearly 50 percent of all pediatric specialists.

Physician workforce trends are evaluated by the ***Council on Graduate Medical Education (COGME)***, which recommends appropriate federal and private sector action on identified needs. The ***Advisory Committee on Training in Primary Care Medicine and Dentistry*** provides the Department of Health and Human Services (HHS) and Congress with guidance and recommendations on HRSA administered medical and dental education programs.

Undergraduate Medical Education for the 21st Century (UME-21), a five-year Nationwide demonstration program, encourages educational partnerships and curriculum innovations in the clinical (third and fourth) years of undergraduate medical education to better prepare graduates to practice high-quality, population-based, cost-effective medicine.

Dentistry: Dental caries are a common problem among U.S. children. Among two-to-nine year old children, untreated tooth decay ranges from 40 to 60 percent. Lack of access to dental care is also critical for AIDS patients, geriatric patients and disabled people in long term care facilities and other institutions. Twenty nine percent of BHPr supported advanced dental trainees in 1999 planned to practice in shortage areas, providing almost 80,000 patient visits a year.

- ***Residencies and Advanced Education in the General Practice of Dentistry grants*** assist dental schools and postgraduate dental training programs in meeting the cost of planning, developing, or operating programs and provides financial assistance to residents in these programs.
- ***Pediatric Dentistry grants*** assist dental schools and accredited postgraduate pediatric training programs in meeting the cost of developing and operating pediatric residency programs. Included is the cost of supporting trainees who plan to pursue the practice of pediatric dentistry. The first awards for this new grant program were made in 2000.

Promoting, Improving Collaboration

Getting health care to where it's needed, in the form it's needed, is the objective of programs in the ***Division of Interdisciplinary, Community-Based Linkages***. BHPr promotes partnerships that best use and distribute Federal, state and local funds to health professionals throughout the Nation.

- Helping schools develop community-based health education centers, the *Area Health Education Centers (AHEC)* program now has 40 programs in 40 states with 170 affiliated centers. In 1999 the AHECs provided training for almost 28,000 health professions students, 52,000 minority elementary and secondary students and over 100,000 health professionals.
- Special *Health Education and Training Centers (HETCs)* address persistent and severe health care needs in states along the border between the United States and Mexico, in Florida and other areas with unmet health care needs. Grantees conduct training programs and provide support for health professionals. HETCs trained 280 students in 1999 and 130 community health workers.
- *Geriatric Education Centers (GECs)* support the training and residencies of geriatrics professionals. Since the program began more than 360,000 health care professionals, educators and practitioners have received training.
- The *Quentin N. Burdick Program for Rural Interdisciplinary Training* supports projects emphasizing interdisciplinary training for health care practitioners in rural areas. Over half the students from this program have gone on to careers in rural and frontier areas.
- *Faculty Training Projects in Geriatric Medicine, Dentistry, and Behavioral and Mental Health* train professionals to teach geriatric medicine, dentistry, and behavioral and mental health.

The newly formed (March 1999) *Advisory Committee on Interdisciplinary, Community-based Programs* will provide advice and recommendations to the HHS Secretary concerning BHPr interdisciplinary medical professions policy and program development.

Assuring Access to Nursing Care

By 2010 the United States is expected to have a shortage of registered nurses. Already there is a shortage of RNs from racial and ethnic backgrounds. To reflect percentages in the population as a whole, 450,000 additional ethnic and minority RNs are needed. BHPr's *Division of Nursing* monitors the supply of and need for a quality nursing workforce. Its quadrennial *National Sample Survey of Registered Nurses*, due in 2001, is the Nation's most extensive and comprehensive source of statistics about licensed RNs in the U.S.

The Division is a National leader in nursing education and practice, assuring an adequate supply and distribution of qualified nursing personnel to meet U.S. health care needs. This includes training nurses in needed specialties, such as nurse midwives, nurse practitioners, and public health nurses, and increasing the diversity of the nursing workforce. Ninety-five percent of nurse practitioners and nurse midwives who graduated from Division-supported programs now practice in primary care settings. Thirty-five to 40 percent practice in underserved areas.

- *Basic Nurse Education and Practice Grants* support projects designed to strengthen the basic nurse workforce. These grants have increased enrollment of students in baccalaureate nursing programs, and have established and expanded over 50 percent of nursing faculty-operated nurse managed centers improving access to primary care and serving as clinical training sites in medically underserved areas. In addition, projects support the preparation of nurses to care for underserved and high-risk groups such as the elderly, individuals with HIV/AIDS, substance abusers, the homeless and victims of domestic violence; career mobility for nurses; cultural competency; skills development for changing health care systems; and informatics.
- *Advanced Education Nursing Grants* support advanced nursing education programs for nurses enrolled in advanced degree programs including combined registered nurse/master's degree programs, post-master's certificate programs, and nurse-midwifery certificate programs. Graduates of these programs serve as nurse practitioners, clinical nurse specialists, nurse-midwives, nurse anesthetists, nurse educators, nurse administrators and public health nurses. In addition, traineeship support is provided to over 6,500 graduate level nursing students yearly; 40 percent of these graduates practice in underserved areas.
- *Nursing Workforce Diversity Grants* support projects to increase opportunities for individuals from disadvantaged backgrounds, including racial and ethnic minorities underrepresented among registered nurses. Funds are used to support pre-entry and retention activities designed to help nursing candidates and students from disadvantaged backgrounds to successfully complete the nursing education. Funds are also available for student stipends. Minority enrollment in Division supported schools is 35 percent compared with a national average of 19 percent.

The National Advisory Council on Nurse Education and Practice advises the HHS Secretary and Congress on issues relating to the nursing workforce, nurse education and improving practice.

Public Health and Allied Health Professions: Building Healthier Communities

For the last 30 years the *Division of Public Health and Allied Health,* while undergoing some name changes; has been helping to staff the public health system with quality personnel. It does so by developing and improving the basic and advanced professional education of public health dentists, other public health workers, preventive medicine residents and health administrators who work in the Nation's health care facilities and state/local health departments.

- *Public Health Traineeships* train eligible individuals in public health professions experiencing critical shortages, such as epidemiology, environmental health, biostatistics, toxicology and nutrition. More than 27,000 students have been supported at accredited schools through these grants

- ***Public Health Demonstration Initiative*** supports key public health professional groups and institutions to explore and develop innovative methods to strengthen the linkages between academic and community public health practice. Between 1991 and 1999 this Initiative supported 22 community/academic partnerships.
- ***Public Health Training Centers Program*** has established eight centers to strengthen the technical, scientific, managerial and leadership competence of the current and future public health workforce. This new program will eventually reach every state.
- ***Health Administration Special Project Grants and Traineeships*** help distribute health administrators to serve in underserved areas and increase the number of underrepresented minorities in the profession, as well as support academic and field of practice linkages, and the development of outcomes-based curricula.
- ***Preventive Medicine Residency Training*** supports development of new residency training programs, maintenance or improvement of existing programs and financial assistance to residence trainees.
- ***Dental Public Health Training*** promotes postgraduate residencies in dental public health.

The division also supports training and education programs for allied health professions, including physical therapy, occupational therapy, medical technology, dental hygiene, respiratory therapy, radiography, radiation therapy, emergency medical technology, mental and behavioral health, and chiropractic.

- ***Allied Health Special Projects Grants*** are awarded to eligible institutions to increase enrollment, provide career advancement, and develop interdisciplinary programs and new curricula in allied health professions. Through this program 1,200 students representing 24 health disciplines are being trained in urban and rural underserved areas.
- ***Chiropractic Demonstration Project Grants*** investigate ways that chiropractors and physicians might collaborate on effective treatment for spinal and/or lower back conditions.

Student Assistance: Overcoming Financial Barriers

Financial barriers discourage many disadvantaged students from health care careers. A substantial number have had to rely on high-cost loans. The ***Division of Student Assistance*** provides scholarships and low-cost loans to financially needy students in health professions and nursing programs. In 1999 more than 38,000 such students received scholarships and low-cost loans. Programs include:

- ***Scholarships for Disadvantaged Students (SDS)*** provides scholarships to full-time students from disadvantaged backgrounds enrolled in health professions and nursing programs.
- ***Loans for Disadvantaged Students (LDS)*** are available on a long-term, low-interest basis for full-time students pursuing careers in allopathic medicine, osteopathic medicine, dentistry, optometry, podiatric medicine, pharmacy or veterinary medicine.
- ***Health Professions Student Loans (HPSL)*** are made specifically to full-time students studying dentistry, optometry, pharmacy, podiatric medicine or veterinary medicine.
- ***Primary Care Loans (PCL)*** support full-time students studying allopathic or osteopathic medicine. Participating students must agree to do residency training in primary care and practice in primary care until the loan is paid.
- ***Nursing Student Loans (NSL)*** are available to full or half-time students in a course of study leading to a diploma, associate, baccalaureate or graduate degree in nursing.
- ***Disadvantaged Faculty Loan Repayment (FLRP)*** encourages disadvantaged representation in health professions faculty positions by repaying educational loans of up to $20,000 a year for each year individuals from disadvantaged backgrounds agree to teach in eligible health professions and nursing schools.
- ***Health Education Assistance Loan (HEAL) Refinancing*** refinances loans previously made under the program to reduce total loan costs. New HEAL loans are not being made.

Health Workforce Information and Analysis: Assessing the Nation's Health Workforce Needs

About 15 cents of every dollar spent in the U.S. is on health care; one out of 12 jobs is in health care. Yet, relatively little is known about the health care workforce, except for physicians. Without data, decision-makers cannot accurately assess and meet the public's health needs. The ***National Center for Health Workforce Information and Analysis*** *(National Center)* collects, analyzes and disseminates health workforce information to facilitate workforce planning efforts at the local, state and National levels:

- ***Four Regional Centers for Health Workforce Studies (Regional Centers)*** are cooperatively working with the National Center. The Regional Centers are located at major academic institutions: University of California at San Francisco, State University of New York at Albany, University of Washington at Seattle, and University of Illinois at Chicago. These Regional Centers conduct analyses of important, pressing health workforce issues of national significance. In addition, the Regional Centers provide more localized assistance to their respective state and region in analyzing their specific health workforce issues. The analyses conducted by the Regional Centers are avaliable on each Center's website which can be accessed through the National Center website located at: www.hrsa.gov/bhpr/healthworkforce.
- ***State Health Workforce Profiles*** includes a separate report for each of the 50 states and for Puerto Rico and the District of Columbia. Each report contains tables,

charts, and maps displaying key information on the current status and trends of 50 health professions occupations, including over 20 public health workforce occupations, and data on employment levels and trends in major practice settings. Each report includes comparisons of the state health workforce with the national health workforce. These reports will be available in December 2000.

- ***Health Workforce Partnership Grant Program*** awards small grants to Primary Care Organizations and Associations to partner with Regional Centers for Health Workforce Studies to assess the most pressing workforce issues in their respective states. Co-funded with HRSA's Bureau of Primary Health Care, this program will have finished researching 16 state issues by 2001, including oral health, recruitment strategies for nurse practitioners and physician assistants, and integration of mental health services at community-based primary care delivery sites.
- ***The National Health Care Workforce*** is tracked in the *United States Health Workforce Personnel Factbook*, which contains data on physicians, dentists, nurses, pharmacists, optometrists, podiatrists and allied health professionals. The National Center also publishes *Health Workforce NEWSLINK*, a quarterly newsletter devoted to health workforce issues. [www.hrsa.gov/bhpr/healthworkforce/newslink]
- ***Area Resource File (ARF)*** contains recent county-level data on physicians, dentists and physician assistants. One of the National Center's most wide reaching data bases, the ARF will eventually contain county-level data for some 50 professions. It also includes data on U.S. health status indicators, and enrollments in and graduation from U.S. health professions training programs.

Quality Assurance Monitoring

The Bureau's ***Division of Quality Assurance*** protects the public by assuring the quality of health care providers through its National Practitioner Data Bank, Healthcare Integrity and Protection Data Bank, and Federal Credentialing Program.

The ***National Practitioner Data Bank (NPDB)*** protects the public by providing a repository of malpractice payments, as well as adverse licensure and privileging actions, taken against licensed health care practitioners. Hospitals are required to query the data bank on practitioners applying for privileges or medical staff membership, and to check every two years on practitioners holding privileges or medical staff membership. State licensing boards and entities providing health care services can also request information for use in licensing and credentialing decisions. At the end of 1999 the NPDB contained 227,541 reports. More than 3.2 million queries were made that year, about two-thirds of them voluntary.

The newly established ***Healthcare Integrity and Protection Data Bank (HIPDB)*** is a National health care fraud and abuse data collection program for the reporting and disclosure of certain final adverse actions, including health care-related criminal convictions and civil judgements, taken against health care providers, suppliers, and practitioners. Primarily a flagging system, the HIPDB is available to federal and state government agencies and health plans. As with the NPDB, the subject of a report may self-query the data bank.

The federal government employs many health care practitioners—physicians, nurses, dentists and allied health providers; however, it lacks a central system for verifying their education and training. Together with the Department of Veterans Affairs, the Division is creating the ***Federal Credentialing Program.*** This Internet-based network of credentialing data will allow agencies and departments to share credentialing information, streamlining the verification process and greatly facilitating the hiring and tracking of federal health care providers.

Vaccine Injury Compensation

The ***Vaccine Injury Compensation Program (VICP)*** provides no-fault compensation to individuals thought to have vaccine injuries. Over 5,800 claims have been made through the program. Awards have ranged from $120.00 to $8.4 million. The VICP has promoted research on new and safer childhood vaccines and reduced lawsuits against vaccine companies, thus protecting the vaccine supply.

Ricky Ray Hemophilia Relief Program

Compassionate payments of $100,000 may be given to individuals with blood clotting disorders, such as hemophilia, who contracted HIV during treatment with anti-hemophilic factor between July 1, 1982, and Dec. 31, 1987. Signed into law in November 1999, the **Ricky Ray Hemophilia Relief Fund**, operated by BHPr's Ricky Ray Program Office, was appropriated $75 million for payments in FY 2000. The president's budget for FY 2001 includes $100 million for the program.

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