Joe and Steve,

Good work on OCAHCC?? (Office of Complementary and Alternative Healtcare Coordination). Here is some suggested wording for the opening paragraph and the recommendation. Let me know if you need any help in communicating this upstairs.

Creating an Office of Complementary and Alternative HealthCare Coordination

The Commission received recommendations from a wide sector of the public for continuing, proactive Federal coordination activities for integrating safe and effective complementary and healthcare practices into the nation's health care system. For example, a meeting held by conventional and complementary medicine leaders held at Georgetown University on **** had as its primary recommendation the creation of a Federal coordination office for complementary and alternative medicine and health care.

For the recommendation if you find it useful.

1. The Commission recommends that The President, Secretary of the Department of Health and Human Services, or Congress should create an Office to coordinate and facilitate integration of appropriate complementary and alternative health care practices into the nation's healthcare systems.

1a. The Proposed Office should be established at the highest possible and most appropriate level with sufficient staff and budget to effectively perform its functions.

1b. The Office's functions would include, but are not limited to, coordination of Federal CAM activities; Federal CAM policy liaison with conventional health care and CAM professionals, organizations, institutions, and commercial ventures; planning, facilitating and convening conferences, workshops, and necessary advisory groups, centralized Federal media point of contact; and facilitation of implementation of the WHCCAMP recommendations.

Coordinating and Centralizing Federal CAM Efforts

Staff Lead: Joe Kaczmarczyk
Members: Donald Warren (Facilitator), Veronica Gutierrez, Wayne Jonas, and Effie Chow

Creating an Office of Complementary and Alternative Medicine.

There is a need to coordinate and centralize Federal CAM efforts. While the NIH's National Center for Complementary and Alternative Medicine (NCCAM) is recognized for its leadership in CAM research, NCCAM should not be expected to coordinate and centralize all Federal CAM efforts in addition to performing its vital research roles. Rather, other options for coordinating and centralizing Federal CAM efforts need to be considered. These options include assigning this responsibility to an existing Federal entity or establishing a new Federal entity to focus exclusively on coordinating and centralizing Federal CAM efforts. Since there is precedent for establishing new mission-specific Federal offices which were the result of task force recommendations such as the Office of Minority Health (OMH) and Office on Women's Health (OWH), consideration should be given to this approach and the creation of an Office of Complementary and Alternative Medicine (OCAM).

The Office OCAM should be positioned at the Departmental or higher level to facilitate its coordination and centralization roles. Locations within the Department of Health and Human Services (DHHS) could include either the Office of the Secretary's Office of Public Health and Science (OPHS) where OMH and OWH are located or within one of the thirteen program offices that comprise the OPHS. Among the OPHS program offices in which OCAM could be located, the Office of the Surgeon General which has a small budget and very small number of fulltime equivalents (FTEs) and the Office of Disease Prevention Health Promotion which could like provide linkage with *Healthy People 2010* and beyond appear to be the most likely possible locations. Alternatively, it could be located in the White House either by creating a new office in the Executive Office of the President following the examples of the Office of National AIDS Policy or Office of Faith-Based and Community Initiatives or by placing it within an existing office such as the Office of Domestic Policy. A White House location certainly would provide an opportunity to influence Federal policy but not permanence, since it would be vulnerable to the vagaries of Washington.

There are three mechanisms for the creation of OCAM. First, the President could establish OCAM in the White House simply through an executive order. Second, the Secretary could establish OCAM by signing and subsequently publishing a Federal Register notice to approve establishing OCAM in either OPHS or one of its component program offices. Third, Congress could create OCAM legislatively and place it wherever it chooses in the Federal government through a much more protracted process but one which would provide permanence, a legislative mandate which is *de rigueur* for influence and effectiveness in the Federal culture, and appropriations.

EDITORIAL SUGGESTION... DELETE THIS SECTION |Because of the potential for significant latency between the conclusion of the White House Commission on Complementary and Alternative Medicine Policy and the completion of the legislative process to create and actually open OCAM, an alternative scenario, in which the momentum of the Commission is maintained and implementation of the Commission's recommendations is initiated to the extent possible, ought to be considered. An alternative scenario could involve a temporary or "foster" home for the responsibilities of proposed Office in either the White House or the Department where it could reside until legislation is enacted.|

Responsibilities of OCAM.

The responsibilities of OCAM should include the following five broad categories:

1. Centralized coordination [or stated as coordination and centralization... ???] of Federal CAM activities;
2. Federal CAM policy liaison with conventional health care and CAM professionals, organizations, educational institutions, and commercial ventures;
3. Planning and convening conferences, workshops, and necessary advisory groups;
4. Centralized Federal media point of contact;
5. Facilitation of implementation of WHCCAMP recommendations.

Coordination and centralization of Federal CAM activities require OCAM to be placed at highest possible level in the Federal Government. If the OCAM were located in DHHS, it would influence primarily HHS Agencies and would have to limit its purview to non-research activities in order to complement rather than compete with NCCAM. Although it would be challenging indeed to coordinate CAM activities across Departments, this could be accomplished by establishing, through OCAM's leadership, a Trans-Departmental CAM Coordinating Committee (TDCCC) that included representation from all Federal Departments and Agencies. Since the extent of Federal CAM activities is unknown despite previous Congressional inquiries, a baseline survey of Federal CAM activities could be conducted and a report prepared by OCAM by collecting the data through the TDCCC. The survey results could form the basis for coordinating Federal CAM activities. Because of its value to the Secretary, Administration, and Congress, this type of Federal CAM activities report could be generated annually to inform Federal CAM policy decisions.

OCAM would be the Federal CAM policy liaison with conventional health care and CAM professionals, organizations, educational institutions, and commercial ventures. This would entail activities such as those described in recommendations and action items in the Education and Training, Information Development and Dissemination, Wellness, Access and Delivery, and Coverage and Reimbursement sections of this Report. Perhaps the most important liaison activity of OCAM would be to establish an OCAM Advisory Council similar to that of NCCAM to bring the various stakeholders together to develop an OCAM agenda that reflects public input. The OCAM Advisory Council could be composed of members from outside of the Federal government, including consumer representation. Alternatively, it could be patterned after the Board of Directors of the Overseas Private Investment Corporation (OPIC) [Http://www.opic.gov] which is a composite of members from both the private and Federal sectors. If OCAM followed the OPIC model, one of the Federal members should be the Director of NCCAM to provide linkage to CAM research.

By planning and convening conferences, workshops, and necessary advisory groups, OCAM would create unique opportunities to explore contentious CAM issues, for example, involving licensure or coverage and reimbursement. OCAM also would bring conventional health care and CAM together to develop dialogue and collaborative activities to address needs identified by the OCAM Advisory Council, TDCCC, and survey of Federal CAM activities.

As the centralized Federal media point of contact for CAM, OCAM would not perform an information clearinghouse function, since NCCAM has a legislative mandate to perform this function. Rather, OCAM would develop and implement a triage model for media calls or e-mail inquiries. So when an inquiry occurred, OCAM would direct the person to the appropriate person at the Departmental or Agency level through a network or previously identified information officers or other points of contact with known expertise and relevant purview. OCAM also could create a website, which could include information about OCAM and its functions along with CAM events calendar postings, links to other Federal websites, and hyper-link e-mail to OCAM.

Facilitating implementation of WHCCAMP recommendations would be arguably one of the most important roles of OCAM. Without legislative authority--or at least, a focus on the WHCCAMP recommendations--staff, and budget dedicated to overseeing, coordinating, and facilitating the implementation of the WHCCAMP recommendations, the likelihood of successful implementation of those recommendations will be diminished significantly. OCAM's role in implementation of the WHCCAMP recommendation and action items could include interaction with and education of members of the Administration and Congress and their staffs as well as advising affected Departments and Agencies on the issues.

The creation of an office, comparable to OCAM described above, has been validated externally. For example, the National Presence—Policy, Coalitions, Voice breakout group at the Second Annual Integrative Medicine Industry Leadership Summit held on May 3-5, 2001 in Scottsdale, AZ listed "Track the White House Commission and provide input on establishing a 'Federal CAM Integrative Health Care Office' and selection of an advisory panel to that office" as their top "action priority" (*The Integrator* 2001;June Vol 5 No 9). While NCCAM should be unencumbered to address the research slice of the CAM

"pie" and receive adequate funding to do so, OCAM would be responsible for the rest of the CAM "pie." This may necessitate increased funding of Agencies plus sufficient budget and staff for OCAM to coordinate Federal CAM activities and collaborate with the appropriate stakeholders. ~~At a minimum, OCAM would require a staff of 5 FTEs and an operating budget of $5 Million.~~

The uncertainty of how OCAM is viewed by the Administration, Secretary, and Congress is a critical challenge. Federal reluctance to create OCAM should be anticipated in light of shrinking budgets and efforts to "right-size Government." Resistance to establishing OCAM should be expected from conventional health care professions, organizations, and institutions. On the other hand, CAM advocates, practitioners, organizations, and institutions may have unrealistic expectations of OCAM.

Let's change the focus on this

Draft Recommendation:

1. The Commission recommends that The President, Secretary of the Department of Health and Human Services, or Congress should create an Office at the highest possible and most appropriate level with sufficient staff and budget to perform functions that include, but are not limited to, coordination of Federal CAM activities; Federal CAM policy liaison with conventional health care and CAM professionals, organizations, institutions, and commercial ventures; planning and convening conferences, workshops, and necessary advisory groups, centralized Federal media point of contact; and facilitation of implementation of the WHCCAMP recommendations.

Recommend the Fed coordination and to facilitate the integration of natural CAM/Alternative into the healthcare system

Julia Ilse

Kaczmarczyk, Joseph (NCCAM)

From: Sierpina, Victor S. [vssierpi@utmb.edu]
Sent: Wednesday, November 28, 2001 3:59 PM
To: Kaczmarczyk, Joseph (NCCAM)
Subject: RE: Request for rieview and comment

Education and Training of Heal...

Joe,
Great document. I have reviewed it with comments by line. Also added some materials and will send you an e-mail with the Alternative Therapies articles I wrote to help round out the teaching examples.

Vic

-----Original Message-----
From: Kaczmarczyk, Joseph (NCCAM) [mailto:kaczmarj@od.nih.gov]
Sent: Tuesday, November 27, 2001 8:26 AM
To: 'vssierpi@utmb.edu'
Subject: FW: Request for rieview and comment
Importance: High

Here's the attached file.

<<Ed Training 16 Nov 01 draft v7 JMK Rich txt.rtf>>
> -----Original Message-----
> From: Kaczmarczyk, Joseph (NCCAM)
> Sent: Tuesday, November 27, 2001 9:24 AM
> To: 'vssierpi@utmb.edu'
> Subject: Request for rieview and comment
>
> 27 Nov 01
>
> Vic,
>
> Attached as a rich text file is the current draft of the education and
> training section of the WHCCAMP final report. If you have the time, could
> you please review it and provide and comments by close of business Tuesday
> 4 Dec 01 by either e-mail or telephone discussion?
>
> Please treat this document confidentially.
>
> Thank you,
> Joe
>
> Joseph M. Kaczmarczyk, DO, MPH
> Senior Medical Advisor
> White House Commission on Complementary and Alternative Medicine Policy
> voice: 301.435.6197
> e-mail: kaczmajo@mail.nih.gov
>

Education and Training of Health Carte Practitioners in CAM

White House Commission Draft

Comments by Victor S. Sierpina, MD
UTMB-Galveston

LINE

50 Insert subheading of "Faculty Development"

60 Insert subheading "Research"

71 Insert subheading "Collaboration"

94-99 List all CAM Education Project 9R25) recipients to date, UNC, UTMB, BCH, RPSL, U Minn in addtion to the ones you have

100 Subheading "HRSA Funding

112 "Legislative issues"

128 "Other Resources"

153 support should be made available..... *from where?*

156-159 supported .... *.by whom?*

165 Insert British, UK or something before the House of Lords to clarify source

191 Excellent to mention the ABHM. I would also mention the role of the American Botanical Council in affiliation with national herbal organizations to attempt to set up a certification program in herbalism

201 Did you leave massage off on purpose? They have a pretty well standardized certification program though I am not sure it is a national certification but ought be mentioned

225 Challenges: need to address here credentialing issues in this segment. Issues of how CAM practitioners can integrative into health systems and what is involved in the credentialing, privileging process

254 Need to add as core competencies: medical record keeping, how to operate in the referral environment, how to collaborate with conventional practitioners, communication within the team, medico-legal issues of care, who's responsible?

280 Great idea

283-86 another excellent idea

296 Challenges: need to add comments about how to resolve issues of trust, turf, world view, diagnostic, therapeutic models

308 Need to address here the referral process, communication, collaboration, medicolegal

396 Need to discuss the intersection of CAM and conventional medical practice

427 "short area designation" is a great idea

467 BACKGROUND:

BELOW IS THE BACKGROUND SECTION I USED IN OUR SUCCESSFUL R25. USE AS MUCH OF IT AS YOU WANT:

Background and Significance

Physicians should routinely inquire about the use of alternative or unconventional therapies by their patients, and educate themselves and their patients about the state of scientific knowledge in respect to these therapies. . . . courses offered by medical schools on alternative medicine should present the scientific view of unconventional theories, treatments, and practice as well as the potential therapeutic utility, safety, and efficacy of these modalities. Medical schools should be free to design their own required or elective experience related to alternative/complementary health care practices.

--

American Medical Association, 1997 [1]

Need for the Project. Complementary and alternative therapies are not consistently taught to healthcare professionals during training. This educational vacuum puts at risk the increasing number of patients who use these therapies.[2] Educational offerings in CAM, though now available at a majority of medical schools, are highly heterogenous, are often offered only as electives, and with few exceptions are neither standardized nor evidence-based.[3, 4]

The Principal Investigator surveyed CAM programs at US medical schools in 1998 and again in 1999. The results, which were presented at regional and national conferences, confirmed that curricula were highly diverse and often dependent on the enthusiasm and efforts of a single faculty champion. Subject matter was often limited to a individual teacher's area of expertise and was therefore not systematic or broadly based. Although there were several well-developed programs, most were neither consistently taught nor evaluated.[5, 6]

In recent testimony before the US Senate, Dr. Andrew Weil identified a key problem for patients: "in the absence of physicians or other healthcare providers who are educated and practiced in the art of integration [of CAM therapies with conventional therapy], patients are torn between the instructions they receive from their conventional physician, alternative care providers, health food clerks, the Internet, and their families in making their own medical decisions. Healthcare providers must be skilled in understanding when and how to incorporate alternative approaches and to counsel patients against useless or fraudulent practices."[7]

Challenges in the Educational Environment and Culture. The holistic, culturally sensitive, post-modern world-view of CAM has the potential to be a cultural change agent in contemporary biomedicine,[8] but integrating CAM therapies into the health care curriculum faces several challenges.

First, academic medicine is in the midst of a critical fiscal crisis, caused by reduced Medicare reimbursements and increased managed care encroachment and regulation. The current academic

culture may not eagerly embrace this major reform in education in a time of crisis.[9, 10] However, true integration of CAM therapies with conventional therapy could result in an improved, less costly system of health care. So this is a time of opportunity as well as challenge.

The second challenge is political. To promote wellness and encourage our learners to become positive health role models for their patients requires fundamental changes, including good mentoring and role modeling, early in the educational process. A potential, however, is that by attracting resources, student enthusiasm, and publicity to a highly visible and publicly popular CAM agenda, we may engender hostility in conventional academics. In institutional settings, educational change often entails political risks. For this reason, this project will invest time and effort in building interdisciplinary teams and developing effective liaison between the university, other alternative medicine programs, and the community, as described in Aim 1.

Because a standardized CAM curriculum does not yet exist, a political battle may ensue between conventional practitioners and alternative practitioners, who have little understanding or philosophical tolerance of the each other. Creating a common, neutral forum for discourse is essential to the advancement of education in this area. We can begin by introducing to each group a basic understanding about the definitions, paradigms, and research methods of the other group.[11-16] Creating curriculum guidelines, as described in Aim 2, is another way to establish agreement among interested parties as to what should be taught, by whom, and how it should be evaluated.[17] Using the widely respected principles of evidence-based medicine in CAM education is yet another way to bridge the gap between scientifically trained clinicians and their CAM colleagues.[18, 19] Such information is increasingly available in well-written, balanced texts on the subject,[20-24] as well as databases, web sites, and other information resources.

A final and more subtle challenge has been described by those in the CAM field, who are concerned that alternative therapies will simply be added to the "black bag" of conventional biomedical therapy and thus not help to foster the patient-centered model so valued by CAM advocates.[25, 26] As long as the model of care remains disease-focused, rather than emphasizing wellness and the body's innate tendency to self-repair and healing, self-care will continue to be neglected by our students as well as our patients. Changing our models of teaching (as described in Aim 2) will help to promote a medical model that emphasizes safe, simple, cost effective, and preventive measures first. To create a new educational culture, in which practitioners are truly holistic, we will encourage sensitive communication skills, awareness of the emotional and spiritual as well as cultural concerns of patients, and self-reflection on the path to learning CAM therapies, beginning at the earliest phases of medical education.

Central, of course, to the university culture is maintaining high academic standards. We will therefore engage in an intensive process of evaluation, followed by publication and dissemination of results of experiments in education, as described in Aim 3. Closely monitoring the effects of educational efforts in CAM on students and faculty, and encouraging feedback from both groups, will help offset initial negative perceptions about the new curriculum.

Positive Factors in Reimbursement and Practice Environment. Health insurance plans increasingly cover alternative therapies.[27-29] Conventionally-trained physicians and other providers such as nurse practitioners, physician assistants, nurses, and pharmacists, need to evaluate alternative therapies and CAM practitioners in order to respond to the requests of patients who expect these covered services to be provided through appropriate referrals or recommendations. Consumer demand for CAM, estimated at over 40% of the US adults,[2] and the need to appeal to a younger, healthier, more prevention-minded clients, have driven these changes in coverage. This movement obligates educators to provide a core knowledge in CAM to trainees, lest they be perceived by patients as poorly informed.

Although insurance coverage of CAM is often driven by economic rather than evidence-based arguments, the challenge for future practitioners is to have solid life-long learning skills, so they can continue to help patients distinguish marketing hype from scientific fact. We need to create professionals who are non-judgmental, yet able to serve as an authoritative, learned intermediaries for the patient about CAM. We propose to teach students solid principles of care and provide well supported information on mechanisms of action of CAM therapies, using relevant case-based learning to demonstrate the multiplicity of world views and paradigms that are embraced by CAM practice and theory.

Shaping the Future of Medical Education and Health Care. Medical students have recognized the environment of today's practice and have lobbied for and promoted the teaching of CAM in their formal training.[30-31] The NCCAM director recently reported that 82% of medical students felt this area ought to be taught in medical school.[32] Several years ago, the Medical Student Section of the AMA's Council on Medical Education introduced Resolution 301 (I-96) to encourage the teaching of CAM therapies in medical schools, thereby shaping AMA policy on this subject. Among the final recommendations of this proposal was the statement highlighted at the beginning of this section.[1]

A number of societal and professional forces have converged to encourage the development of this CAM Education Project. Leland Kaiser, a well known health care futurist and creator of a think-tank in health care management, wrote an essay, "Designer Health Care for a Designer Nation: A New Paradigm" in which he envisions a decentralized, deinstitutionalized, electronically integrated society.[33] The future model of health and health care goes beyond the classical medical goals of treatment and prevention to potentiation. This model fits well with the emerging model of CAM therapies, with its emphasis on patient-centered care and a belief in our capacity for self-conscious design and healing, as described by Drs. Larry Dossey, Deepak Chopra, Herbert Benson, and others.[34-36] Kaiser also emphasizes the important supportive role of community, spiritual beliefs, and collaboration, and reminds us of the public's increasing demand for personal choices. The use of CAM therapies, therefore, is part of a new model that has reconceived disease as transformation rather than merely pathology. ***This future paradigm values intuition and personal, social, and ecological responsibility by well-informed patients who make their own choices as active participants in their health care.***

We must prepare our students for life and practice in this future world of health care. Developing an effective CAM curriculum is no longer an optional "add-on" to medical education, but a requirement in a changing world.[37] In the same ways that we needed to adapt our methods of teaching and practice to address such issues as sexuality, substance abuse, domestic violence, and palliative care, we must provide our learners with the tools to practice in this increasingly consumerist-patient era, in which the informed patient is often using or interested in CAM therapies.[38] At the very minimum, our strategic emphasis must include:

1) **teaching health care professionals enough about CAM to be informed intermediaries for advising their patients who use these therapies.[39]**
2) **providing evidence-based information about CAM to our students, residents, and practicing clinicians.[40]**
3) **teaching our learners to be able to use scholarly methods to critically evaluate the best evidence available on new CAM therapies that arise.[41]**

To do this, we must begin providing an effectively taught curriculum that is up-to-date, accurate, systematic, well-evaluated, and relevant to both basic and clinical science (Aim 2). Finally we must start disseminating this curriculum to the widest possible health care professional audience[42, 43] (Aim 3). This project will help bring long-needed reform to health care and provide an environment conducive to higher quality, lower cost, integrative, and patient-centered care.

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LINE 493—ON

I attached to a separate e-mail a series of articles since Nov 2000 that I have written on CAM education that may help fill out this section better in terms of the types of current educational offerings now available at the r25 sites and elsewhere. Feel free to use (please cite the article however) to make this section more complete

LINE 559-560 Those articles cited fronm Academic Medicine were pretty "hostile" to introducing CAM into medical training and were negatively biased. See Academic Medicine, 2001; 76(9): 863-864 for my powerfully eloquent and thoughtful letter to the editor in response. (feel free to cite)

Line 571-2

Need to mention the problems with getting accreditation for CME in CAM, especially from the American Academy of Family Medicine.

596 Describe

612 Need some info on CME issues

634 Add ABHM again

642 What about postgraduate education and CME for conventional practitioners

686 Excellent idea

691—741 Good recommendations. The operational details need to be ffleshed out, at least conceptually, accountability assigned, funding and

political sources identified, barriers to overcome mentioned and how in this section

Responsibilities for CAM Central from Access and Delivery:

No later than 6 months following the receipt of the White House Commission on Complementary and Alternative Medicine Policy's report, the Secretary of Health and Human Services should establish a national policy advisory board that will support and coordinate efforts with a designated Federal office for CAM to develop policy guidelines on issues related to the access and delivery of CAM.

Within 18 months of being established, the national policy advisory board appointed by Health and Human Services (HHS) will research, develop and publish a set of national standards for the practice of CAM. These standards will establish minimum educational, ethical and practice guidelines for any practitioner wishing to provide health care via CAM approaches, and focus on ensuring patients with necessary safeguards.

With guidance from the HHS' national advisory board on CAM policy, the designated Federal office for CAM should actively promote the development of consensus and practice standards that are specific to a wide variety of CAM practices.

With the support and facilitative efforts of the designated Federal office for CAM, CAM practices and professions should establish a single, voluntary, national organization to register, regulate, and represent its members.

Within 8 months of being established, the HHS' national policy advisory board should begin a process to develop national uniform scopes of practice for CAM practices, primarily to address those practices deemed to present the most potential risks to patients. States are encouraged to use these scopes of practice to provide the necessary legal authority and licensure of such practitioners.

State medical boards strongly are encouraged to work closely with HHS' advisory board through the designated Federal office for CAM to develop standard operational

guidelines for the regulation and oversight of licensed physicians practicing CAM, which are based on national uniform scopes of practices developed by the HHS board.

The Federal Government, including but not limited to HHS, should fund and support efforts by the designated Federal office on CAM to coordinate detailed and expanded epidemiologic surveys of CAM patterns of use, with special attention to ethnic and vulnerable populations.

The Federal Government, including but not limited to HHS, should fund and support efforts by the designated Federal office on CAM to collaborate with private sector studies and demonstration projects that evaluate the usefulness, effectiveness and cost-benefits of collaborative care models at three delivery levels: global health care systems, such as hospitals, community health centers, and managed care settings; specialized health care systems, such as hospice care; and small clinical settings, such as individual and group practices.

Based on studies and demonstration projects evaluating the effectiveness and cost benefits of collaborative care models at three delivery levels, the Federal Government, including but not limited to HHS, should fund and support efforts by the designated Federal office for CAM to convene strategic planning conferences addressing the needs of seriously ill and dying patients, as well as other special populations, to determine best practice guidelines that incorporate conventional palliative care with appropriate and effective CAM approaches.

Within 3 years of being established, the designated Federal office for CAM shall report to the Secretary of HHS on the use of indigenous healing traditions in the United States to identify common use, best practices, and challenges and potential areas for collaborative learning between such traditions and conventional care. The Commission urges this report to include recommendations for the future as regards appropriate protection of such traditions, as well as research and development of such practices as part of

community-based health care. Members from such traditions should be involved closely in this endeavor.

The Federal Government, including but not limited to the Department of Agriculture and HHS, should fund and support efforts by the designated Federal office on CAM to evaluate the feasibility, costs vs benefits, and overall impact on allowing Food Stamp Program Participants to use food stamps to purchase specified single or multiple vitamin-mineral products that do not exceed the nutrient recommendations of the Food and Nutrition Board of the Institute of Medicine.

CAM Central Comments

Groft, Stephen (NCCAM)

From: Kaczmarczyk, Joseph (NCCAM)
Sent: Wednesday, November 14, 2001 11:42 AM
To: Groft, Stephen (NCCAM)
Subject: RE: CAM Central

14 Nov 01

Steve,

After reviewing the current draft of the education and training section for references to CAM Central, I identified the following information which, in some cases, refers to CAM Central in the text but not in the draft recommendation.

Under access to funding and other resources for CAM faculty, curricula, and program development at CAM and conventional institutions...
Funding sources for CAM education and training other than NCCAM and HRSA BHPr should be identified and possible funding from other NIH institutes, Centers for Disease Control and Prevention, Agency for Health Care Quality and Research, Department of Education, foundations, and other public and private sources should be explored. In addition, collaboration between funding sources and organizations such as the American Association of Medical Colleges, American Association Colleges of Osteopathic Medicine, American Dental Education Association, American Association of Colleges of Nursing, Association of Schools of Allied Health Professions, Association of Schools of Public Health and comparable CAM organizations should be established to identify programs, faculty, resources, and opportunities to improve CAM education and training. Identification of funding sources, collaboration between funding sources and organizations, development of selection criteria for competitive award processes for CAM faculty, curricula, and program development at accredited CAM and conventional institutions could be achieved through Federally-sponsored workshops and conferences facilitated by the **proposed Federal CAM Coordinating Office.**

Under national CAM education and training standards, there is a recommendation which reads...
The Commission recommends that conferences should be convened by the **proposed Federal CAM Coordinating Office** to assemble the leadership of professions, educational institutions, and appropriate organizations to determine the feasibility of and possible mechanisms for establishing national CAM education and training standards.
And the text reads...
Chiropractic, traditional Chinese acupuncture, and naturopathic physicians have evolved perhaps the closest toward establishing national education and training standards. Because of their progress, chiropractic, traditional Chinese acupuncture, and naturopathic physicians are appropriate candidates for conferences

convened by the **proposed Federal CAM Coordinating Office** to assemble the leadership of their respective professions, educational institutions, and appropriate organizations to determine the feasibility of and possible mechanisms for establishing national CAM education and training standards for chiropractic, traditional Chinese acupuncture, and naturopathic physicians.

Under communication and collaboration between CAM and conventional students, practitioners, researchers, educators, institutions, and organizations, the text reads...

The elements of the core curriculum for CAM education and training and best pedagogic methods of incorporating them into existing curricula could be determined by a series of demonstration projects conducted at a number of representative CAM education and training programs supported, for example, by NCCAM, HRSA Bureau of Health Professions, Department of Education, foundations, or innovative partnerships. Similarly, these curricular elements and pedagogic methods could be ascertained through conferences facilitated by the **proposed Federal CAM Coordinating Office**. Since these two approaches are not mutually exclusive, both demonstration projects and conferences could be undertaken, if adequate funding were available, and the results, models, and recommendations complied and made available on the internet.

Please note that although the current version of the core CAM curriculum for conventional health care professionals at professional, postgraduate, and continuing education levels does not contain any references to CAM Central, it is under revision and may eventually contain references to CAM Central.

Joe

-----Original Message-----
From: Groft, Stephen (NCCAM)
Sent: Friday, November 09, 2001 4:02 PM
To: Axelrod, Corinne (NCCAM); Chang, Michele (NCCAM); Fisher, Ken (NCCAM); Jim Swyers; Kaczmarczyk, Joseph (NCCAM); Kingsbury, Doris (NCCAM); Miller, Maureen (NCCAM); Pollen, Geraldine (NCCAM)
Subject: CAM Central

During a discussion with Donald Warren, he asked if we could collect any text from the other workgroups that would relate to CAM Central. Can you extract any recommendations and background information from your document, create a new document with this information, and send to me to put together for Donald. Noon on wednesday would be good. then we can look at revise and get out to the Commission members next Friday as scheduled.

Thank you.

Steve Groft

Groft, Stephen (NCCAM)

From: Axelrod, Corinne (NCCAM)
Sent: Friday, November 16, 2001 2:58 PM
To: Groft, Stephen (NCCAM); Kaczmarczyk, Joseph (NCCAM)
Subject: CAM Central

Here are the recommendations that I suggest CAM Central would have a direct role in:

Wellness: recommendations 3,4,6,7,8,9
Info recommendations: 1,4

CDR Corinne Axelrod, M.P.H., L.Ac.
Senior Program Analyst
White House Commission on Complementary and Alternative Medicine Policy
301-435-2212
301-435-1691 (Fax)
axelrodc@mail.nih.gov
http://whccamp.hhs.gov

TOPIC: Coordinating and Centralizing Federal CAM Efforts
Staff Lead: Joe Kaczmarczyk
Facilitator: Donald Warren

F. 8/16
6-8 pm

Issue: How Can Federal CAM Efforts Be Coordinated and Centralized?

Discussion: There is a need to coordinate and centralize Federal CAM efforts. While the NIH's National Center for Complementary and Alternative Medicine (NCCAM) is recognized for its leadership in CAM research, NCCAM should not be expected to coordinate and centralize all Federal CAM efforts in addition to performing its vital research roles. Rather, other options for coordinating and centralizing Federal CAM efforts need to be considered. These options include maintaining assigning this responsibility to an existing Federal entity, establishing a new Federal entity to focus exclusively on coordinating and centralizing Federal CAM efforts, or creating a quasi-governmental, public-private entity to coordinate and centralize Federal CAM efforts.

Since there is precedent for establishing new mission-specific Federal offices such as the Office on Women's Health and the Office on Minority Health, consideration should be given to this approach, along with answering a number of questions. What should this office be called? Where should it be located in the Federal organizational structure? When, how, and by whom should it be established? What should its functions include? How should it be funded? What should it relationship to NCCAM be?

Naming this new office perhaps should be delayed until its location and functions are clearer. Although a new Federal CAM office could be located in an Agency, it would be better to position it at the Departmental or higher level to its facilitate coordination and centralization roles. Locations within the Department of Health and Human Services (DHHS) could include the Office of the Secretary, Office of the Surgeon General [which does not have a budget or sufficient number of FTEs to support coordinating and centralizing CAM], or even within an existing Office such as the Office of Disease Prevention Health Promotion which could like provide linkage with *Health People 2010* (and subsequent) activities. Alternatively, it could be located at the White House in the Office of Domestic Policy which would provide an opportunity to influence policy but not permanence, since it would be vulnerable to the vagaries of Washington.

Who establishes this proposed Office will determine when, how, and where it's located. For example, the President, at his discretion, could establish the Office in the White House Office of Domestic Policy rather quickly and easily. Similarly, the Secretary could establish the Office relatively quickly by doing so without authorizing legislation and position it within the Department. Congress could create the Office legislatively and place it wherever it chooses through a much more protracted process but one which would provide permanence, a legislative mandate [which is *de rigueur* for influence and effectiveness in the Federal culture], and appropriations. Because of the potential for significant latency between the conclusion of the White House Commission on Complementary and Alternative Medicine Policy and the completion of the legislative process to create and implement the proposed Office, an alternative scenario, in which

the momentum of the Commission is maintained and implementation of the Commission's recommendations is initiated to the extent possible, ought to be considered. An alternative scenario could involve a temporary or "foster" home for the proposed Office in either the White House or the Department where it could reside until legislation was enacted.

Although the functions of the proposed Office will be determined in large measure by whom and how the Office was created, those functions ought to include coordination and centralization of all Federal CAM efforts in such a way that the Office complements rather than competes with NCCAM. The exact set of functions of the Office will reflect the Commission's recommendations contained in the Final Report. Likewise, the funding of the proposed Office will be determined by whom and how the Office was created. Both the functions and funding will impact the relationship of the Office to NCCAM. NCCAM will have approximately $100 million and nearly 100 FTEs to address just the research slice of the CAM pie, while the proposed office would be responsible for taking care of the rest of the CAM pie. This would require resources that would exceed NCCAM's resources.

Background: In addition to testimony, the background information, which will be added subsequently, will be derived from legislation establishing NCCAM, PHS Office on Women's Health, and HHS Office on Minority Health as well as *Integrative Medicine Industry Leadership Summit 2001* Report of the National Policy Working Group.

Challenges: The uncertainty of how the proposed Office is viewed by the Administration, Secretary, and Congress is a critical challenge. Agency resistance, particularly from NCCAM, should be anticipated. Resistance to establishing the proposed Office also should be expected from conventional health care professions, organizations, and institutions and especially from the AMA, ADA, and Federation of State Medical Boards. On the other hand, CAM advocates, practitioners, organizations, and institutions may have unrealistic expectations of the proposed Office.

Draft Recommendations:

Summary of Coordinating and Centralizing Federal CAM Efforts
Work Group Conference Call #1 16 August 2001

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Absent: Effie Chow (in Spain)

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Donald Warren focused the discussion on starting the Office. Wayne Jonas asserted that there needed to be "inside, outside communication with each Federal Agency and key members of Congress." Wayne said that value of the "inside communication" is as a means of validating the strategy.

Steve Groft asked about locating the Office at NCCAM? Wayne Jonas answered by saying, "You need to bounce this off key people" to be certain that you're "not stepping on anybody's toes." He continued, "Start with NCCAM. NCI's Office of Cancer Complementary and Alternative Medicine (OCCAM) is a good example" that doesn't compete with NCCAM. Veronica Gutierrez asked, "What does that office do?" Wayne Jonas and Steve Groft briefly describe OCCAM.

Joe Kaczmarczyk was asked what he envisioned as the roles of the Office. He responded by invoking a CAM-as-a-pie metaphor and described NCCAM as one slice, the research slice, of that pie, with the remainder of the pie corresponding to the Federal CAM activities which the Office would coordinate and centralize. In addition, Joe saw the Office as a liaison with conventional health care, CAM, academia, and consumers for non-research aspects of CAM.

After Ann Phelps was identified as a key contact in the White House Office of Domestic Policy to ask about the strategy, Wayne Jonas asked for some background on her. Since neither Steve Groft nor Joe Kaczmarczyk could provide this information, Joe was given the task of obtaining this information. Steve Groft indicated that there are plans to visit involved Agencies, but he is awaiting the Office of the Secretary's reaction to the Interim Progress Report before acting on those plans. Wayne Jonas emphasized the importance of Secretary Thompson's initial reaction to the Interim Progress Report to the Work Group's strategy. Steve Groft said that he intends to send a copy of the Interim Progress Report to the White House Office of Economic Policy, because they contacted him previously about the Commission. Steve added that Senators Harkin, Hatch, Mikulski, and Spector should be included among the key people contacted, especially because of their impact on the Secretary. Donald Warren declared, "Let's get to them after the Interim Report goes public." Then, Wayne Jonas delineated the evolving strategy:

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4. Communicate with the Federal sector
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When Wayne asked Steve Groft for his reaction to the above list, Steve quickly rejoined, "I'd stop short of the Hill. Briefings will be provided." Steve Groft continued, "For the October meeting, have... be able to discuss activities of the Office." Donald Warren inquired about Congressional briefings which Steve answered by describing "bipartisan briefings after the OK from the Department."

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Respectfully Submitted on 20 August 2001 by,
Joseph M. Kaczmarczyk, DO, MPH
Senior Medical Advisor, WHCCAMP

Groft, Stephen (WHCCAMP)

From: Kaczmarczyk, Joseph (WHCCAMP)
Sent: Monday, August 20, 2001 4:38 PM
To: Donald Warren; Effie Chow; Veronica Gutierrez; Wayne Jonas; Wayne Jonas; Axelrod, Corinne (WHCCAMP); Chang, Michele (WHCCAMP); Fisher, Ken (WHCCAMP); Groft, Stephen (WHCCAMP); Jim Gordon (E-mail); Jim Swyers (E-mail); Kingsbury, Doris (WHCCAMP); Miller, Maureen (WHCCAMP); Pollen, Geraldine (WHCCAMP)
Subject: Summary of CAM Central Conference Call #1 16 Aug 01

Importance: High

20 Aug 01

Members of the Coordinating and Centralizing Federal CAM Efforts Work Group,

I've attached an MS Word file and a Rich text file containing the summary from the Coordinating and Centralizing Federal CAM Efforts Work Group's first conference call which took place on 16 August 2001.

Please call me at 301.435.6197 if you have an difficulty opening the attached files.

In addition, I'm including below the text of the summary in the body of this e-mail message.

Thank you,
Joe

Summary CAM
:entral Work Group..

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After Donald Warren summarized the discussion to this point, Wayne Jonas inquired rhetorically about "how to buffer HHS... and Steve Straus' response" and answered with "look for support from the other HHS organizations... AHRQ, CDC, and HRSA." Donald Warren asked, "How can we make this a win-win for Straus?" Wayne Jonas replied that Steve Groft should meet with Steve Straus and ask Steve Straus to draft the initial tasks of the Office and unload the burden of activities which Straus dosen't want to house in NCCAM. Steve Groft interjected that he also wants to talk with Paul Coates, the Director of the NIH Office of Dietary Supplements, and ask him for advice.

Veronica Gutierrez inquired if the Office would have an advisory council which would include CAM representatives. Joe Kaczmarczyk responded by saying that it should have an advisory council composed of primarily stakeholders--particularly individuals who represented organizations to magnify the effect of their membership on the council-from conventional health care, CAM, and academia, as well as Steve Straus and representatives from DOD, VA, and Education. Joe recommended that the Office's advisory council should develop the Office's agenda which would result in increased likelihood of the council members buying in to a common agenda, having to defend the agenda to their constituencies, obtaining Steve Straus' cooperation, and coordinating CAM activities across Departments. Steve Groft indicated that "select members of WHCCAMP" could serve on the advisory council "with a quarter rotating off each year."

Donald Warren redirected attention to the Office of the Secretary to which Steve Groft responded, "We should hear from the OS in the next week and a half." Wayne Jonas then asked, "Is there any process to contact the White House? Is that premature?" Referring to the Interim Progress Report, Steve Groft explained, "One we have a product in hand, we can contact the Office of Economic Policy, Office of Presidential Personnel, and Office of Domestic Policy." Wayne Jonas summarized tasks to be accomplished as:

1. Define tasks and duties of the Office
2. Elaborate potential scenario(s), general structure of and rationale for proposed office, and relationship to NCCAM and other entities
3. Ascertain Secretary Thompson's response to concept of proposed office
4. Communicate with the Federal sector
5. Meet with key members of Congress (especially Senators)
6. Explore Commissioners meeting with the White House.

When Wayne asked Steve Groft for his reaction to the above list, Steve quickly rejoined, "I'd stop short of the Hill. Briefings will be provided." Steve Groft continued, "For the October meeting, have... be able to discuss activities of the Office." Donald Warren inquired about Congressional briefings which Steve answered by describing "bipartisan briefings after the OK from the Department."

Donald Warren summarized to this point and mentioned that he was going to meet with Sally Yamini this weekend. Wayne Jonas asserted that "outside folks can determine if there is an avenue for communication." Joe Kaczmarczyk interjected that Sally Yamini and Jacqueline Offutt can provide background information.

Wayne Jonas asked if there is going to be another conference call... after the next iteration of the straw man document. Donald Warren queried Wayne, "Are you to introduce me to these people, Wayne?" Wayne Jonas responded laconically, "Yes."
Although a definitive date for another conference call was not set, there will be another conference call scheduled after the next iteration of the straw man document.

Respectfully Submitted on 20 August 2001 by,
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Summary of the Coordinating and Centralizing Federal CAM Efforts Work Group
Conference Call #2 5 September 2001

Present: Donald Warren (Facilitator), Veronica Gutierrez, Effie Chow (briefly by air phone), Wayne Jonas, Steve Groft, and Joe Kaczmarczyk (Staff Lead)

After updates on local activities by Veronica and Don, Steve Groft informed ~~the Work Group that the White House apparently is "not resistant" to the idea of CAM~~ Central and ~~feels the~~ office--~~if it were created--should be located in the Office of the Secre~~tary of ~~HHS.~~ Steve also provided a rather brief update on the status of the Interim Report and reviewed the format for the October meeting.

Don asked Veronica if she received Wayne Jonas' e-mail about action steps and sequence. Veronica replied that she was in her office and didn't see it yet. When Don was seeking clarification of Wayne's comments, Wayne Jonas joined the call and explained that sequence referred to "sequence of events... contacting people on the Hill, in HHS, in the White House, and key individuals... ." Steve Groft reiterated his update. Wayne then asked, "Was the CAM Central recommendation in the Interim Progress Report?" Steve replied, "The topic was mentioned without a specific recommendation, and Office on Women's Health (OWH) and Office of Minority Health (OMH) were cited as examples."

Don dealt sequentially with the following five broad categories of possible functions of CAM Central developed by Joe Kaczmarczyk:

1. Coordination of Federal non-research CAM activities
2. Federal non-research CAM policy liaison with conventional health care and CAM professionals, organizations, and institutions
3. Planning and convening consensus conferences and blue ribbon panels
4. Centralized medial point of contact
5. Facilitation of implementation of WHCCAMP recommendations.

In response to the first category, Wayne urged dropping "non-research" and using a paragraph to preface the categories by delineating the purpose and differentiating it from NCCAM's research activities. Wayne then made the point that this office may need to have some research involvement that would include those aspects not under NCCAM's purview such as non-Federal research and research conducted by DOD to fulfill the Executive Order's mandate. Steve Groft said that the language was "coordination of research." Wayne suggested that Steve discuss this with Steve Straus. Don asked Veronica, "What do think?" Veronica agreed with Wayne's suggestions.

After hearing the second category, Wayne again urged removal of "non-research" and including examples such as "AMA, ACOG, AAFP, ACA, and acupuncture associations." Both Don and Veronica disagreed and recommended "leave out the tricky lists." Wayne acknowledged that it would be more astute to omit lists.

When the third category was mentioned, Steve Groft reacted strongly and indicated that he "had a problem with 'consensus conferences' " which have a very specific meaning at NIH. Steve suggested using language such as workshops, conferences, and blue ribbon panels. Veronica interjected that "consensus" is controversial and Wayne agreed. Steve then added that CAM Central, however, could participate in or suggest NIH consensus conferences.

Don lead the discussion of the fourth category by stating that he thought this would be "a point of contention with Straus." Steve suggested, "See if he wants to be the point of contact for non-research CAM inquiries." Steve also envisioned CAM Central as being able to "direct inquiries to the appropriate information officers." Wayne asked if the Office would be putting out documents. Steve replied, "What do you think?' Joe answered, "That would be encroaching on NCCAM's information role." Veronica recommended using a calendar model for information. Joe reminded the group that NCCAM has legislative language concerning information dissemination. After Wayne confirmed that there was legislative language about an NCCAM clearing house, he referenced the Executive Order and then posed and answered the rhetorical question "How would this be coordinated with research... media clearing house? Not clear."

Joe reiterated the triage model for media calls. Wayne asked, "Do we want another clearing house? If so, how would this relate to NCCAM?" Wayne recommended further discussion as a full Commission and broaching this with Steve Straus. Although Steve endorsed the calendar model, Wayne did not, saying," In my experience, it was inadequate and not easy to do." Steve noted that NCCAM had factsheets on 6 CAM interventions and NCI's OCCAM had several of the same. Wayne mentioned PDQ factsheets, and Steve added, "There's room for a lot of work." Wayne rejoined that he wasn't sure "if an information clearing house should be a function of CAM Central." Steve advised "staying away" from a clearing house function. Wayne agreed and speculated about CAM Central emulating "the Office of Disease Prevention...not as far as guidelines...similar format but not guidelines... with information on licensing and credentialing. Carve out a niche and facilitate access to others... ." Veronica alluded to the multiplicity of State organizations. Steve admonished, "Be very cautious in what you permit... be sensitive to the States."

Joe recounted that OWH and OMH which arose from task force recommendations began with small staffs (3 FTEs) and small budgets which he described as "pocket change." Wayne agreed with a clear and laconic, "Yeah." Steve said," A clearing house would be $750,000 right there, but you could get a website up and running for $100,000."

Don described the fifth category as "by far the most important." Wayne agreed and said that it was "essential... one of the main functions." Consequently, Veronica suggested "putting it first." Joe disagreed, saying that he put it last so that it wouldn't appear to be self-serving. Don said, "Let's go back to the centralized media point of contact. That's pretty much contingent upon the meeting with Steve Straus."

Then, Don sequentially reviewed the bulleted expansion of each category which Joe prepared as part of the proposed agenda.

1. Coordination Federal CAM activities
   - Coordinate HHS non-research CAM activities if the Office were located in HHS
   - Coordinate CAM across Departments (DOD, VA, Education, Agriculture, etc,) through inclusion in Advisory Council.

Joe described two possible scenarios: (1) an advisory council for CAM Central which would include public input for coordinating HHS CAM activities; (2) a Federal Trans-Departmental CAM Coordinating Committee to coordinate CAM more broadly across Departments such as DOD, VA, Education, Agriculture, and perhaps even Justice and State. Wayne responded that a "public advisory council and the other coordinating committee are not mutually exclusive." Don asked, "How would you coordinate these two?" Wayne answered, "It would be the responsibility of CAM Central. The public advisory council would be the ultimate authority as representatives of the taxpayers."

2. Federal CAM policy liaison with conventional health care and CAM professionals, organizations, and educational institutions
   - Facilitate development and implementation of basic or core curricula (undergraduate, postgraduate, and CME/CE) for conventional and CAM practitioners proposed by Education and training Work Group
   - Assist with identification of scholarship and loan program opportunities
   - Assist with development of postgraduate training (e.g., residencies and fellowships)
   - Assist with interaction and relationships between conventional health care and CAM.

Wayne recommended adding high school and below to the educational institutions as well as the Department of Education and another bullet "Facilitation with other types of public education on CAM in health care." Everyone agreed to the addition of that bullet.

3. Planning and convening consensus conferences and blue ribbon panels
   - Explore contentious issues involving licensure, access and delivery, education and training, information development and dissemination, reimbursement, etc.
   - Bring conventional health care and CAM together for productive dialogue and building infrastructure.

Don said, "Forget the consensus conferences!" Wayne played out loud with linguistic revisions such as "collaborative infrastructure" and said, "The prime activity is facilitating dialogue... brining together different groups... emphasize dialogue!" Joe interjected, "Delete infrastructure." Wayne proffered, "Development of dialogue and collaborative activities... practice standards... infrastructure." Joe invoke the policy level perspective and said, "Leave it at 'develop dialogue and collaborative activities.' " Steve recounted examples of genetics and public education based on his experience with ORD. Wayne acknowledged Steve's example.

4. Centralized media point of contact
    - Refer CAM inquiries to designated (previously identified) individuals in the appropriate Federal Agencies.

Don summarized this function as "Almost like a switchboard." In light of the prior extensive discussion of this proposed function, no further discussion ensued.

5. Facilitation of implementation of WHCCAMP recommendations
    - Interact with and educate members of Administration and Congress and their staffs on the issues.

Don summed this up with "Educate the staff; get the staff involved." As the case with the preceding proposed function, no further discussion occurred.

The discussion then focused on next steps. After Joe raised the question about the need to name CAM Central before the October meeting, Veronica suggested the "Office of Integrative Health Care." Joe responded by saying," In Government, it's de rigueur to have an acronym that can be pronounced." The Work Group decided that naming "can wait." Joe then asked about rank ordering the proposed functions of CAM Central, and after some discussion, the Work Group endorsed the following rank ordering:

1. Coordination of Federal CAM activities
2. Federal CAM policy liaison with conventional health care and CAM professionals, organizations, and institutions
3. Planning and convening conferences, workshop, and blue ribbon panels
4. Centralized medial point of contact
5. Facilitation of implementation of WHCCAMP recommendations.

It was agreed that the Work Group would present at the October meeting a draft recommendation that proposes creation of the Office, its location, and functions that "included but are not limited to... ." Don volunteered to write the recommendation on his return from San Francisco and circulate it to the Work Group for review and comment.

Following Steve's review of the process for the October meeting, there was a brief discussion of the need for another conference call before the October meeting. The Work Group felt that another conference call wasn't needed--unless reaction to Don's draft recommendation or Steve Groft's meeting with Steve Straus indicated that one was necessary.

Respectfully Submitted on 7 September 2001 by
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Coordinating and Centralizing Federal CAM Efforts

Staff Lead: Joe Kaczmarczyk
Members: Donald Warren (Facilitator), Veronica Gutierrez, Wayne Jonas, and Effie Chow

Issue: How Can Federal CAM Efforts Be Coordinated and Centralized?

Background: There is a need to coordinate and centralize Federal CAM efforts. While the NIH's National Center for Complementary and Alternative Medicine (NCCAM) is recognized for its leadership in CAM research, NCCAM should not be expected to coordinate and centralize all Federal CAM efforts in addition to performing its vital research roles. Rather, other options for coordinating and centralizing Federal CAM efforts need to be considered. These options include assigning this responsibility to an existing Federal entity or establishing a new Federal entity to focus exclusively on coordinating and centralizing Federal CAM efforts.

Since there is precedent for establishing new mission-specific Federal offices which were the result of task force recommendations such as the Office of Minority Health (OMH) and Office on Women's Health (OWH), consideration should be given to this approach, along with answering a number of questions. What should this office be called? Where should it be located in the Federal organizational structure? When, how, and by whom should it be established? What should its functions include? How should it be funded? What should it relationship to NCCAM be?

Naming this new Office should be delayed until its location is more certain. The Office should be positioned at the Departmental or higher level to facilitate its coordination and centralization roles. Locations within the Department of Health and Human Services (DHHS) could include either the Office of the Secretary's Office of Public Health and Science (OPHS) where OMH and OWH are located or within one of the thirteen program offices that comprise the OPHS. Among the OPHS program offices in which the proposed Federal CAM Office could be located, the Office of the Surgeon General which has a small budget and very small number of FTEs and the Office of Disease Prevention Health Promotion which could like provide linkage with *Health People 2010* and beyond appear to be the most likely but less than ideal possibilities. Alternatively, it could be located in the White House either by creating a new office in the Executive Office of the President following the examples of the Office of National AIDS Policy or Office of Faith-Based and Community Initiatives or by placing it within an existing office such as the Office of Domestic Policy. A White House location certainly would provide an opportunity to influence policy but not permanence, since it would be vulnerable to the vagaries of Washington.

Who establishes this proposed Office will determine when, how, and where it will be located. For example, the President, at his discretion, could establish the Office in the White House Office rather quickly and easily. Similarly, the Secretary could establish the Office relatively quickly by doing so without authorizing legislation and position it

within the Department. Congress could create the Office legislatively and place it wherever it chooses through a much more protracted process but one which would provide permanence, a legislative mandate which is *de rigueur* for influence and effectiveness in the Federal culture, and appropriations. Because of the potential for significant latency between the conclusion of the White House Commission on Complementary and Alternative Medicine Policy and the completion of the legislative process to create and implement the proposed Office, an alternative scenario, in which the momentum of the Commission is maintained and implementation of the Commission's recommendations is initiated to the extent possible, ought to be considered. An alternative scenario could involve a temporary or "foster" home for the proposed Office in either the White House or the Department where it could reside until legislation is enacted.

Although the functions of the proposed Office will be determined in large measure by whom and how the Office is created, those functions ought to include the following five broad categories:

1. Coordination and centralization of Federal CAM activities
2. Federal CAM policy liaison with conventional health care and CAM professionals, organizations, educational institutions, and commercial ventures
3. Planning and convening conferences, workshops, and necessary advisory groups
4. Centralized Federal media point of contact
5. Facilitation of implementation of WHCCAMP recommendations.

Coordination and centralization of Federal CAM activities require the proposed Office to be placed at highest possible level in the Federal Government. If the Office were located in DHHS, it could influence essentially only HHS Agencies and would have to limit its purview to non-research activities in order to complement rather than compete with NCCAM. It would be challenging indeed to coordinate CAM activities across Departments. This could be attempted by establishing a Trans-Departmental CAM Coordinating Committee that possibly could include Departments of Defense, Veterans Affairs, Education, Agriculture, Justice, State, and others. However, how would the DHHS Office establish its leadership role and staff and fund this Trans-Departmental CAM Coordinating Committee? Clearly, it would be easier and more effective to coordinate CAM activities across Departments if the proposed Office were located in the White House. In addition, it would be easier--but a daunting task nonetheless--to ascertain the extent of Federal CAM activities which is unknown despite previous Congressional inquiries.

Federal CAM policy liaison with conventional health care and CAM professionals, organizations, educational institutions, and commercial ventures could entail, for example, activities such as facilitating:

- Development and implementation of basic or core curricula (undergraduate, postgraduate, and CME/CE) for conventional and CAM practitioners proposed by WHCCAMP Education and Training Work Group;
- Identification of scholarship and loan program opportunities;
- Development of postgraduate training (e.g., residencies and fellowships);

- Development of public education on CAM in health care (including high school and below through involvement of the Department of Education);
- Interaction and relationships between conventional health care and CAM (including CAM commercial ventures).

Perhaps one of the most important liaison activities of the proposed Office would be to establish an Advisory Council similar to that of NCCAM to bring the various stakeholders together to develop an agenda that reflects public input.

Planning and convening conferences, workshops, and necessary advisory groups could create unique opportunities to:

- Explore contentious CAM issues, for example, involving licensure, access and delivery, education and training, information development and dissemination, and reimbursement;
- Bring conventional health care and CAM together to develop dialogue and collaborative activities.

Being the centralized Federal media point of contact for CAM would not involve any information clearinghouse function, since NCCAM has a legislative mandate to perform this function. Rather, the proposed Office could develop and implement a triage model for media calls or e-mail inquiries. So when an inquiry occurred, the proposed Office could direct the person to the appropriate person at the Departmental or Agency level through a network or previously identified information officers or other points of contact with known expertise and relevant purview. The proposed Office also could create a website which could include information about the Office and its functions along with CAM events calendar postings, links to other Federal websites, and hyper-link e-mail to the proposed Office.

Facilitation of implementation of WHCCAMP recommendations is arguably the most important role of the proposed Office, because without authority--or at least, a focus on the WHCCAMP recommendations--staff, and budget dedicated to overseeing, coordinating, and otherwise facilitating the implementation of the WHCCAMP recommendations, the likelihood of successful implementation of those recommendations is diminished significantly. This function could include interaction with and education of members of the Administration, Congress and their staffs, and affected Departments and Agencies on the issues.

This list of functions of the proposed Office is dynamic and will evolve with the addition of activities identified and suggested by the other WHCCAMP Work Groups. Although developed by the WHCCAMP Coordinating and Centralizing Federal CAM Efforts Work Group, the above list of functions resembles and is validated by the following paraphrased activities delineated by the "National Presence—Policy, Coalitions, Voice breakout group" at the Second Annual Integrative Medicine Industry Leadership Summit held on May 3-5, 2001 in Scottsdale, AZ which called for the establishment of a "Federal Office of Complementary and Alternative Medicine and Integrative Health Care":

- The national Office will have authority to oversee, coordinate, and direct all Federal CAM and Integrative Health Care activities;
- The Office shall establish "Blue Ribbon" panels to advise the Office and Congress on CAM and Integrative Health Care policy and legislative recommendations;
- In approaching research, this Office shall work to complement the role of the NIH's NCCAM;
- An Advisory Council shall be established for this Office with representative organizations including national CAM, integrative medicine, public health and world medicine associations, academic consortia, and councils;
- The mandates of this Office will include, but not be limited to, implementation of the recommendations made by the White House Commission on Complementary and Alternative Medicine Policy.

The funding of the proposed Office will be determined by whom and how the Office is created. While NCCAM will continue to require adequate funding to address the research slice of the CAM "pie," the proposed office will be responsible for taking care of the rest of the CAM "pie." This may necessitate increased funding of Agencies plus sufficient budget and staff for the proposed Office to coordinate Federal CAM activities and collaborate with the appropriate stakeholders.

Challenges: The uncertainty of how the proposed Office is viewed by the Administration, Secretary, and Congress is a critical challenge. Federal reluctance should be anticipated in light of shrinking surplus estimates and budgets and efforts to "right-size Government." Resistance to establishing the proposed Office should be expected from conventional health care professions, organizations, and institutions. On the other hand, CAM advocates, practitioners, organizations, and institutions may have unrealistic expectations of the proposed Office.

Draft Recommendation:

1. The President, Secretary of the Department of Health and Human Services, or Congress should create an Office at the highest possible and most appropriate level with sufficient staff and budget to perform functions that include, but are not limited to, coordination of Federal CAM activities; Federal CAM policy liaison with conventional health care and CAM professionals, organizations, institutions, and commercial ventures; planning and convening conferences, workshops, and necessary advisory groups, centralized Federal media point of contact; and facilitation of implementation of the WHCCAMP recommendations.

Proposed Agenda for CAM Central 5 September 2001 Conference Call

1. Updates
2. Discussion of possible functions of CAM Central
   A. Categories:
      1) Coordination Federal ~~non-research~~ CAM activities
      2) Federal ~~non-research~~ CAM policy liaison with conventional health care and CAM professionals, organizations, and educational institutions
      3) Planning and convening ~~consensus~~ conferences and blue ribbon panels
      4) Centralized media point of contact
      5) Facilitation of implementation of WHCCAMP recommendations

   B. Coordination Federal ~~non-research~~ CAM activities
      - Coordinate HHS ~~non-research~~ CAM activities ~~if located in HHS~~
      - Coordinate across Departments (DOD, VA, Education, Agriculture, etc,) through inclusion in Advisory Council

   C. Federal ~~non-research~~ CAM policy liaison with conventional health care and CAM professionals, organizations, and educational institutions
      - Facilitate development and implementation of basic or core curricula (undergraduate, postgraduate, and CME/CE) for conventional and CAM practitioners proposed by Education and Training Work Group
      - Assist with identification of scholarship and loan program opportunities
      - Assist with development of postgraduate training (e.g., residencies and fellowships)
      - Assist with interaction and relationships between conventional health care and CAM

   D. Planning and Convening ~~consensus~~ conferences and blue ribbon panels
      - Explore contentious issues involving licensure, access and delivery, education and training, information development and dissemination, reimbursement, etc.
      - Bring conventional health care and CAM for productive dialogue and building infrastructure

   E. Centralized media point of contact
      - Refer CAM inquiries to designated (previously identified) individuals in appropriate Federal Agencies

   F. Facilitation of implementation of WHCCAMP recommendations
      - Interact with and educate members of Administration and Congress and their staffs on issues

Meetings

3. Next Steps
    A. Tasks:
        - Name for "CAM Central" for October Meeting
        - Prioritize or rank-order categories of possible CAM Central functions
        - Sequence and strategy
        - Recommendations and Challenges to be presented at October Meeting
            - Creation of office and its location
            - Possible functions

    B. Scheduling another conference call