

**NATIONAL POLICY DIALOGUE
TO ADVANCE INTEGRATED HEALTH CARE:
FINDING COMMON GROUND**

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FINAL REPORT

Published by

Integrated Health Care Consortium(c)
Steering Committee for the National Policy Dialogue

Report Editors
Sheila Quinn
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March 2002

Dear Colleague:

We have prepared this report to help focus the health care debate in the coming millennium. Dozens of key stakeholders contributed to and participated in the National Policy Dialogue to Advance Integrated Health Care in November 2001. Participants came to the landmark meeting armed with their own experience, expertise and biases, and dedicated to the goal of identifying common ground. Incredible strides were made; vital relationships were begun; horizons were expanded; and a great deal of common ground was, in fact, discovered. This report summarizes what we were able to accomplish in just two and a half days. We left the meeting invigorated and challenged by the ideas and potential, and hope that you, too, will look upon this material as a tool for achieving your organization's or institution's integrated health care agenda.

As representatives of consumers and practitioners, educational institutions and industry, we are dedicated to promoting national policies that will facilitate research, promote appropriate standards for professions as well as products, increase consumer access to complementary and alternative therapies, and create a truly integrated health care system. We believe that a coordinated national effort is needed to ensure that the American public benefits from advancements in the science and understanding of all health care systems, disciplines and modalities. The public will be well served by an objective and open examination of our health care environment, and by the restoration of health care decision-making authority to consumers.

To carry this work forward, we have created the Integrated Healthcare Policy Consortium (IHPC), which is one of several working groups under the umbrella of the Collaboration for Healthcare Renewal Foundation. Participants represent a plethora of stakeholders, including conventional academic medicine, complementary and alternative academic medicine, , insurance companies, professional organizations of CAM providers, researchers and consumers. New participants are always welcome.

We look forward to pursuing these and other recommendations that will help create a vital integrated health care system in the United States; one that recognizes the value of health promotion and disease prevention, as well as the value that a collaboration of diverse systems and modalities can bring to bear on this significant undertaking.

Sincerely,

The Steering Committee

National Policy Dialogue to Advance Integrated Health Care

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**NATIONAL POLICY DIALOGUE
TO ADVANCE INTEGRATED HEALTH CARE:
FINDING COMMON GROUND**

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INTRODUCTION

National Policy Dialogue
to Advance Integrated Health Care:
Finding Common Ground

**NATIONAL POLICY DIALOGUE
TO ADVANCE INTEGRATED HEALTH CARE:
FINDING COMMON GROUND**
Final Report

March 2002

INTRODUCTION

Background

The National Policy Dialogue, which met October 31 - November 3, 2001 at Georgetown University in Washington DC, was a groundbreaking and successful effort to stimulate communication among leaders in the nation's healthcare community about the future of integrated health care. Dialogue participants carefully reviewed the status of existing public and private initiatives and funding (see "Preparation" on page 2), and then debated what an integrated health-care system would look like, how to achieve it through a defined national policy framework, and how to evaluate it.

Participants represented over fifty national stakeholder organizations with an interest in, or commitment to, the advancement of integrated health care. Among those present were numerous individuals who have served or are serving in national policy positions. Their positions have included formal and informal roles advising diverse federal agencies, members of Congress from both parties, and the White House on CAM policy over the past decade.

Participants worked in general session and in seven separate issue-oriented Working Groups to develop core recommendations - many for federal policy changes - in such areas as education, service to the underserved, access, regulation, research, quality of care, public health, and federal benefits.

Common Ground

A certain amount of overlap emerged in the recommendations of the Working Groups, revealing areas where common ground has been developed more deeply. Key recommendations that appeared in several Working Group reports include:

1. Establish a federal office to foster the creation of an integrated health care (IHC) system focused on health promotion and disease prevention.
2. Significantly increase federal research allocations for health promotion and disease prevention, and examine the role of CAM/integrated approaches in these areas.
3. Establish a national consortium of conventional and CAM educators and practitioners.

"This was the first time I've been part of a discussion where allopathic physicians who offer acupuncture got to see, in a very polite, diplomatic way, how they're perceived by traditionally-trained acupuncturists."

Candace Campbell,
American Association for
Health Freedom

4. Assure widespread access to CAM/IHC in rural and underserved communities.
5. Achieve regulatory recognition for each profession seeking it, in every state and within federal programs, based on competency standards set by the profession.
6. Develop a national agency that acts as a clearinghouse for defining the qualifications and scope of practice for health care providers in each discipline, system or modality.
7. Ensure that CAM is effectively integrated into the Healthy People 2020 development and implementation process.

Participants in the Dialogue were clear that, while there is significant agreement on these recommendations, time constraints did not allow for formal consensus to be reached. These recommendations represent “common ground”; each participant has had an opportunity to review and provide input to the report prior to publication.

Multi-Stakeholder Process Led by Integrated Consortium

The Dialogue findings are among the first to reflect common ground among such diverse parties as educators from accredited conventional and CAM schools and professional organizations; representatives of regulated conventional and CAM practicing disciplines; payers (Medicare, private insurance companies, HMOs, Indian Health Service); natural health care product manufacturers; employers; consumer advocacy groups; and government agencies. The collective experiences and perspectives of this unique group generated an exceptional exchange of information, ideas, objectives, and proposed action steps. Only those recommendations representing common ground among the participants are included in this report.

The Dialogue was developed by a multi-stakeholder ad hoc group called the Integrated Health Care Consortium, led by Candace Campbell, with the American Association for Health Freedom, with significant support from a core team including Aviad Haramati, PhD, with Georgetown University Medical School, Pamela Snider, ND, with Bastyr University, and Sheila Quinn, with the Institute for Functional Medicine. Members of the Consortium Steering Committee are listed in Appendix III. The Dialogue was co-hosted by Georgetown University, Bastyr University, and the American Association for Health Freedom; additional funding was provided by diverse sponsors (see “Appreciations” page, Appendix V).

Preparation - Policy Documents, Survey

The Dialogue focused specifically on identifying common ground for meaningful public policy recommendations. Every participant prepared for the Dialogue by reviewing the National Plan to Advance Integrated Health Care, the Integrative Medicine Industry Leadership Summit Reports 2000/2001, the

“I sat around a table with the president of a naturopathic college, the president of the organization that oversees schools of acupuncture and oriental medicine, the president of the American Holistic Medical association, and a director of chiropractic education. This was an extraordinary discussion.”

*Aviad Haramati, PhD,
Georgetown University*

NCCAM Five-Year Strategic Plan, and the White House Commission on Complementary and Alternative Medicine Policy Interim Progress Report. The Dialogue opened with representatives of each document presenting a summary of findings. In addition, the Steering Committee circulated a survey prior to the start of the conference, and prepared a report for participants describing those areas where some measure of common ground already appeared to exist; the survey report is included in Appendix VI. Finally, the principles, mission and vision statements of participating organizations were assembled and provided to attendees to focus awareness on existing common ground.

Next Steps - New Alliances on Public Policy Issues

The Dialogue created the opportunity for the formation of new alliances among providers, educators, researchers, payers and consumers who have a commitment to safely and effectively advancing integrated health care. It has also made it possible for individuals and groups to begin working together on a shared policy agenda that all can use to promote their respective organizational goals. Publication of this report will bring the information about goals and recommendations to any interested individual, organization or institution wishing to collaborate on these vital issues. The report can also serve as an evaluation tool as accomplishments of the future are measured against today's assessment of what is needed. Finally, it is our hope that policymakers, regulators, legislators and other decision makers in the healthcare community will act upon these recommendations to hasten the day when every American has access to an effective, cost-efficient integrated healthcare system

“Imagine the potential of joint backing by integrative medicine programs at academic medical centers like Duke, Georgetown, and Maryland; professional organizations like the American Chiropractic Association and the American Association for Health Freedom; organizations representing natural health care research and education like Bastyr University, Southwest College and the Council of Colleges of Acupuncture and Oriental Medicine...”

John Weeks,
Principal, Collaboration for
Healthcare Renewal
Foundation

Working Group Recommendations

National Policy Dialogue
to Advance Integrated Health Care:
Finding Common Ground

WORKING GROUP RECOMMENDATIONS

The following pages present first a summary of, and then the detailed reports from, the seven Working Groups at the Dialogue: Research; Education; Underserved and Special Needs Populations; Regulation and Access to CAM Products and Services; Access to CAM in Federal Benefits and Healthcare Programs; Clinical Practice and Quality of Care; Public Health and Community Health. Participants self-selected for the group they were most interested in and preliminary reports from each group were presented to the general session. Written records were kept (by each group, by volunteer note-takers, and by a graphic recorder) and synthesized to produce this report.

Dialogue participants are acutely aware that policies for inclusion and reimbursement of services and providers optimally rest on a clear evidence base. Participants also recognize that even in conventional disciplines, the evidence base is not optimal, while in CAM/IHC, the long-standing problem of underinvestment in research (on safety, effectiveness and cost) restricts the ability of decision makers to rely on the evidence base in a meaningful way at the present time. Therefore, recommendations to build the evidence base are balanced with many recommendations for assuring accountability and safety while research data are being collected, analyzed and reported.

All but one of the respondents agreed that CAM/IHC research is best approached through research designs using broad measures.

WORKING GROUP RECOMMENDATIONS - SUMMARY

Research

- Congress and federal research agencies should significantly increase federal research allocations for health promotion and disease prevention, and examine the role of CAM/integrated approaches in these areas.
- Federal policy makers and agencies should assure that the methods of researching CAM and integrated health care are relevant to the questions being asked. Methodologies should be expanded to include: descriptive and qualitative research such as observational and case studies; analysis of individualized care and of multi-factorial causation and treatment; exploration of whole systems approaches; and examination of the process of integration, the potential clash of paradigms, values, and economic interests.
- Focus additional research resources on examining the effects of CAM/IHC on global health indices including productivity, absenteeism, functionality, quality of life, sense of well being, cost/cost offsets, and safety in order to better support and inform the decision-making processes of employers, insurers, consumers, and government purchasing agencies.
- Federal research funds should target the development of research infrastructure and expertise in those CAM/IHC institutions interested in doing more research. It will be very important to take advantage of their educational and clinical experience, and to address the historic lack of expertise and experience in scientific methods and publications which puts them at a disadvantage in securing funding.
- Significantly increase funding of CAM research to fulfill these goals, to more

accurately reflect the level of CAM use by the public, and to ensure a growing body of evidence about safety and efficacy that will eventually be adequate to support federal/third party reimbursement and benefit inclusion decisions.

Education

- Establish a national consortium of conventional and CAM educators and practitioners.
- The consortium will encourage conventional and CAM educational institutions to embrace their responsibility to educate the public so that health care consumers can make more informed choices in health care, resulting in enhanced quality of life.

Underserved and Special Needs Populations

- Assure widespread access to CAM/IHC in rural and underserved communities by 2004.
- Establish Federal CAM/IHC Office to engage CAM/IHC community in HP2010's objectives concerning the underserved and special needs communities.

Regulation and Access to CAM Products and Services

- Achieve regulatory recognition for each health care profession seeking it, in every state and within federal programs, based on competency standards set by the profession.
- Create universal, non-discriminatory access to CAM products and services.
- Broaden public health education efforts to embrace more fully the role of CAM services and products.

Access to CAM in Federal Benefits and Healthcare Programs

- Establish a federal office to foster creation of an integrated health care system with an emphasis on health promotion and disease prevention.
- Include authorized CAM/IHC providers and accredited CAM schools in all federal healthcare programs and initiatives. Congress should pass legislation mandating non-discrimination in all appropriate federal health care programs and initiatives.
- Carry out three pilot projects to get people off disability through the use of an integrated health care approach.

Clinical Practice and Quality of Care

- Develop a national agency that acts as a clearinghouse for defining the qualifications and scope of practice for all health care providers.

Public Health and Community Health

- Ensure that CAM is effectively integrated into the HP2020 development and implementation process.
- Increase awareness of the meaning and practice of holistic health, including its acknowledgment of the integral relationship between our physical and social environment and our individual health and public health.

CAM leaders agree that whole person CAM approaches should be examined through whole system research that acknowledges that the most pronounced savings from a given intervention may only be measured indirectly, such as by assessing time lost from work. The interests of the purchasers and payers of health care are not reflected in today's research priorities, which currently fail to look at costs.

DETAILED REPORTS FROM WORKING GROUPS

1. RESEARCH

Participants: John Weeks, John Astin, PhD, John Balletto, LMT, NCTMB, Carlo Calabrese, ND, MPH, Milt Hammerly, MD, Konrad Kail, ND, PA, Sheila Quinn, Anthony Rosner, PhD

Overview: In a pre-conference Survey, the participants in the National Policy Dialogue (NPD) expressed strong agreement in two areas regarding research. All but one of the respondents agreed that CAM/IHC research is best approached through research designs using broad measures. In a more focused question, nearly 4 in 5 (77%) felt that 40% or less of CAM/IHC research dollars should focus on controlled trials; the majority of funds should go toward understanding “real world” experience in utilizing, delivering, integrating and reimbursing for CAM. In response to a more focused question on researching cost issues, 93% said that more research funding should target costs, cost-offset and utilization information in order to support federal health funding decisions. The goals of the Research Working Group reflected these generally held perspectives of the larger group.

Challenges and Context: Research priorities and funding directions for CAM are not presently focused on facilitating appropriate use of CAM in individual health care. Instead of the conventional “pyramid of evidence” hierarchy that places double-blind, randomized, placebo-controlled trials (RCTs), and meta-analyses of such trials, at the top of the evidence hierarchy, a “house of evidence” model is recommended. Depending on the stakeholder(s), the questions, and the desired outcomes, different methodologies may be more useful than RCTs for researching CAM and integrated care. The NIH’s current “low hanging fruit” approach, which promotes, for instance, exploration of single agent trials of botanical medicines, while valuable for a limited, reductive set of questions, do not focus the investigation on the claims of value among practitioners and consumers that created the word-of-mouth movement toward CAM use. Such claims are rarely related to the use of a single agent; they tend to be related to an individual’s experience: greater quality of life, diminished pain, better ability to live and work productively, sense of better health, greater satisfaction with care, and a belief that, following CAM use, recommended conventional treatments are not always necessary. NPD Working Group discussions revolved around the need to increase and re-allocate funding toward assessing actual CAM practice and claims in these key, interrelated areas: CAM’s role in health promotion and primary prevention; outcomes-oriented study of current practices, including individualized, multi-modality approaches and whole systems approaches; and the role of CAM in decreasing the global costs of health.

RESEARCH RECOMMENDATION #1: Congress and federal research agencies should significantly increase federal research monies allocated to health promotion and disease prevention, and examine the role of CAM/integrated approaches in these areas.

Reason: The evidence base regarding the causal factors of most chronic diseases, and of growing health care costs, suggests that the federal research budget should have a pronounced focus on methods of health promotion and disease preven-

tion. The need for a re-focus of health care around this evidence is commonly cited by most professions and practitioners in the CAM/integrated health care (IHC) field as the basis for their work. Research funding should, in general, include high allocations toward these approaches, with a specific focus on the role of CAM/IHC in meeting these goals. The need for such research was also noted by National Policy Dialogue participants working in the areas of public health, community health and services to the underserved.

Legacy: With resources adequately directed to primary prevention and health promotion, citizen-consumers, their practitioners, and health care purchasers will gain more expansive understanding of the role for self-care tools and prevention-oriented strategies which will create better health and assist in focusing appropriate use of scarce resources.

***RESEARCH RECOMMENDATION #2:* Federal policy makers and agencies should assure that the methods of researching CAM and integrated health care are relevant to the questions being asked. Methodologies should be expanded to include descriptive and qualitative research such as observational and case studies; analysis of individualized care and of multi-factorial causation and treatment; exploration of whole systems approaches; and examination of the process of integration - the potential clash of paradigms, values, and economic interests.**

Reason: Research should be organized to look at actual practices, rather than the way these practices may be refracted to fit reductive research designs. RCTs have a role in generating sound evidence of efficacy, whether in conventional medicine or CAM/IHC, but with CAM/IHC as with many areas of conventional medicine (e.g., surgery, psychotherapy, epidemiology), certain research questions are best answered with other methods. Examples are observational studies, qualitative research (e.g., to study the actual process of and potential barriers to successful integration of CAM/conventional approaches), and health services research. Such strategies will allow more understanding of such issues as the role of whole systems of care (e.g., Traditional Chinese Medicine, naturopathic medicine), integrated models (e.g., combination CAM/conventional approaches), and individualized treatment approaches (with a corresponding focus on examining sources of individual variability in responsiveness to CAM/IHC).

Legacies: Integrated care will advance as CAM providers, who may now discount single agent, RCT research findings as inadequate to measure multifactorial and individualized approaches, have a chance to see outcomes from analysis of therapeutic approaches that reflect their own bent. The focus on these methodology issues for CAM/IHC will enhance the tools of researchers exploring other health care challenges, particularly in the areas of primary prevention and health promotion.

***RESEARCH RECOMMENDATION #3:* Focus additional research resources on examining the effects of CAM/IHC on global health indices including productivity, absenteeism, functionality, quality of life, sense of well being, cost/cost offsets, and safety in order to better support and inform the decision-making processes of employers, insurers, consumers, and government purchasing agencies.**

Research should be organized to look at actual practices, rather than the way these practices may be refracted to fit reductive research designs.

Reason: Access to CAM/IHC services for many people, and the ability of CAM/IHC to become part of mainstream delivery, will be enhanced by inclusion in covered benefits. Good inclusion decisions in an era of rising health care costs need both clinical and financial inputs; good data on the global impacts of CAM on the health of citizens, including any direct and indirect costs and cost offsets, are needed to improve decision making. Notably, CAM leaders agree that whole person CAM approaches should be examined through whole system research that acknowledges that the most pronounced savings from a given intervention may only be measured indirectly, such as by assessing time lost from work. The interests of the purchasers and payers of health care are not reflected in today's research priorities, which currently fail to look at costs.

Legacies: Through focusing specifically on impacts of CAM/IHC on the global costs of health, we will more quickly move toward a system which is not only the most effective but also the most cost effective for all the stakeholders whose decisions impact care options and health freedoms.

RESEARCH RECOMMENDATION #4: Federal research funds should target the development of research infrastructure and expertise in those CAM/IHC institutions interested in doing more research. It will be very important to take advantage of their educational and clinical experience, and to address the historic lack of expertise and experience in scientific methods and publications which puts them at a disadvantage in securing funding.

Reason: Establishing integrated care models suitable for mainstream payment and delivery and for research poses a problematic paradox at the gateway: most institutions and individuals with expertise in CAM/IHC delivery are not experienced in research, while those with research expertise typically have little experience with CAM/IHC. Until the past decade, CAM professionals and their related educational institutions and organizations existed almost entirely without federal research support (most still do). At the same time, researchers in well-funded conventional institutions were not developing skills in asking useful CAM/IHC questions. Our ability to understand the value of CAM/IHC through research will be optimized by ensuring that the providers most experienced in delivery of CAM/IHC are extensively involved in setting and carrying out the research agenda. Resources must be directed toward interested CAM educational institutions, and toward integrated care facilities in mainstream payment and delivery, to develop the necessary infrastructure and scientific expertise with which to carry out effective research. Funding support for CAM faculty to undertake research fellowship training at academic medical centers and resources for medical researchers, methodologists, etc. to serve as visiting scholars at CAM educational institutions will be essential to achieving these goals. Such "cross-pollination" would significantly advance the cause of researching CAM/IHC in ways that are philosophically and practically congruent with these therapeutic approaches and would also serve to foster greater collaboration between the CAM/IHC and conventional medical research communities.

Legacies: For integrated care delivery centers, this initiative will help ground research in the practicality of care delivery and the outcomes of greatest interest to consumers. For interested CAM professional institutions, this allocation of funding will help make historically excluded parts of the health care community active participants in the research family.

RESEARCH RECOMMENDATION #5: Significantly increase funding of CAM research to fulfill these goals, to more accurately reflect the level of CAM use by the public, and to ensure a growing body of evidence about safety and efficacy that will eventually be adequate to support federal/third party reimbursement and benefit inclusion decisions.

Reason: Current allocations of CAM research dollars do not adequately reflect the broad use by consumers, nor the increasing integration of CAM into inpatient care, outpatient clinics, employee benefit plans, HMO offerings and individual self-care. Demographic changes and other factors anticipate increased use, particularly as Baby Boomers age and children who grew up with CAM as a routine part of their care mature. In addition, the research priorities identified above require allocation of additional funds if they are not to take resources away from the present research agenda. There was consensus that at present the current level of funding for NCCAM in fiscal year 2001 of \$89.1 million (less than of 1/2 of 1% of the NIH budget) is insufficient relative to the public health need (i.e., increasing use of many of these therapies by large segments of the public). The need for increased research funding for CAM/IHC is particularly important given the lack of available private sector resources and incentives to fund research in these areas since many of these approaches constitute non-patentable therapies. There are many federal agencies that can appropriately share part of this ambitious research agenda. Congress should set aside a specific amount of research funding for CAM/IHC research not just for NCCAM but throughout the federal government research infrastructure, including the VA, Armed Forces, Federal Employees Health Benefits, Community Health Centers, and the Centers for Medicare and Medicaid Services.

Legacy: Our knowledge will expand at a pace that adequately reflects the public's need and desire to identify effective therapies.

Additional areas:

While there was insufficient time to arrive at consensus on a variety of other research-related issues, two additional areas identified by the Working Group as very important were: 1) the importance of more effectively communicating the scientific evidence regarding the safety and efficacy of CAM/IHC approaches to the relevant stakeholder groups (i.e., patients/consumers, conventional and CAM/IHC providers, third-party payers, employers, policy makers); and 2) the need to increase private sector participation (e.g., natural products industry, insurers/managed care organizations) in CAM/IHC research and to encourage their appropriate collaboration with federally funded research efforts.

2. EDUCATION

Participants: Elizabeth Goldblatt, PhD, MPA/HA, Aviad Haramati, PhD, Thomas Kruzel, ND, Dennis Robbins, PhD, MPH, Scott Shannon, MD, Vivek Shanbhag, MD (Ayurved), ND, Kevin Spelman, MS, Cora Lee Von Egmond, DC.

Overview: A consortium of conventional and CAM/IHC educators and practitioners is needed to identify a core education for conventional and CAM disciplines. This consortium will foster knowledge, respect and understanding of each system, develop educational standards for survey courses on CAM/IHC and create an interdisciplinary body to accredit continuing education programs on CAM and integrative medicine. Additionally, the consortium will also support training opportunities in integrative health care settings and recommend competency-based training for health care professions using CAM and integrative therapies to ensure public safety.

As we think about “integrative medicine,” it is essential that each discipline retain its own genius and its own contribution to health and wellness, rather than be subsumed by another system. As we work together and support each other, we must come to some resolution with over-lapping scopes of practice. Often the best medical care involves a combination of different health care providers, approaches and treatments.

NPD Working Group participants felt it was important to underscore the point that conventional providers include not only physicians, but nurses, pharmacists, physical therapists, and other allied healthcare providers.

Challenges and Context: Conventional and CAM educational institutions have a responsibility to educate the public as part of their mission. Presently there are many different approaches to health care, each with its own history, philosophy, treatment modalities and educational agendas. Despite many differences, all share a common thread in emphasizing standards of education and patient care, a desire to serve those who are ill, and the importance of public safety. Because of preconceived notions or ignorance as to what the system represents, these systems have become isolated from each other. The result has been a lack of appropriate referral among health care practitioners and also a lack of acknowledgment of patient benefits derived from well-integrated care. Each system has perpetuated its own set of beliefs, often to the exclusion of others and sometimes to the detriment of the patient, unclear of the motives or practices of the other. The health care consumer is often left to fend for him or herself in deciding what is the best form of treatment for a given condition.

Education of the patient, once thought not to be very important, has become critical. Many Americans are now turning to a variety of sources for their health care information. Some of the information available in the public sector (e.g., on the Internet) is inaccurate and misleading; even accurate information, if specific to a given individual, may provide to others little (if any) of the benefit obtained through actual consultation and treatment from a CAM/IHC provider. Many patients who are desperate try a variety of treatments that may or may not provide them with appropriate care. The end result is that appropriate and readily

The consortium of CAM/IHC educators will foster knowledge, respect and understanding of each system, develop educational standards for survey courses on CAM/IHC and create an interdisciplinary body to accredit continuing education programs on CAM and integrative medicine.

available medical care may be delayed or forsaken entirely, resulting in greater rates of morbidity and mortality.

EDUCATION RECOMMENDATION #1: Establish a national consortium of conventional and CAM educators and practitioners.

Reason: This consortium will identify a core education for all conventional and CAM educational institutions, created by educators from the respective institutions themselves to ensure that the healthcare professionals of the future understand what all systems of health care can offer. This will result in health care providers, both conventional and CAM, learning at an early point in their training what other systems and modalities offer. The consortium will develop educational standards to ensure that factual and accurate information is taught across all disciplines and that the type of information is in accordance with the teachings and principles of the respective disciplines.

An interdisciplinary body will be created to accredit continuing education programs in CAM/IHC for all medical disciplines so that medical, nursing, pharmacy students and other health care professional students and practitioners, whether conventional or CAM, continue to learn about and respect the value of CAM and integrative health care approaches.

Federal support is necessary to fund training opportunities in integrative health care settings so that medical students and health care practitioners, whether conventional or CAM, can learn about integrative approaches in order to provide better and more cost-effective patient care.

Legacies: The results of this collaboration are many. An improvement in patient care may be expected as patients work with a variety of health care professionals who have an understanding of the different systems of health care and an appreciation for the patient benefits derived from various modalities of care. Cross referrals among educated professionals will result in better patient care and outcomes. Ultimately this will lead to a broader and more effective health care system, resulting in lower medical costs. The system will also result in an improvement in professional competencies of each profession resulting in a better and more respectful collaboration among practitioners.

EDUCATION RECOMMENDATION #2: The consortium will encourage conventional and CAM educational institutions to embrace their responsibility to educate the public so that health care consumers can make more informed choices in health care, resulting in enhanced quality of life.

Reasons: As patients become more actively involved with their health care, they often seek information from a variety of sources. Some of the sources do not provide accurate information while others provide partial or incomplete information, or may use medical information as a pretext for unethical sales practices. Additionally, the many healing traditions often view their modalities as being separate and incompatible with others. Thus, options presented to the patient may be devoid of objectivity with respect to other traditions and modalities. CAM and conventional institutions, educated as to the other's benefits and lim-

“Patients who are educated about their disease and to the many treatment options available for their condition, become empowered partners in the process which ultimately leads to better outcomes and overall patient satisfaction with health care.”

*Thomas Kruzel, N.D.
Southwest College of
Naturopathic Medicine*

itations, will be better able to provide the public with reliable and objective information.

Many healing traditions see the doctor as teacher, educating the patient in wellness and prevention of disease. The responsibility for patient education lies also with teaching institutions, as they are repositories of medical knowledge and research. Their participation in such a consortium assures that accurate and timely information can be disseminated to an increasingly sophisticated public. An educated public sector will make better health care choices, as patients are able to ask more informed questions of their medical providers.

Legacies: Patients will become partners with their health care providers in making the choices that are best for their particular condition. Ultimately health care costs will be lowered, as patients will no longer have to try many different modalities in order to arrive at that which suits them best. Patients who feel empowered also have better outcomes in the treatment of their diseases. Quality of life should improve, as well as overall patient satisfaction with health care.

Presently there are many different approaches to health care, each with its own history, philosophy, treatment modalities, and educational agendas. Despite many differences, all share a common thread in emphasizing standards of education and patient care, a desire to serve those who are ill, and the importance of public safety.

3. UNDERSERVED AND SPECIAL NEEDS POPULATIONS

Participants: Pamela Snider, ND; Lloyd Friesen, DC; Wilbur Woodis, MA, NCC; Mark Farrington, RN, MSN; Alan Trachtenberg, MD, MPH; Marino Passero, DC

Overview: Since the publication of Healthy People 2010 (HP2010) by the U.S. Public Health Service, goals and objectives for the nation's health care over the next decade have been defined and are being monitored. HP2010's two overarching goals, to increase quality and years of healthy life and to eliminate health disparities, are supported tactically by HP2010's strategy to develop new public health partners. Greater access to CAM and integrated health care can benefit the American public at large, and can particularly benefit special needs, rural and underserved populations. These populations face the greatest challenges in meeting HP2010's prime objectives, and at significant economic cost. Conventional health care providers are migrating away from underserved and rural populations. Health disparities in these communities are the highest in the United States. Providers for these communities need both motivation and expertise in health promotion to have an impact on increasing health status in these populations. CAM's strengths include a strong focus on health and wellness and disease prevention. CAM/IHC providers* are motivated to work in these communities; they are natural public health allies. CAM/IHC is an obvious and important resource in meeting HP2010's goals and can play a significant and cost-effective role in health recovery and in increasing years of healthy life in these communities.

Challenges and Context: Integrated healthcare pilot programs in Community Health Centers (CHC), such as CHC of King County's Natural Medicine Clinic and others, have had positive outcomes. While conventional medicine (CM) providers receive federal funding to work in these clinics and communities, CAM providers and traditional healers for the most part cannot receive this funding. As a result, certain underserved and special needs populations now have limited or no access to CAM and IHC providers. CAM services and therapeutic agents are reimbursed very little or not at all by Medicare/Medicaid programs, National Health Service Corps (NHSC) or rural residencies. Low-income persons, veterans, tribal communities, rural communities, the underinsured, and the disabled are among those groups which could benefit by having greater access and more diversity in health care options. Artificial barriers and out-dated limits in federal programs (particularly concerning issues of access to providers and reimbursement for services) disempower communities from making reasoned choices. These barriers and restrictions serve to inadvertently deepen disparities and limit access to care which could be readily available.

The social authority of communities to choose from a broad range of CAM/IHC and CM providers is paramount. Communities and clinics that are educated about CAM/IHC providers' scope of practice and training will make reasoned choices about the appropriate provider mix for their needs. Traditional healers from recognized communities of practice are a valuable and essential resource. Bringing CAM to underserved communities must be a priority and will require amendments to authorizing legislation of key federal programs such as the Centers for Medicare and Medicaid Services (CMS) and National Health Service

Low-income persons, veterans, tribal communities, rural communities, the uninsured, and the disabled are among those groups which could benefit by having greater access and more diversity in health care options.

Corps (NHSC). Outcomes data on CAM/IHC should be tracked against HP2010 goals with an emphasis on decreasing disparities, increasing healthcare access and community satisfaction.

Key strategies to put CAM/IHC to work in underserved communities:

1. Education and outreach on CAM/IHC provider options
2. Medicare/Medicaid coverage of services and therapeutic agents
3. Broader range of authorized providers in National Health Services Corps and State Loan Forgiveness programs
4. Central federal coordination of CAM/IHC provider services and outcomes
5. Outcomes data focused on HP2010 goals and objectives

UNDERSERVED RECOMMENDATION #1: Assure widespread access to CAM/IHC in rural and underserved communities by 2004.

Objectives:

- Enhance social authority of communities to choose from range of providers:
- Authorize inclusion of direct access CAM/IHC providers in National Health Services Corps and State Loan Forgiveness Programs.
- Establish and fund national educational outreach program on Integrated Care Options for Communities in Need. Educate underserved communities, hospitals and clinical sites about CAM/IHC providers available to their community.
- Assure access to CAM/IHC providers in underserved areas through CAM/IHC private practice (with appropriate percentage of service being provided to targeted populations).
- Include the full range of CAM/IHC providers in integrated community health clinics throughout the United States.
- Authorize hiring CAM/IHC providers in the regional, state and local United States Public Health Clinics, and rural and critical access hospitals.
- Authorize inclusion in CMS (HCFA-Medicare/Medicaid) of direct access CAM/IHC provider services for all covered conditions within the provider's scope of practice.
- Assist Indian Health Services in integrating direct access CAM/IHC providers in tribal health centers and in their administration.
- Increase primary care CAM/IHC provider participation in conventional rural residency programs.
- Provide funding to accredited CAM/IHC schools for curricula and training in rural, underserved and special needs populations. Establish required and elective courses, rotations, and residencies, exchange programs between CAM and CM schools. Include traditional healers from recognized communities of practice.
- Authorize and fund rapid establishment of integrated care teams in Community Health Centers. Use varied CAM/IHC teams as appropriate to community need and provider availability through New Start/Expansion Program; HRSA; Consolidated Health Centers Program.
- Establish recruitment and retention programs for CAM/IHC providers in underserved communities. Enhance capacity of existing state and federal recruitment and retention programs to include CAM. A powerful strategy is

to establish exchange programs between the communities and students both in CAM accredited schools and integrative medicine programs. Collaborate with USPHS regions I-X, Indian Health Services, Bureau of Primary Health Care, the Substance Abuse and Mental Health Services Administration.

(See Appendix I for additional material on stages, tasks and success factors.)

Legacies: The expected outcome is a gradual shift in health status in these populations to more years of healthy life and decreased disparities. The shift toward wellness and prevention models is also expected to decrease health care costs over time. Communities able to choose among community-based, qualified providers will be empowered communities engaged in health promotion and preventive approaches to treatment of disease. Integrated care teams will have a serious impact on the leading health indicators through their innovative community-based co-management protocols. Traditional healers, working with CAM/IHC and CM providers and supported by their communities will be represented at the federal policy table and will be supported in their work by federal funding. The removal of discriminatory access barriers, and increased research and reimbursement funding will provide a foundation for their expertise to positively impact public policy. These traditional healers and CAM/IHC practitioners can influence public policy to recognize that the need for a healthy environment and a sense of “family” and belonging are core principles of health promotion and fundamental to individual health and leading health indicators.

UNDERSERVED RECOMMENDATION #2: Establish Federal CAM/IHC Office to engage CAM/IHC community in HP2010’s objectives concerning underserved and special needs communities.

Reason: CAM/IHC service to underserved communities must be well coordinated, and focused sharply on Healthy People 2010’s objectives. Multiple programs and agencies must be efficiently linked to achieve this desired outcome. The collaborative expertise of diverse CAM/IHC groups and federal departments in a central CAM/IHC office is needed to engage diverse stakeholder communities in strategic planning and collaborative work toward HP2010’s objectives re: underserved and special needs communities.

Objectives:

- Commit to health care pluralism. Reduce disparities and increase national health status by increasing access to CAM/IHC for rural, underserved, and special needs populations. Increase focus on health promotion to “pay down the national health debt.”
- Monitor HP2010 overarching goals and relevant objectives. Coordinate data collection and track outcomes on CAM integration in coordination with regional, state and local agencies in rural and underserved communities.
- Direct, oversee and coordinate incorporation of CAM/IHC services in all federal programs involved in service to rural and underserved and special needs populations.
- Ensure that CAM plays a strong role in achieving the re-invented health care system envisioned by the Institute of Medicine and others.

The expected outcome is a gradual shift in health status in these populations to more years of healthy life and decreased disparities. The shift toward wellness and prevention models is also expected to decrease health care costs over time.

- Initiate dialogue with private sector (employers, health plans insurers, and trust funds) to establish strategic partnerships to decrease health costs and to decrease disparities in health status and benefits (coverage and reimbursement).
- Build trust and collaboration by establishing diverse stakeholder participation. Include underserved and rural representatives, CAM/IHC providers in all federal meetings and advisory boards. Inclusion of CAM/IHC providers answers a need for cultural competence.
- Increase provider mobility through assessment of credentialing, licensing, and social recognition of established communities of practice including traditional healers.
- Prioritize care in accordance with hierarchy of treatment as needed in rural and underserved areas. Increase emphasis on determinants of health (education, environment, empowerment and healthy behaviors). Align resource investment and policy priorities with this principle in partnership with CAM's therapeutic order. *(See Appendix II for additional work on stages and tasks.)*

Legacies: Centralized, coordinated and supported CAM/IHC services for rural, underserved, and special needs populations partnered with diverse stakeholder participation will foster trust and collaboration, enhance expert solutions, increase access to care, decrease disparities and costs, and empower communities to achieve better health. Diverse and previously contentious stakeholders are working cooperatively to achieve their common goal of national health promotion for all citizens. The anticipated results: lifespan will include an increased healthspan. An estimated 15% drop in per capita health care costs will be achieved by 2012 for these communities.

* *Licensed primary care and direct access CAM/IHC providers: naturopathic physicians, doctors of chiropractic, integrative and holistic medical doctors and nurses, acupuncturists, midwives, massage therapists and nutritionists, certified CAM technical providers and traditional healers from recognized communities of practice.*

4. Regulation and Access to CAM Products and Services

Participants: Barbara Mitchell JD, LAc, Sherman Cohn, JD, Bob Benson, MBA, Cliff Korn, LMT, NCTMB, Tony Martinez, JD, Paul Mittman, ND, Carole Ostendorf, PhD, Charles Resseger, Eliot Tokar, Ruth Walsh, MA, CPM, Choeying Phuntsok, TMD

Overview: Motivated by a desire to secure effective health treatments matched to their individual needs, a substantial segment of the American public has moved beyond sole reliance upon conventional medical care systems and resources. Surveys suggest that more than 40% of adults utilize one or more CAM services each year, even though they often must pay 100% of the cost of those services out of their own pockets. A minority of CAM users relies solely upon those therapies; many have created a de facto personal integrative health care system, with each user deciding when to access conventional providers and when to select CAM options.

Context and Challenges: What lies behind this quiet revolution? A desire for greater emphasis on health promotion, illness prevention, wellness and self-care is one major driving factor. Personal values about choice of supplements, medications, and modalities is another. A search for more effective treatment is yet a third. Comfort with a health care provider who provides generous time and personal attention to patients also appears to be an additional important factor.

Whatever each individual's reasons, utilization of CAM therapies is substantial and growing. Yet significant barriers exist to even fuller utilization of these therapies. Approximately half of Americans will not access CAM therapies in 2001. The reasons include lack of awareness of the therapies and their benefits, uncertainty about the effectiveness of those therapies or the qualifications of providers to offer them, inability to pay for them because third-party payers cover few such services, and limited availability of qualified providers.

In large measure, the result is a two-tiered system: one segment of the population with above-average education and income extensively utilizing CAM, believing they benefit from those choices, and returning to use them again - contrasted with a lower income group effectively frozen out of access to CAM services. From a public policy perspective, the result is unfair and expensive: too many citizens are denied access to cost-effective services, and whole-system costs are increased when health care is provided in unnecessarily expensive settings.

Remedies to these inequities have at least four dimensions:

1. Broadened consumer knowledge of the full array of health care options, which potentially could aid their physical, psychological and spiritual well being;
2. Open, flexible, health care system entry point and referral structures, rather than single gate-keeper, pyramidal models for access to services;
3. Improved ability for consumers to assess both allopathic and CAM health care provider qualifications; and

Goal: To achieve regulatory recognition for each health care profession seeking it in every state and within federal programs, based on competency standards set by the profession.

4. Affordability for all.

REGULATION AND ACCESS RECOMMENDATION #1: Achieve regulatory recognition for each health care profession seeking it in every state and within federal programs, based on competency standards set by the profession. Such recognition should reflect ethical principles (including protection of the public) and should maintain pluralism, with flexibility to permit differences of approach within the broad scope and traditions of the profession. Any such regulation should be by a board consisting of consumers as well as members of the profession being regulated.

Reasons: Accountability to the public matters; accountability, of course, may take different forms. Acknowledge significant differences in how far various health care professions have progressed along the professionalism and recognition curves. Also recognize that differences on this scale exist regionally, contributing to different rules and guidelines in different states, as well as differences in the availability of qualified providers. Protecting the public from harm is a legitimate public policy goal.

Each profession - together with consumers using those therapies - should have the leading voice in development, promulgation and enforcement of standards of practice. We oppose regulation of CAM professions by the conventional allopathic profession or by any other CAM profession (models sometimes used by states for administrative convenience and cost savings).

While supporting variation in regulation among and even within professions, we urge that standards focus on demonstrable service provision competencies. Standards may be utilized for accreditation, certification, licensure and/or other forms of community or cultural recognition. Accordingly, regulatory recognition may not equate to licensure for all health care professions at all stages of their development. This is particularly true in the case of professions newly emerging in the United States that have not yet evolved nationally recognized standards. These newly emerging health professions should be encouraged even when they may not yet have the critical mass to support forms of recognition common to more heavily populated professions.

Professional recognition has a positive value beyond its public protection dimensions. Thoughtful recognition helps create a health care environment in which providers can practice in good conscience, with the well being of patients foremost in their minds and without the fear of censure or recrimination for the use of complementary and alternative therapies. A robust commitment by CAM providers to professional accountability also gives consumers wider choices, allowing them to embrace intelligently and with more assurance the fullness of diverse health systems.

Health care profession regulation is a state responsibility in the U.S. and should remain so to facilitate response to diverse stages of professional development in different parts of our nation. Nonetheless, the federal government should provide important leadership by modeling thoughtful recognition standards for CAM providers in determining eligibility for participation and funding in Federal health care programs.

Professional recognition has a positive value beyond its public protection dimensions. Thoughtful recognition helps create a health care environment in which providers can practice in good conscience, with the well being of patients foremost in their minds and without the fear of censure or recrimination for the use of complementary and alternative therapies.

In addition, to encourage the exploration and eventual acceptance of emerging professions, federal research programs should encompass such therapies and federal financial support should aid those professions in developing recognition infrastructure. The federal government should be encouraged to embrace a leadership role in engaging employers, clients, patients and other CAM stakeholders in support of this professional recognition goal.

REGULATION AND ACCESS RECOMMENDATION #2: Create universal, non-discriminatory access to CAM products and services.

Reason: CAM's historic business model of cash payment and referral by self/family/friend will never be sufficient to close the access gap. It is necessary to include CAM benefits as permitted services in federal health care and private, third-party funded health care programs and plans, extend financial coverage eligibility to encompass any profession formally recognized within the patient's state of residence, and include CAM providers in a coding/reimbursement system that is universally applied to all health providers (i.e., Resource Based Relative Value System). The power of gatekeeping medical professionals who now prevent access to CAM therapies should be nullified.

As measures advance to bring the now 44 million Americans without any health care benefits into coverage, it will be necessary to include CAM therapies as permitted services.

The intent is for CAM providers to work with allopathic physicians and other conventional health care professionals for the benefit of patients. Indeed, the preference is for thoughtful integrative health care practices that preserve the unique contribution of each modality, embodied in mutually respectful relationships, as well as informed patient referrals in all directions across the system. The goal should be a comprehensive, patient-focused health care system with major emphasis on prevention, wellness and self-care.

The federal role is at least threefold in support of these endeavors. First, set the example by including CAM therapies in Medicaid, Medicare, and other fully or largely federally funded health care programs. Second, support expanded health care service coverage to embrace populations now served little or at all. Third, set the example and template for private third-party payers by providing adequate funding, by articulating the overall health system cost effectiveness gained by embracing CAM services as part of a holistic approach to health care, and by developing provider eligibility guidelines for participation in federal funding.

REGULATION AND ACCESS RECOMMENDATION #3: Broaden public health education efforts to embrace more fully the role of CAM services and products.

Reason: Only a more fully informed citizenry can make intelligent choices among the full array of health care alternatives and individual provider qualifications. Regulatory recognition is of limited value if consumers and other medical professionals are unaware of standards and distinctions. These audiences deserve sound, sufficient, and understandable information about CAM modalities and providers.

The intent is for CAM providers to work with allopathic physicians and other conventional health care professionals for the benefit of patients. Indeed, the preference is for thoughtful integrative health care practices that preserve the unique contribution of each modality, embodied in mutually respectful relationships, as well as informed patient referrals in all directions across the system.

While a significant burden will and should remain the responsibility of individual CAM health care professions, the federal government can provide enormous value by broadening conventional health education initiatives, particularly those addressed to students and other young adults, to encompass CAM modalities. The federal government can also play a constructive leadership role in educating allopathic doctors about the benefits of CAM therapies. Finally, the federal government also should assume a greater leadership role in providing authoritative, quality information about CAM practices and products, based on input from CAM and western bio-medical professionals, in a readily accessible form.

Legacies: Broad, effective acceptance and implementation of these objectives would result in several constructive legacies over time:

- an allopathic community well informed about CAM modalities and providers,
 - consumers knowledgeable about CAM and empowered to act upon that knowledge,
 - income no longer a barrier to obtaining access to the most helpful forms of health care for an individual's particular situation,
 - increased focus on wellness, self-care and health promotion,
 - better health outcomes, because more alternatives are considered in each circumstance and greater emphasis is accorded to prevention and wellness, and
 - lower average cost per person served, in Medicare and Medicaid as well as private payer models.
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There was an interesting dialogue between those of us who believe strongly in credentialing and licensure as the avenue to public accountability, and the emerging professions who are not sure if that's the appropriate solution for them. Even if they are not ready for licensure, they still need a place in discussions at the federal table. They need support rather than territorial battles."

*Pamela Snider, N.D.
Associate Dean of
Naturopathic Medicine
Bastyr University*

5. ACCESS TO CAM IN FEDERAL BENEFITS AND HEALTHCARE PROGRAMS

Participants: Candace Campbell, Louis Sportelli, DC, Matt Russell, Garrett Cuneo, Michael Traub, ND, Tom Shepherd, DHA.

Overview: There was unanimous agreement by participants in the National Policy Dialogue that access to CAM/IHC in federal benefits and healthcare programs would be rapidly accelerated by the establishment of a federal office. The mission of the office would be to foster creation of an integrated healthcare system with an emphasis on health promotion and disease prevention. The name of the federal office should reflect its mission - promotion of an integrated health care system that will support the paradigm shift in healthcare thinking from a sickness-disease model to a wellness model, and involve non-allopathic disciplines.

Challenges and Context: Disparities in funding for CAM and integrated medicine have placed CAM/IHC providers and educational programs at a distinct disadvantage in the national health care system. Parochialism and self-interest need to be overcome in favor of an egalitarian system where the playing field is leveled and all forms of health care are accessible to the public. Examples of this doctrine of fairness are replete in government programs that do not permit discrimination, do not encourage the creation of monopolies, and do not permit a violation of equal protection. Programs in health care, however, ignore all these fundamental doctrines of equality.

In the pre-conference Survey, only one person agreed that federal coverage of CAM is presently adequate. Nearly 3/4 (72%) registered strong disagreement and another 18% mild disagreement. A total of 80% agreed (62% strongly) that health care costs will be reduced with increased use of CAM; 93% agreed that licensure was necessary for access to CAM.

Federal Benefits and Programs Recommendation #1: Establish a federal office to foster creation of an integrated health care system with an emphasis on health promotion and disease prevention.

Reason: A federal office would help to:

- ensure access to and accountability from CAM/IHC providers in federal healthcare programs,
- bring diverse expertise to the table, and
- coordinate federal CAM/IHC activities, including research, public and professional education, policy, legislation, health services, outcomes, cost-effectiveness, and field research.

In approaching research, this office would work with NCCAM and other federal agencies in facilitating communication of additional research needs and recommendations. An Advisory Council for the office would be established and include specific representation from the licensed and emerging health professions.

“We want to stress that the version of a federal office we support focuses on the creation of an integrated system, not on promoting CAM. The term CAM is, we hope, a short-lived one that will eventually be outmoded by integration.”

Candace Campbell,
American Association for
Health Freedom

Legacy: A federal office will help foster the creation of the integrated healthcare system that Dialogue participants felt should become the model for health care delivery in the future. The office will help strengthen the CAM professions and allow them to become an integral part of the national health care system. It will facilitate consumer access to CAM/IHC, thereby making substantial contributions to decreasing mortality, morbidity and healthcare costs through education, utilization, research, and equal access. It will also eliminate the tremendous waste of taxpayer dollars, time and effort that occurs in the present uncoordinated, patchwork system.

FEDERAL BENEFITS AND PROGRAMS RECOMMENDATION #2: Include authorized CAM/IHC providers and accredited CAM schools in all federal healthcare programs and initiatives. Congress should pass legislation mandating non-discrimination in all appropriate federal health care programs and initiatives.

Reason: The exclusion of most CAM providers and educational programs from federal benefits programs is unjust and undemocratic. It is also inefficient and bad public policy. Congress should mandate a nondiscrimination policy for all federal health care programs and initiatives. The public demand for CAM/IHC is stymied by federal regulations, which need to be changed to improve public access. Continued protection of and support for the present allopathic monopoly on health care is based on neither science nor economics, but on guild politics and should be re-evaluated.

Students and graduates of accredited CAM institutions, for example, are at a disadvantage in federal student loan programs compared to students and graduates of conventional medical institutions. The maximum allowable amount of borrowing must be increased so that students incurring comparable costs for their education have access to comparable funding. Similarly, eligibility for federal student loan forgiveness programs must be made available for CAM primary care providers.

Legislation mandating Medicare coverage of nutrition education services for diabetics, for instance, should not be limited to provision by registered dietitians when other qualified and highly trained practitioners may be able to provide the same services. Naturopathic physicians, doctors of chiropractic, integrative and holistic medical doctors and nurses, acupuncturists, midwives, massage therapists and nutritionists, certified CAM technical providers and traditional healers from recognized communities will all have a role to play in delivering integrated care.

Legacy: Passage of such legislation will be seen as comparable in national significance to legislation guaranteeing civil rights and equal rights. It will dramatically expand patients' options while significantly reducing health care costs and federal expenditures on health care.

FEDERAL BENEFITS AND PROGRAMS RECOMMENDATION #3: Carry out 3 pilot projects to get people off disability through the use of an integrated health care approach.

Reason: If successful, billions of dollars could be saved in disability payments,

The doctrine of fairness, which is replete in government programs, that does not permit discrimination, does not encourage the creation of monopolies, and does not permit a violation of equal protection, is found every where except in health care.

millions of individuals would enjoy improved quality of life, and the value of an integrated health care system could be accurately measured. Collecting data on the value and benefits of an integrated system is necessary for the federal government to justify including CAM/IHC in its health care programs. Only a large pilot program sponsored by the Federal Government and properly funded and carefully monitored can effectively demonstrate economic viability and long term benefits of an integrated system because there is strong opposition to changing the status quo. The resultant data could be used to demonstrate cost reductions from the utilization of low cost, more conservative measures currently not permitted in the present health care environment. Funding currently exists within the Social Security Administration that can be used for this purpose, so additional appropriations would not be necessary. There is broad-based support for this recommendation, and the talent is available to design the project and to deliver it. The beauty of this recommendation is in its relative simplicity, low cost and valuable outcomes. Examples of possible projects include CAM/IHC treatment of low back pain and cardiovascular disease (e.g., the Ornish Program).

Legacy: A Government Accounting Office report demonstrating CAM/IHC efficacy, cost-effectiveness and cost savings in the area of rehabilitation will spur federal agencies to utilize CAM/IHC more widely in their programs. It will also help foster the change to an integrated health care system and, most likely, save billions of dollars in health care costs while improving the quality of life for millions of Americans.

The mission of an office of CAM/IHC medicine would be to foster creation of an integrated health care system with an emphasis on health promotion and disease prevention.

6. CLINICAL PRACTICE AND QUALITY OF CARE —

Participants: Tim Birdsall, ND, Ron Hoffman, MD, Rich Liebowitz, MD, Roberta Lee, MD, Suzanne Myer, MS, RD, Carolyn Talley, LMT, Don Warren, ND

Challenges and Context: Health care consumers are currently living in an environment which is replete with multiple and diverse practitioners and healing systems. Many of these approaches are not well defined in terms of the education necessary for their practice, as well as the boundaries of the practitioner's ability to diagnose and treat various conditions. This is true of not only new and emerging professions, but also conventionally trained allopathic physicians who are now offering complementary and alternative modalities. In order to ensure that well-informed decisions are made, and the public protected, it is necessary that a system be developed for informing the public about minimum educational standards and the scope of practice for each profession. It is paramount that minimum standards be uniform throughout the nation, with consistency across all fifty states.

CLINICAL PRACTICE RECOMMENDATION #1: Develop a national agency that acts as a clearinghouse for defining the qualifications and scope of practice for all health care providers.

Reason: In order for patients to be informed about the training and skills of any health care provider, standards must be established that clearly and precisely describe what it means to see a practitioner in any particular discipline. The basis of this classification should be through the work of those practicing within the system to be defined. At the very least, educational and clinical minimums necessary to establish a practitioner in the field must be articulated, as well as the range of conditions treated and procedures performed. The purpose of this is not to regulate; rather it is to clearly define what any practitioner in the delivery of health care has as a base of knowledge and clinical competency. This process, however, could serve as the first step in developing a road map for emerging professions to potential licensure as well as inclusion in federal programs. This is the first step in more accurately informing and educating the public about the capabilities of health care providers.

This system of classification should be non-hierarchical, inclusive, self-determining and self-defining. The new federal agency recommended by Dialogue participants would be responsible for disseminating the information. The agency's staff and advisors would include practitioners of conventional medicine, CAM, and the public. Input would be obtained from already existing agencies, and this clearinghouse might potentially reside in an organization such as the Institute of Medicine.

Several tasks need to occur prior to the establishment of this new federal agency. An executive committee with broad representation would be the first step in reaching consensus on the approach and any existing precedent. An inventory of existing professions would be necessary as a prelude to help gauge the scope of the undertaking. It is expected that input would be requested from Congress, the Department of Education, CMS, HHS, the Federation of State Medical Boards, professional organizations, accrediting agencies, and the public.

Legacy: This agency will educate and protect the public, enabling consumers to make informed decisions regarding choices in health care. Fraudulent claims would be more easily recognized and titled practitioners would be forced to comply with established standards. While the federal government would have established these minimum standards, individual states would remain free to further refine the standards.

The purpose of a national agency that acts as a clearinghouse is not to regulate; rather it is to clearly define what any practitioner in the delivery of health care has as a base of knowledge and clinical competency.

7. PUBLIC HEALTH AND COMMUNITY HEALTH —

Participants: Michael Dyer, MSW, JD; Rick Gallion; Melane Hoffman; Clyde Jensen, PhD; Wayne Jonas, MD; Janet Kahn, PhD; Duchy Trachtenberg, MSW

Overview: It is well documented and widely acknowledged that a large and growing proportion of American adults uses one or more forms of CAM. Thus, much of the impetus driving research into CAM results from the public health imperative to learn more about any health behavior of high prevalence in the American population.

It is certainly challenging, and often misguided, to speak of CAM as though there were a single CAM when in fact there are multiple forms of alternative and complementary medicine. Some forms of CAM are whole systems of medicine (e.g., Ayurveda, naturopathic medicine) and some are healing modalities that appear in a variety of medical systems (e.g., therapeutic massage). Nevertheless, we can identify five distinct areas of concern in relation to CAM and public health. These include: 1) the need for a CAM /IHC Office in the Office of the Secretary of DHHS, to oversee, evaluate, and coordinate the Department's CAM activities; 2) the need to establish specific points of contact for CAM/IHC in all relevant federal agencies, possibly by creating an office (or Coordinating Officer) in each agency; 3) the need for equitable access to CAM; 4) the need for education of the public and policy makers, in the broad range of different aspects of CAM; and 5) the need to accommodate the health traditions of culturally distinct populations, and to acknowledge the potential of CAM to address existing health disparities.

PUBLIC AND COMMUNITY HEALTH RECOMMENDATION #1: Ensure that CAM is effectively integrated into the HP2020 development and implementation process.

Reason: A CAM/IHC summary incorporated into Healthy People 2020 (the Public Health Service's next large-scale revisiting of the nation's health goals) would serve to identify the established and potential ways CAM/IHC might contribute to the creation and realization of HP2020 goals. We recommend beginning with a review of the existing HP2010 report, identifying opportunities for CAM/IHC to be integrated into future iterations of the Healthy People process. In addition, we would also recommend the completion of a thorough needs assessment/survey of CAM/IHC health practices in health departments and agencies at all levels of government.

Legacy: If appropriately integrated into HP2020 plans and activities, CAM/IHC could be an important factor in building growing constituencies and rallying grass-roots support for HP2020, by tapping into the strength of health consumer and self-determination constituencies.

PUBLIC AND COMMUNITY HEALTH RECOMMENDATION #2: Increase awareness of the meaning and practice of holistic health, including acknowledgment of the integral relationship between the physical and social environment and individual health and public health.

Reason: One of the central arenas of public health concern is environmental health. This is an area in which CAM/IHC has distinct offerings to make

because many CAM modalities have a long history of attention to the relationship between individual well being and the environment (e.g., all forms of indigenous medicine).

Thus we propose three strategic objectives:

1. encourage attention to environmental factors (both social and physical) as part of integrative, holistic health care, by all practitioners, conventional as well as CAM;
2. clarify the unique perspective of the CAM community on environmental and public health; and
3. preserve environmental integrity as a personal health imperative and a public health measure. The group recognized a critical need to develop a unified voice in the CAM community on environmental issues in public health and integrative care.

Legacies: Holistic prevention and treatment of disease would be encouraged and provide a greater focus on preservation of natural resources. In a very tangible way, it would establish more effective outreach to traditional healing communities, thereby enhancing the important contribution CAM offers throughout the world.

CAM/IHC providers, while fully embracing the principles incorporated in Health People 2020, recognize that without the incorporation of CAM/IHC providers into the public health care system, the goals and objectives of Healthy People 2020 will not be met.

SUMMARY AND FUTURE DIRECTIONS

National Policy Dialogue
to Advance Integrated Health Care:
Finding Common Ground

Summary and Future Directions

Four dominant themes emerged in the National Policy Dialogue. All are critical for the development of a clinically effective, economically viable integrated healthcare system:

- Federal leadership, organization and oversight;
- Ongoing collaboration among conventional and CAM professionals at every level - education, research, delivery of care, regulatory activities, and reimbursement;
- Equality of patient access to the full range of practitioners;
- Health promotion as a priority in our healthcare system.

Interconnectedness of Core Themes

It's important to note the vital interconnection among these elements. One example will serve. Equality of access for patients is predicated upon ready availability of qualified providers, relatively uniform national minimum standards of education and practice, an informed public, and reasonably consistent reimbursement models. Achieving each of these large component goals will require

- significant collaboration among providers and educators to set and disseminate minimum standards and to educate the public about the various options in care, including the importance of health promotion;
- governmental leadership to help support and guide emerging professions and their educational training, and to provide adequate funding for research; and
- a high level of coordination and leadership to ensure that all appropriate public and private agencies, organizations and individuals participate in the planning and implementation of the many activities that will help to achieve the goals.

We can get a glimpse of how critical each of the dominant themes will be as we move ahead.

Organized, Ongoing Collaboration

Transforming these themes into reality is a complex, lengthy process, requiring attention to myriad intermediary action steps and goals. Participants at the National Policy Dialogue were eager to find a mechanism for continued collaboration. Most of the recommendations generated by the conference and mentioned in this report will need the best efforts of all of us - and more - to be successful. John Weeks, principal in the Collaboration for Healthcare Renewal Foundation, a nonprofit 501(c)(6) organization, offered an organizational base and start-up funding for a coalition of interested groups and individuals. The offer was accepted and the Integrated Healthcare Policy Consortium emerged as the ongoing umbrella under which all Dialogue participants will be invited to continue to consult, collaborate, meet, discuss and act to advance mutual goals. [It is not yet clear whether or not the Integrated Healthcare Consortium, which formed the Steering Committee for the Dialogue, will continue to have a separate organizational life.] IHPC anticipates that the policy work and collaboration will be enhanced by the connection with other projects and integrated healthcare industry organizations that are part of the CHRF.

“Just the fact that you had people representing these varied interests together in one room having frank conversations, was remarkable progress.”

Richard Liebowitz, MD
Duke University

Additional information can be obtained by contacting any member of the Steering Committee for the Dialogue, most of whom are serving on either the Executive Committee or the Advisory Committee of the new Consortium (see Appendix VII for these lists).

Dialogue Objectives

Looking back to the objectives established by the Steering Committee for the Dialogue, significant progress is evidenced by this report and by the commitment to ongoing collaboration among participants. Those objectives were:

- Identify and articulate important policy directions and initiatives that represent common ground and that can be used for three important purposes:
 1. To build strong alliances among providers, educators, researchers, payers and consumers who have a commitment to advancing integrated health care safely and effectively;
 2. To make it possible for individuals and groups to work together on recommendations to policymakers, legislators and regulators for high priority issues in integrated care; and
 3. To develop a dynamic, shared policy agenda that all attendees can use to promote their respective organizational goals for integrated health care.
- Provide a forum in which key stakeholders in integrated care can communicate effectively based on information (not assumptions) and collaboration (not exclusion).
- Enhance the effectiveness, knowledge, and vision of leaders in the integrated health care arena.
- Develop the basis for a report that can be used by policymakers, professional associations, academic institutions, and others on seven important topics:
 1. Research issues and goals
 2. Education, training and accountability of health professionals
 3. Underserved and Special Needs Populations
 4. Regulation and Access to CAM Products and Services
 5. Access to CAM in Federal Benefits and Healthcare Programs
 6. Clinical Practice, Quality of Care, and Delivery Systems
 7. Public and Community Health

These objectives have now also formed the foundation for the Mission Statement of the Integrated Healthcare Policy Consortium. There was such strong common ground around these topics that they have great usefulness in providing a platform for ongoing policy development and legislative action. The high level of satisfaction articulated by conference participants and the material presented in this report confirm that the ***National Policy Dialogue to Advance Integrated Care: Finding Common Ground*** did an excellent job of meeting the original conference objectives.

“The dialogue report should be very useful to those complementary and alternative medicine and integrated medicine interests with an active presence in

Washington, D.C.”

John Weeks
Principal, Collaboration
for Healthcare Renewal
Foundation

APPENDICES

National Policy Dialogue
to Advance Integrated Health Care:
Finding Common Ground

APPENDIX I

Underserved and Special Needs Populations

Recommendation #1: Assure widespread access to CAM/IHC in rural and underserved communities by 2004.

Stages/Tasks:

- Identify, draft, introduce and support necessary authorizing legislation and appropriations amending CMS, Medicare/Medicaid, NHSC, others. Amend Primary Health Services provision in NHSC Reauthorization Bill. Include CAM/IHC providers, primary care, direct access, technical CAM providers and traditional healers from recognized communities of practice on list for communities to choose from.
- Expand CMS/HCFA regulations to include reimbursement parity. Address coding issues as necessary, in consultation with national CAM/IHC organization representatives.
- Create and fund CAM/IHC provider outreach and education program for communities on integrated care options
- Link these efforts to efforts to establish Federal CAM/IHC Office.
- Insure universal access to effective health care for all US residents.

Success Factors:

- Congressional support
- White House Commission on CAM Policy support
- Appropriate funding
- Identification and removal of other federal policy barriers (Example: Public Health Services Act Title VII and VIII - inclusion of appropriate CAM providers and accredited CAM institutions needed to support institutional collaboration)
- Stakeholder collaboration and support
- Federal agency interest and collaboration

APPENDIX II

Underserved and Special Needs Populations

Recommendation #2: Establish Federal CAM/IHC Office.

Stages/Tasks:

- Establish diverse Advisory Council in consultation with national CAM, IHC, Public Health & World Medicine Associations, academic consortia and councils. Include CM, CAM, emerging health professions and traditional healers, selected world medicines, consumers, nursing, integrative medicine and private sector, education and product industry.
- Establish national credentialing roundtable to address issues impacting rural and underserved areas: longitudinal mobility, social authority, standards of training and care, title acts versus practice acts.
- Provide education regarding CAM/IHC providers and services for rural and underserved communities.
- Establish interdisciplinary “Blue Ribbon Panels” on 10 leading health indicators with CAM, CM, public health and other stakeholders to develop consensus on integration strategies to impact the leading health indicators.
- Ensure mechanisms to collect data, and monitor and assess outcomes in all programs regarding disparities, access, health status, quality of life and patient satisfaction.
- Authorize and fund replication of King County Natural Medicine Clinic model in Community Health Centers. Identify and replicate other viable integration models. Develop new models and collect data on outcomes of all models.

APPENDIX III

National Policy Dialogue Survey Results

Fall 2001 (Pre-Conference)

The number of responses for each option appears in brackets; the percentage, as a total of all who answered that question, follows the brackets. Responses were confidential.

RESEARCH ISSUES AND GOALS

1.1 CAM/integrative approaches should be evaluated through research designs that examine a broad set of measures, including such things as functionality, cost, satisfaction, cost-offsets, and effects on productivity, rather than focusing solely on biomedical indicators.

Strongly agree	[35]	90%
Mildly agree	[3]	8%
Neutral (neither agree nor disagree)	[0]	
Mildly disagree	[1]	2%
Strongly disagree	[0]	

1.2 To help federal health financing agencies and employers understand how to cover integrated services that include CAM, a higher percentage of federal research dollars should focus on issues such as cost, cost-offsets and utilization comparisons between conventional and integrated care.

Strongly agree	[25]	64%
Mildly agree	[27]	10%
Neutral (neither agree nor disagree)	[1]	2%
Mildly disagree	[2]	4%
Strongly disagree	[1]	2%

1.3 To date, progress in integration has been driven more by politics and market forces than by research.

Strongly agree	[24]	62%
Mildly agree	[12]	31%
Neutral (neither agree nor disagree)	[1]	2%
Mildly disagree	[2]	4%
Strongly disagree	[0]	

1.4 You have \$100-million per year to invest in CAM-related research that will impact decisions about integrated care. You will divide the budget into two categories: (a) the percentage to spend on controlled trials to determine the efficacy of specific CAM interventions; and (b) the percentage to spend on analysis of the "real world" experience in utilizing, delivering, integrating and covering CAM. The percent of the \$100 million you would spend on controlled trials is:

20% [6] 16% 40% [23] 61%
 60% [6] 16% 80% [3] 8%
 100% [0]

EDUCATION, TRAINING AND ACCOUNTABILITY

2.1 Conventional medical institutions should offer enough CAM education to enable graduates to refer to and collaborate with CAM providers.

Strongly agree [37] 95%
 Mildly agree [2] 4%
 Neutral (neither agree nor disagree) [0]
 Mildly disagree [0]
 Strongly disagree [0]

2.2 Conventional medical institutions should offer enough CAM education to enable graduates to demonstrate competencies and practice CAM.

Strongly agree [3] 8%
 Mildly agree [2] 21%
 Neutral (neither agree nor disagree) [7] 18%
 Mildly disagree [9] 23%
 Strongly disagree [12] 31%

2.3 Standards or scope of practice guidelines generally do not permit integrative or collaborative work among CAM and conventional providers.

Strongly agree [2] 5%
 Mildly agree [16] 41%
 Neutral (neither agree nor disagree) [3] 8%
 Mildly disagree [9] 23%
 Strongly disagree [9] 23%

2.4 Practice standards or guidelines generally do permit practitioners to learn and use the skills of other disciplines:

Strongly agree [1] 2%
 Mildly agree [14] 36%
 Neutral (neither agree nor disagree) [5] 13%
 Mildly disagree [15] 38%
 Strongly disagree [4] 10%

2.5 Professional regulatory authorities should conduct peer review, require national or state board examinations, and promote standards of care.

Strongly agree [21] 55%
 Mildly agree [6] 16%
 Neutral (neither agree nor disagree) [6] 16%
 Mildly disagree [4] 11%
 Strongly disagree [1] 2%

2.6 CAM licensing bodies have sufficient authority to enforce standards and allow for public input and resolution of complaints.

Strongly agree [4] 10%
 Mildly agree [15] 38%
 Neutral (neither agree nor disagree) [8] 21%
 Mildly disagree [9] 23%
 Strongly disagree [3] 8%

CAM USE IN UNDERSERVED AND SPECIAL NEEDS POPULATIONS

3.1 Efforts to reduce health disparities, disease, and disability in underserved and special needs populations will benefit from an effective partnership between CAM and conventional providers.

Strongly Agree [28] 72%
 Mildly Agree [6] 15%
 Neutral (neither agree nor disagree) [4] 10%
 Mildly Disagree [1] 2%
 Strongly Disagree [0]

3.2 Ensuring Medicare/Medicaid coverage through HCFA for CAM providers and services is central to (a) removing federal and state barriers to the use of CAM services by the underserved and special populations, and (b) providing funding through the National Health Services Corps for CAM providers to work in the Public Health Service and in community clinics.

Strongly Agree [23] 59%
 Mildly Agree [10] 27%
 Neutral (neither agree nor disagree) [2] 5%
 Mildly Disagree [2] 5%
 Strongly Disagree [2] 5%

REGULATION AND ACCESS TO CAM PRODUCTS AND SERVICES

4.1 I need more accurate information about the different state regulatory models under which providers from CAM disciplines function (e.g., licensure, certification, registration, no regulation).

Strongly Agree [17] 44%
 Mildly Agree [15] 38%
 Neutral (neither agree nor disagree) [4] 10%
 Mildly Disagree [1] 3%
 Strongly Disagree [2] 5%

4.2 A well-defined scope of practice, such as that established under a licensure law, is important in developing integrated care models that include CAM practitioners.

Strongly Agree [21] 54%
 Mildly Agree [13] 33%
 Neutral (neither agree nor disagree) [3] 8%

Mildly Disagree [1] 2%
 Strongly Disagree [1] 2%

4.3 Making state regulatory standards for CAM more consistent is necessary to increase patient access to competent CAM providers and integrated care.

Strongly Agree [15] 38%
 Mildly Agree [16] 41%
 Neutral (neither agree nor disagree) [3] 8%
 Mildly Disagree [5] 13%
 Strongly Disagree [0]

ACCESS TO CAM IN FEDERAL BENEFITS AND FEDERAL HEALTH SERVICES

5.1 Federal Health Programs now pay for an adequate range of CAM practitioners, therapies and services.

Strongly Agree [1] 2%
 Mildly Agree [0]
 Neutral (neither agree nor disagree) [3] 8%
 Mildly Disagree [7] 18%
 Strongly Disagree [28] 72%

5.2 Increased coverage of CAM therapies and services would, over time, reduce health care costs.

Strongly Agree [24] 62%
 Mildly Agree [7] 18%
 Neutral (neither agree nor disagree) [6] 15%
 Mildly Disagree [2] 5%
 Strongly Disagree [0]

5.3 Americans have adequate access to health care products and devices found to be safe and effective in other countries.

Strongly Agree [1] 2%
 Mildly Agree [1] 2%
 Neutral (neither agree nor disagree) [3] 8%
 Mildly Disagree [21] 54%
 Strongly Disagree [13] 33%

CLINICAL PRACTICE, QUALITY OF CARE AND DELIVERY SYSTEMS

6.1 It is important to have CAM and conventional providers practicing together within the same clinical site.

Strongly Agree [9] 23%
 Mildly Agree [16] 41%
 Neutral (neither agree nor disagree) [9] 23%
 Mildly Disagree [4] 10%
 Strongly Disagree [1] 2%

6.2 It is important to have standardized protocols that are agreed upon by CAM and conventional providers for the treatment of well-defined disease states.

Strongly Agree [7] 17%
Mildly Agree [15] 37%
Neutral (neither agree nor disagree) [4] 10%
Mildly Disagree [11] 27%
Strongly Disagree [4] 10%

6.3 It is important to have tracking of patient outcomes by provider type when determining which approaches should be offered by a delivery system.

Strongly Agree [18] 46%
Mildly Agree [17] 44%
Neutral (neither agree nor disagree) [2] 5%
Mildly Disagree [2] 5%
Strongly Disagree [0]

6.4 It is important to have licensure and credentialing for CAM acceptance in an integrated Network.

Strongly Agree [24] 62%
Mildly Agree [12] 30%
Neutral (neither agree nor disagree) [3] 8%
Mildly Disagree [0]
Strongly Disagree [0]

6.5 The gatekeeper role at integrated facilities should be based on the biomedical model that has a physician at the center.

Strongly Agree [2] 5%
Mildly Agree [2] 5%
Neutral (neither agree nor disagree) [6] 15%
Mildly Disagree [10] 26%
Strongly Disagree [19] 49%

6.6 In integrated clinics, there should be direct access to CAM providers who can assess triage needs.

Strongly Agree [17] 44%
Mildly Agree [11] 28%
Neutral (neither agree nor disagree) [10] 26%
Mildly Disagree [1] 2%
Strongly Disagree [0]

APPENDIX IV

Integrated Healthcare Policy Consortium Executive Committee and Advisory Committee

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