APPENDIX B
IHPC Top Five Priorities Statement

INTEGRATED
HEALTHCARE POLICY
CONSORTIUM

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Top Five Priorities for the National Prevention, Health Promotion, and Public Health Council

Introduction

The creation under the Patient Protection and Affordable Care Act (PPACA) of the National Prevention, Health Promotion, and Public Health Council acknowledges that one key to reducing health care costs is through efforts to prevent disease onset and progression and to deepen our understanding and commitment to helping people enhance their own health. This will require substantial change in the orientation of a health care system which has been focused on disease treatment, often to the neglect of health promotion. We celebrate the creation of this inter-agency Council as it is an acknowledgement that virtually every aspect of federal domestic policy affects Americans' health, and paying attention to this is where health promotion begins. We also applaud the creation of the grassroots Advisory Group on Prevention, Health Promotion and Integrative and Public Health, which can provide much needed perspective and data to the Council.

As the Council and the Advisory Group begin your work we would like to offer a few suggestions from the field of integrated health care.

1. **First,** we hope that you will **give strong attention to primary prevention** as well as secondary, and bear in mind that **health promotion and disease prevention are about human behavior first and foremost**. In our technology-oriented world it is easy to become captivated by the promise of genomic discovery with its possibility of altering people's inborn propensities, as well as other high tech interventions. It is possible to focus on requirement of colonoscopies or other diagnostic procedures, and forget that information alone is not preventive. It is only when information guides behavior that

preventable disease will be prevented. We urge you to seek the low cost, low tech interventions that are available through both conventional and complementary and alternative health care disciplines. It is well known that changing people's behavior is far more difficult than securing changes in knowledge or stated attitudes. We urge attention to how best to provide and incentivize patient education that works, including development of health coaching criteria to ensure quality and revised reimbursement structures that allow for time spent with patients whether individually or in groups.

2. We also encourage you to adopt systems thinking when considering human health and wellbeing, and this is reflected in a number of suggestions made below. This will put an emphasis on **whole systems of care as most likely to yield positive health outcomes.** By this we mean at least two things:

    a. If it takes a village to raise a child, it also takes a village – or at least a team, to keep each of us going well. This is reflected in the Affordable Care Act in the proposal for Medical Homes. We encourage you to **promote the use of teams which can provide the kind of continuity of care and attention that allows the dots of a person's health presentation and data to be connected** and potentially harmful patterns to be recognized and corrected.
    b. We also implore you **to allow all health care providers to practice to the full extent of their scope of practice**. When systems of medicine are implemented piecemeal, such as Medicare's reimbursement of chiropractors for spinal segment adjustment only, one disrupts the optimal practice of medicine and reduces a health care provider to the status of technician. We must have systems of reimbursement that honor the full training and expertise of every direct entry provider. **There are synergies that are destroyed and quality of care and attention that is prohibited when techniques or services are separated from the whole diagnostic and treatment system in which they are embedded.**

3. Recognizing that attending to health promotion and wellness at this unprecedented level requires some reorientation of our assumptions and resources, we recommend that **you begin by gathering information**, perhaps through the Congressional Research Service. We need a **comprehensive review of <u>all</u> federal health care programs *(Medicare, DoD, VA, FEHBP, etc.)* to identify the existence and scope of any currently existing programs and benefits available specifically for the purpose of wellness, health enhancement and disease prevention. All cost-benefit information should be included in this review.**

4. Over 40% of Americans use some form of complementary and alternative medicine (CAM), including medical systems that have traditionally been oriented toward the establishment and maintenance of optimum health and wellbeing. We encourage the Council and Advisory Group to **conduct hearings to inform**

yourselves fully about the practices and outcomes of both integrative health care (patient-centered multi-disciplinary collaboration) and individual systems including naturopathic medicine, acupuncture and Oriental medicine, Ayurvedic medicine, chiropractic medicine, therapeutic massage, homeopathy and professional midwifery, as they relate to both primary and secondary preventive efforts. **We encourage the inclusion of all regulated health care professionals in medical homes and their community health teams.** (See attached document for regulation criteria.)

5. **In all policy-creation and** rulemaking related to health care in this era the Council should require **attention to issues of equity as they relate both to patients and providers.**

    a. **Patient Equity Issues** revolve around access to both the social and environmental conditions (e.g. walking paths, healthy school lunches, clean air and water) as well as specific healthcare interventions that promote health and wellbeing and mitigate disease onset and progression. Wellbeing should not be available only to those who can afford it and are easy to reach and teach.
    b. **Provider Equity in Reimbursement** rules is a matter of patient access and is sorely needed. We suggest the following:
        i. **If a particular service is reimbursed it must be reimbursed for any licensed (**or otherwise qualified – see attachment**) health care professional for whom it is included in their scope of practice.**
        ii. **It is likely that cost savings and improved care will both be supported by more widespread adoption of team and care-based reimbursemen**t such as is practiced with hospice reimbursement. We suggest the council examine such de-siloing of reimbursement as medical homes and community health teams are being established.
        iii. **Explore the use of patient-specific data in decision-making re: reimbursement.** The principle for this is described in a current bill, HR 396. While large clinical trials yield critical information about treatment safety and efficacy writ large, we all know that averages do not apply to all people equivalently. Even when the "overall" results of a treatment are good, there are some people who are tremendously responsive to it and others who are non-responsive or harmed by it and for whom alternative treatments should be covered.

About IHPC: *The Integrated Healthcare Policy Consortium (IHPC) is a broad coalition whose Partners for Health represent over 300,000 clinicians and healthcare educators committed to public policy that supports a health-oriented, integrated system, ensuring all people access to the full range of safe and regulated conventional, complementary, and alternative healthcare professionals. Integrated Health Care describes a coordinated system in which healthcare professionals are educated about one another's work and collaborate with one another, and with their patients, to achieve optimal well-being for the patient including physical, emotional and spiritual well-being. Visit www.ihpc.info to learn more.*

Appendix C
National Healthcare Workforce Policy Statement

IHPC Policy Statement on the National Healthcare Workforce in the Era of Integration

IHPC applauds the inclusion in the Affordable Care Act of an expanded definition of the healthcare workforce that includes, as stated in Section 5101, "...licensed complementary and alternative medicine providers, integrative health practitioners..." (See full definition below.) We recognize that while licensed complementary and alternative medicine providers can be readily identified (and include acupuncturists, chiropractors, massage therapists, naturopathic physicians, and professional midwives), "integrative health practitioners" have yet to be defined.

Seeking a balance between strongly held values of patient access to health care therapies and professionals of their choice AND proper recourse if inappropriate or unethical care should occur, we support:

1) Inclusion of all licensed complementary and alternative health care providers.
2) Inclusion of all state certified health care providers.
3) Inclusion of all nationally certified health care providers, when the certification agency is accredited by the National Commission for Certifying Agencies (NCCA) of the Institute for Credentialing Excellence (ICE).

For healthcare professions that do not yet have either state licensure/certification/registration or national certification, IHPC encourages such professions to obtain state licensure/certification/registration and/or national certification.

From the Affordable Care Act

HEALTH CARE WORKFORCE The term "health care workforce" includes all health care providers with direct patient care and support responsibilities, such as physicians, nurses, nurse practitioners, primary care providers, preventive medicine physicians, optometrists, ophthalmologists, physician assistants, pharmacists, dentists, dental hygienists, and other oral healthcare professionals, allied health professionals, doctors of chiropractic, community health workers, health care paraprofessionals, direct care workers, psychologists and other behavioral and mental health professionals (including substance abuse prevention and treatment providers), social workers, physical and occupational therapists, certified nurse midwives, podiatrists, the EMS workforce (including professional and volunteer ambulance personnel and firefighters who perform emergency medical services), licensed complementary and alternative medicine providers, integrative health practitioners, public health professionals, and any other health professional that the Comptroller General of the United States determines appropriate.

Appendix G
Abbreviations & Acronyms

ACA	Affordable Care Act
ACCAHC	Academic Consortium for Complementary and Alternative Health Care
AMA	American Medical Association
CAM	Complementary and Alternative Medicine
CCH	Certified in Classical Homeopathy
CDC	Centers for Disease Control and Prevention
CER	Comparative Effectiveness Research
CMS	Center for Medicare and Medicaid Services
CPM (or LM)	Certified Professional Midwife (or Licensed Midwife)
CPT® Codes	Current Procedural Terminology codes
HHS	US Department of Health and Human Services
DC	Doctor of Chiropractic
DHt	Diplomate of the American Board of Homeotherapeutics
DO	Doctor of Osteopathy
HCFA	Health Care Financing Administration
HCPAC	Health Care Professions Advisory Committee
HCPCS	Healthcare Common Procedure Coding System
HIPAA	Health Insurance Portability and Accountability Act
ICE	Institute for Credentialing Excellence
IHPC	Integrated Healthcare Policy Consortium
JD	Doctor of Laws
LAc	Licensed Acupuncturist
LLM	Master of Laws
LMT	Licensed Massage Therapist
MD	Doctor of Medicine
ND (or NMD)	Doctor of Naturopathic Medicine
NCCA	National Commission for Certifying Agencies
NCCAM	National Center for Complementary and Alternative Medicine
NHWC	National Healthcare Workforce Commission
NP	Nurse Practitioner
PCOR	Patient-Centered Outcomes Research
PCORI	Patient-Centered Outcomes Research Institute
RN	Registered Nurse