Transcript from AACIPM Fall Symposium

Equity in Access to Comprehensive Integrative Pain Management for People with Pain - September 24, 2020

37 minute transcript - accompanying video can be found here.

Moderator: Ariana Thompson-Lastad, PhD

- Sharad Kohli, MD, Family physician, People's Community Clinic, Austin, TX
- Mary Faria, PhD, FACHE, President & CEO, AOMA Graduate School of Integrative Medicine
- Shari Ling, MD, Deputy Chief Medical Officer, Centers for Medicare and Medicaid Services
- David W. Miller, MD, LAc, Immediate Past Chair, American Society of Acupuncturists

Interactive Discussion about Access to Acupuncture as an Example

Amy Goldstein, Director, AACIPM (00:00):

We are now going to introduce our panel discussion. And I would like to introduce our moderator for this discussion, Arianna Thompson-Lastad, who is a board member at Integrative Medicine for the Underserved. Dr. Thompson-Lastad will introduce those panelists who have not yet spoke to us today and the rest of the panel discussion. So, thanks to everyone and looking forward to hearing from you.

Ariana Thompson-Lastad, PhD (00:34):

Hi everyone. Thank you for staying on. So, thanks to all the presenters just now for your presentations. And we're going to dive a little bit deeper into an interactive conversation on the topic of access to acupuncture for underserved communities to talk about opportunities and barriers from different perspectives. So, I'll just say before we get started that Dr. Ling from Medicare, who just spoke is going to need to get off before the end of the panel. So, if you are in the audience and you have questions that you'd like her to answer now is a great time to go ahead and put those in the Q&A. The other additional two people who will be joining us here, who are here already, who you did not just see present are Dr. David Miller who's a physician and acupuncturist and Immediate Past Chair of the American society of acupuncturists, as well as Dr. Mary Faria. Who's the president and CEO of the AOMA graduate school of integrative medicine in Austin, Texas, and has many years of healthcare administration experience. So they are both here to be able to provide expertise related to acupuncture access.

Ariana Thompson-Lastad, PhD (01:51):

The question I'd like to start with for any of you who might have comments, who are on the panel is, have any of you heard of successful examples of acupuncturists getting reimbursed from Medicare? Or I've learned more from Dr. Ling's presentation, the acupuncturists themselves wouldn't be getting reimbursed, but the provision of acupuncture getting successfully reimbursed from Medicare in 2020. And if so, what kinds of settings are those in, or what does that look like? And if not, what do you see the main barriers being, if any of you in the audience have heard of successful examples of this happening, feel free to comment in the chat as well?

David Miller, MD, LAc, Amer Soc of Acupuncturists (02:30):

Faria, I could take a stab at that if that's okay. Yeah. And so, I was consulting with our insurance expert, the chair of our insurance committee, Maury West too. And we're, we're monitoring the

situation. And as of yet, we've not heard of successful reimbursements coming in, claims have been submitted, but they're still in the processing stage. I think because it was such a new determination in January and then the rules didn't get released until April. That then there was a lag time again before claims started being submitted. And so, if people do have knowledge of actual reimbursements coming through, we'd love to hear those.

David Miller, MD, LAc, Amer Soc of Acupuncturists (03:02):

I just like to speak to the point though, that part of the challenge I think for our professional base is that we have a workforce analysis underway right now and our preliminary data from that is showing that at least two thirds of our practitioners are still solo practitioners in private practice. So typically, licensed acupuncturist practice without supervision, and so supervisor relationships are not typical. So, there's an additional challenge to this in that our providers have to also establish those relationships before they can begin the process of treating patients and getting reimbursed. And so I guess one of my questions also for Dr. Ling would be, again, we're seeking some more information and clarity on what it means to have direct supervision, meaning if someone is in a remote location would it be possible for them to use a zoom consult to have direct supervision, right? Or do they have to actually be in the same office as the provider, because particularly for rural practitioners or sometimes even urban practitioners, that can be a real challenge.

Shari Ling, Centers for Medicare & Medicaid Services (04:05):

Yeah. So, thank you for the question. And the short answer is I don't know, but this is a really great question, particularly in light of some in the context of the public health emergency, but I certainly will take that back to my colleagues. Now because, there were many flexibilities afforded in the context of the public health emergency. Now, particularly when it applies to rural providers there too, I think the public health emergency was not the required trigger but there are still constraints applied to some of the tele-health benefits. But that is a really great question. And I think actionable for us. So, thank you so much for that question.

Shari Ling, Centers for Medicare & Medicaid Services (05:11):

When it comes to like claims coming in though and being submitted, I see in the chat that Lester Zaleski waiting for forms for Medicare to apply for acupuncture, reimbursement. Lester, I will also let our colleagues know about that. That's in a different part of our center and you need to wait for specific forms to be sent or that you haven't received a reply to forms that you had submitted and you're waiting for a response. If you could just tap that to me for clarity, that will help enormously since Medicare advantage has some flexibilities though. And most of our focus is on initially on the analysis of unfortunately, the fee for service and maybe some of our other colleagues who actually aren't in the MA space. I know there was an earlier panel. I'm curious to know how that is working hoping that there is a smoother process there in the MA space, given the uptake and preponderance in several States now. Thank you. And I'm looking at the Q and A.

Ariana Thompson-Lastad, PhD (06:51):

So yeah, Dr. Ling there's this other brief question for you can an acupuncture session be reimbursed during the same visit that a physician or I assume other clinician provides additional services? I don't know if that's something you can touch on briefly. And the other quick question is just whether there will be additional learning sessions or opportunities for people to give input?

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Shari Ling, Centers for Medicare & Medicaid Services (07:12):

Yeah. And I think as we will take back all of these questions, I think one of our opportunities really does come through the Todd Graham provision as well as the 6032 provisions, because some of this is... as we said earlier I think there's a service. And then there's all that wraps around with the services, the care that is provided to the person around just the treatment itself. And that is more of a bundle if you will, or a model. And that's something that we are really interested in, how to, and what would that look like with clarity? What would be the component pieces of an integrated pain management model?

Shari Ling, Centers for Medicare & Medicaid Services (08:12):

And not saying that there is one magic recipe for everyone, but how could you impart the flexibility so that it could be tailored to each individual based on what they have responded to in the past, what they're likely to respond to, putting the pieces together in a more integrated pain model, I think would be enormously helpful. So, if you have additional thoughts about this, please do type them in. And Amy, if I could impose on you to perhaps compile them and Ellen, she'll be monitoring the chat as well, but it would be really helpful for us as we go forward. So, thank you.

Amy Goldstein, Director, AACIPM (09:06):

Yes, we'll be happy to do that.

Ariana Thompson-Lastad, PhD (09:09):

So, everyone, please do give Dr. Ling your input in the chat about broader questions in this area. There's one other question for you, which says specifically...

Shari Ling, Centers for Medicare & Medicaid Services (09:21):

I don't think there's a contra-indication to the same... I know what you're referring to because there had been some limitations on same visits, but I don't think we state anywhere that, that cannot be done, but that's the kind of question that helps us to provide that clarity that would matter at the point of care. And these are in the questions and answers or in the questions. So, if we could get those as well, that would be great as well as from the chat

Amy Goldstein, Director, AACIPM (10:10):

Definitely.

Shari Ling, Centers for Medicare & Medicaid Services (10:12):

Yeah. And one more if I may, there's a question about requiring prior authorization for spinal cord stimulators. So now I think for... And what is CMS doing to identify and eliminate barriers to alternative agency-wide? So again, we are implementing section 6032 and the Todd Graham provision. So, this gives us a close look at... first of all, we have to visit the evidence that supports the use of the recommended treatment and service. And there are some broadly applicable treatments and services and others that are very specific to a population. So, we have to look at what that evidence is. And also, we are in the process of reviewing, I think was mentioned earlier, challenges with receiving and repairing durable medical equipment with devices such as spinal cord stimulators.

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Shari Ling, Centers for Medicare & Medicaid Services (11:37):

This is again prior authorization and utilization review is part of some of the protections, if you will, program integrity protections. However, is that not a reason not to look at this so we are looking at these various treatments and services and trying to understand all of the barriers and if prior authorization, it's one of several tools that can be used for program integrity. There are other tools that also can be used as well as other administrative requirements, that we are going to commit to looking at that potentially impede the ease with which needed therapies and treatments are received by our beneficiaries, who can really benefit from the receipt of these treatments and services and meaningfully improve their outcomes.

Shari Ling, Centers for Medicare & Medicaid Services (12:52):

I thank you for your question. And we are in the process of looking at some of the administrative processes, it's called Patients Over Paperwork. And based on the earlier question or discussion, just waiting to hear back from our office of burden reduction, to know if we have already begun to look at durable medical equipment, or if that is, now on the radar, but I just was curious if we had already started looking at this and we are looking at the journey for people with painful symptoms that especially where function is compromised or impaired because of it. We're already looking at that as part of our Patients Over Paperwork initiatives. So appreciate your asking about that. Thank you.

David Miller, MD, LAc, Amer Soc of Acupuncturists (13:54):

Dr. Ling to another question, if I could, it's maybe part commentary part question, and that is, we're very delighted that acupuncture has been covered for chronic low back pain in seniors, but I think what our society is wondering to some degree as well is, can the evidence that supported that inclusion also be translated to other conditions which are similar? That is to say that the physiology of the low back is not entirely unique, obviously within the human body. And if acupuncture is good for pain in one region of the body whether it be musculoskeletal, perhaps neurologically originating. It's simply impossible to develop robust studies with control groups and things like that for pain in every part of the body, right? Nor really should it be necessary. We could extrapolate from the existing data that acupuncture has beneficial for musculoskeletal and perhaps neurologic pain. Is there any discussion in CMS backing off of the specificity of the coverage, determination to include broader pain conditions?

Shari Ling, Centers for Medicare & Medicaid Services (15:03):

So remember that the acupuncture determination is a national coverage determination, and it was very specific, but importantly... actually to open the window by striking down the national non-coverage determination, I think there's still... and this something that we have an entire shop dedicated to coding. And to that discussion is it similar enough or is it different enough that that which is covered versus not covered yet? I think that the closer and clearer that the evidence can be, although inconvenient I think start with, it would be an interesting exercise if you will.

Shari Ling, Centers for Medicare & Medicaid Services (16:07):

what is similar enough physiologically, functionally as opposed to something that is very distinct and that type of paradigm would be something that we could look at in asking ourselves, so how close this evidence needs to be because you're right, there's a lot of gray, but when it comes to coding, keep in mind that they are discrete entities, how a condition is coded. So, it actually may matter from that and even though clinically, it might seem like shades of gray, if you will.

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Shari Ling, Centers for Medicare & Medicaid Services (16:58):

So that type of thinking would be helpful for us in thinking about what could be the edges. We were very specific in this determination, because that is what the evidence was strongest in. So, the more evidence that is received with the greater clarity about what the conditions and in what kind of patients, I think the better the ability to actually look at and review the available evidence. I hope that helps for you in responding to your question. But I appreciate your asking it. Thank you so much. Apologies. I do have to go, but again, thank you all and appreciate your flexibility.

Ariana Thompson-Lastad, PhD (18:02):

Thank you so much, Dr. Ling. And so again, people in the audience feel free to put additional questions for her in the chat that we'll be able to pass on afterwards. So, the next question I wanted to give to Dr. Faria, which is that during Dr. Kohli presentation, he mentioned the partnership between your school and the FQHC, where he works about increasing acupuncture access. And so I'm wondering if you can speak just a little bit more about how that's worked and how you see that kind of relationship affecting acupuncture access for people who wouldn't have it otherwise?

Mary Faria, AOMA Graduate School of Integrative Medicine (18:36):

Thank you. Well, for us, in school it's worked very, very well. It's neutrally beneficial. We're able to provide students that are in their fourth or fifth year of acupuncture school, working on their masters to provide services and an exchange our students get... so that the client gets the benefit of the acupuncture and again, these students are supervised, so there's a professional with them, but they are five-year master program. They're usually fourth year students that are going out into the clinics to get clinical experience. So, our benefit is that our students get some great experience with a varied number of patients. So, they get to see different types of patients. Excuse me. We have partnerships like this throughout the community. One with people's community clinic has a long standing strong partnership so we're pleased to be able to do that. But it allows our students to have a place to practice.

Ariana Thompson-Lastad, PhD (19:41):

Dr. Kohli I don't know if you want to add anything either about that from the FQHC side, getting that kind of partnership.

Sharad Kohli, MD, People's Community Clinic (FQHC) (19:47):

Yeah, it's been a great relationship. I mean as Dr. Faria said, we've had this relationship since 2003, actually. And I think definitely we have a lot of patients who are not interested in taking medications and want alternatives and different options for pain. And so, it provides that opportunity and I mean, not only the acupuncture piece of it, but even just the Chinese medicine and the herbs, we have patients who actually are interested in herbal medicines as well. So, recommendations can be made for patients for along those lines. So I agree, I think it's been a great relationship. I think it's one of those things that if you have a school in your area, in your clinic, I think trying to make those relationships and those partnerships, if possible.

Ariana Thompson-Lastad, PhD (20:41):

So folks in the audience we have about 10 more minutes, feel free to put in additional questions into the Q&A and in the meantime, I'm going to ask a couple more questions that we've developed beforehand. One is related to acupuncture access in hospital settings. So, we heard earlier on this panel from Maggie Buckley, who's a patient who shared an experience of visiting

the ER during COVID at a time when she typically used acupuncture for her pain, but wasn't able to access it because of the pandemic. She actually saw a physician in the hospital who supported acupuncture and had provided battlefield acupuncture in the VA context in the past, but wasn't able to access it in the hospital setting and instead was prescribed to less helpful, more expensive medication. So curious to hear from any of you on the panel or people in the audience who might like to share in the chat about any examples that you're aware of acupuncture successfully being implemented in inpatient or emergency room settings.

Mary Faria, AOMA Graduate School of Integrative Medicine (21:39):

I can take one, good news is that many health care systems are starting to embrace it here in Austin, Baylor Scott White is a great example and they've been hiring a lot of our best grads and using them in different environments in the hospital. In other settings, it's a little more challenging, some systems aren't ready for that. I know many physicians are and as the physician in the emergency room that you mentioned, we're dealing with something similar for what we're working with a physician at our children's hospital here in Austin, who really, really wants to see acupuncture in the emergency room where she works to be able to treat pediatric patients.

Mary Faria, AOMA Graduate School of Integrative Medicine (22:21):

And unfortunately, we're trying to figure out how to make that happen. And we think that probably the best way to at least introduce it in that environment is in a research model where we actually partner and begin to do some studies and introduce the value of the acupuncture. But yeah, there are a lot of physicians that are very interested, but it gets a little complicated I guess for the hospital systems, in terms of credentialing if they haven't created a good system to credential those practitioners, but many of them have, and Baylor Scott is one [inaudible 00:22:56] doing a good job with it.

David Miller, MD, LAc, Amer Soc of Acupuncturists (22:59):

I could add too, our research director, Jeff Dusek here at UH, just got a significant NIH grant to study the use of acupuncture in the emergency room. So, we're going to be initiating a project along those lines.

Mary Faria, AOMA Graduate School of Integrative Medicine (23:14):

Right.

Sharad Kohli, MD, People's Community Clinic (FQHC) (23:14):

I want to just like add on to what Mary was just saying, because I think she mentioned the physicians who are really interested. I think that's part of it is because I think sometimes it takes a physician champion or a clinician champion in the practice to really kind of shepherd that process along and help align and really advocate. And I think that's kind of a lot of what's happened in our clinic is that we've had acupuncture for a very long time in our clinic, but it was sort of like siloed in the corner and a lot of people in the main practice didn't really know what was going on over there.

Sharad Kohli, MD, People's Community Clinic (FQHC) (23:48):

And so part of it is just like, you need to have people in the main clinical team kind of saying hey, let's kind of bring this in and make this kind of part of our team. And so, we were able to bring our acupuncture instructor, get them on our electronic health record, making referrals, just like we would to any other resource within the clinic. And so, it's not silent that it becomes just a part of the actual team. And so, I think it is important to have some champions who are really going

to be able to advocate to administration as well and say, this is the reason why we need to be doing this.

Mary Faria, AOMA Graduate School of Integrative Medicine (24:27):

I have to agree with you the physician champions are key. I think in being able to move this forward because they see the benefit and they value this team approach and in this integrative approach, because they've seen the success with it. I know in some of the other partnerships we have in our community it's clear, we've demonstrated that we've been able to reduce emergency room visits. We've been able to reduce hospitalizations. We've been able to demonstrate that, we've been able to reduce costs and show that we've been able to improve patient outcome. But again, how do we transition and how do we get more healthcare providers to be willing to partner with us to begin that work so that they can see the results?

Ariana Thompson-Lastad, PhD (25:25):

Sorry, I just muted myself from some background noise. So I want to bring in a question that is related to some of what was discussed on the morning panel today, around geographical differences in workforce availability for providing different kinds of pain care and hear from any of you, what you think the ideal workforce actions would be to make acupuncture more broadly accessible, including for people insured through Medicaid or uninsured people? So particularly some people have brought up in the comments, role of physician acupuncturists versus licensed acupuncturists, thinking about different trends that are happening in reimbursement, not just for Medicare, but with private insurance or Medicaid. I know in a prep discussion, we had some conversations about loan repayment programs and how those could change the workforce accessibility. So just interested to hear from any of you touch on that topic.

Mary Faria, AOMA Graduate School of Integrative Medicine (26:27):

Look, one of the things I've thought about it, wouldn't it be interesting to see a model where students would need to repay their loan and all of these professionals who gone through clinical training, they probably have student loans. And if you could put together teams nationally and allow the teams to go into underserved, rural areas, areas that don't have the access that other parts of the country may have, that might be... and then forgive their loans if they're committing to a given number of years to provide that service. But I think rather than doing it on an individual basis, instead do it in a team fashion, so you can put together an integrative team, they all go to a community for a period of time. That might be a... it's just an idea. How to make that happen is the big question, but that might be one opportunity.

David Miller, MD, LAc, Amer Soc of Acupuncturists (27:31):

I would agree with that. I think that's a great combination of ideas, the loan forgiveness plus a team-based approach. I think many of our providers would love to be serving the underserved better, but just don't have the opportunity to do that because of financial constraints. And then also business constraints it's very hard to go in and establish a practice in an underserved community and make it viable and make a living and all of these things. So if there could be infrastructure that's already created to do the billing and payment component, people would love to come in and just provide the service.

Ariana Thompson-Lastad, PhD (28:03):

Yeah. I'm thinking about this presentation this morning and trying to remember the presenter's name from United Healthcare, talking about the major impact of one chiropractor in a low-

income neighborhood in Atlanta, who was a black female chiropractor, not representative of the overall chiropractic workforce, but appeared to be having a major impact on opioid prescribing in that area. So I think this speaks to the potential impact of even small numbers of providers being able to offer care to people who don't have it currently.

David Miller, MD, LAc, Amer Soc of Acupuncturists (28:37):

I think if there were also ways to lower the cost of education and bringing in also providers from those underserved... sorry, individuals from those underserved communities to become providers themselves would diversify our workforce meaningfully, which we really need to do at least in our professional group here.

Mary Faria, AOMA Graduate School of Integrative Medicine (28:56):

We can even do that, start with some small steps there was an acupuncture protocol called NADA that I'm sure David's very familiar with, but there is an opportunity where we could certify people that could be very low cost and they could start making a real difference in their community if they were able to use this protocol. So I think if we took some small steps towards what you suggested, David, to reduce the cost and get more practitioners from those underserved areas trying, that's another great idea.

Sharad Kohli, MD, People's Community Clinic (FQHC) (29:30):

Yeah. Actually in our clinic, we have two of our social workers got trained in NADA, from one of AOMA graduates, actually. But we've been running into challenges around kind of the credentialing of social workers doing acupuncture because we've never really had to address that. And so our board is asking a lot of questions that we're still in the process of doing that, but I think it provides a great opportunity especially for patients with substance use. In Texas, it's covered, a social worker can do for some substance use to actually get the NADA protocol done for them.

David Miller, MD, LAc, Amer Soc of Acupuncturists (30:10):

Also potentially working on training programs to help providers understand the unique needs of different underserved communities as well, could be really important. A number of colleagues we've been a discussion about where are the gaps in care provision based on racial bias and provider education bias. And if we could work on those two, that would be very meaningful.

Ariana Thompson-Lastad, PhD (30:35):

Yeah. And I hear people often speak about that in combination with the other piece you were touching on around making sure that training in acupuncture and other integrated professions is accessible to everyone who wants it as well. So we have about five more minutes and anyone is still welcome to ask questions in the Q&A, and in the meantime, I want to ask a question about COVID and whether anyone has stories of successful ways that acupuncture has been able to be provided during COVID or acupuncturists using their other tools and skills to provide care using tele-health during COVID?

Mary Faria, AOMA Graduate School of Integrative Medicine (31:16):

We have definitely had to be very, very creative and we immediately went to tele-health for herbal treatments. So people can benefit from herbs as well as the acupuncture. And as we began to reopen our clinics, we've been very, very careful about safety and certain things, certain kinds of modalities that acupuncturist would do like cupping and something called Gua sha, and we're not even doing prone positions. So we're limiting what we can do to make it as

safe as possible. And we're creating a very safe environment. We did iteration after iteration of testing before we actually reopened our clinic during COVID. And I'm just so proud of our team, really working hard to make the environment as safe as possible for anyone coming through with really strong screening of the patients that are coming through. So yeah, you can do it. It's just, you've got to be sure and do all of the work to make sure you're creating a safe environment.

David Miller, MD, LAc, Amer Soc of Acupuncturists (32:18):

I think it's a great question too, because I think some of our providers here at UH have done a great job, the acupuncturists in reaching out to patients during the COVID crisis with tele-health and, and like you said, Mary, the use of herbal medicine and also teaching things like when did the beginning of like Tai Chi Qigong exercises and creating that therapeutic relationship, nutritional counseling, redirection having a sounding board for people and just being part of their care team, even just to being present for them has been really important. And teaching patients, things like Gua sha cupping, but also acupressure and other techniques that they can really practice on their own. And I think there's a whole realm that could be developed around that. Especially if telehealth medicine can remain covered post-crisis, I think that would create an opportunity for even further development of whatever skill sets are needed to provide care. But it really is a much more comprehensive training than just the acupuncture, which is wonderful, but there's a whole body of knowledge also that's available.

Ariana Thompson-Lastad, PhD (33:22):

I attended a community acupuncture clinic recently that's experimenting with doing outdoor treatments in their parking lot. That was really amazing to get to see the creativity people have put into it. As we're wrapping up, curious if any of you have quick questions for each other on the panel?

David Miller, MD, LAc, Amer Soc of Acupuncturists (33:44):

I don't think so, personally.

Ariana Thompson-Lastad, PhD (33:56):

I have another question [crosstalk 00:33:59].

Sharad Kohli, MD, People's Community Clinic (FQHC) (33:59):

[crosstalk 00:33:59].

David Miller, MD, LAc, Amer Soc of Acupuncturists (34:01):

Few other connections, so we get a chance to chat.

Sharad Kohli, MD, People's Community Clinic (FQHC) (34:05):

Can I ask if maybe David or Mary, if you could try to help clarify what... I thought I heard with Dr. Ling's comment about the supervision. The supervision stated that there would need to be a physician or a billable Medicare practitioner, but is that someone who has trained in acupuncture, then?

David Miller, MD, LAc, Amer Soc of Acupuncturists (34:22):

Interestingly, it does not have to be someone trained in acupuncture. So, it would really just, I assume, be for providing, making sure everything's safe in some way, part of it comes down to the fact that licensed acupuncturist are not part of Medicare from the social security act, right.

So, they can only fit in under the auxiliary provider category, which demands supervision by statute.

Sharad Kohli, MD, People's Community Clinic (FQHC) (34:45):

Right. Because I heard, she said it must be directly available to provide assistance, but I didn't know what that actually meant, because for instance like if I'm supervising a pain program, for instance, in my clinic and we have an acupuncturist, would that suffice, for instance, versus me actually doing the medical acupuncture training or something like that? So that's a [crosstalk 00:35:07] question.

David Miller, MD, LAc, Amer Soc of Acupuncturists (35:08):

Yeah, no, I'm sure you don't need to be a provider of acupuncture, but how close you need to be on site or not onsite is open.

Mary Faria, AOMA Graduate School of Integrative Medicine (35:17):

And we've seen the same thing in Western medicine in programs like cardiac rehab, where you have to have a physician supervising the program and there's always been the question do they need to be right on site? Do they need to be... We're going to really have to look to some answers for this though, because I love the idea of, could you do it virtually, could a physician be with an acupuncturist with a patient virtually, so I'm hoping we can get those answers because the supervision can be a barrier.

Ariana Thompson-Lastad, PhD (35:55):

Yeah, that seems especially important in the context of COVID in tele-health where people might be providing care from home. And so, can their supervisor also be in a different location? I just want to point people's attention as well, to the chat, not the Q&A where people have shared a few different interesting things about an upcoming webinars related to acupuncture care in underserved communities and models of bundled payment, which I know is its own whole topic that we could probably discuss that another time. We need to wrap up, right Amy?

Amy Goldstein, Director, AACIPM (36:29):

Yes.

Ariana Thompson-Lastad, PhD (36:29):

Okay. Thank you all so much for taking the time to be part of this conversation and just want to acknowledge that of course, acupuncture is one of many different kinds of care that need to be provided together and separately, but we wanted to take some time to just zoom in, to have a more focused discussion on that piece.

David Miller, MD, LAc, Amer Soc of Acupuncturists (36:47):

Thank you.

Sharad Kohli, MD, People's Community Clinic (FQHC) (36:49):

Thank you.

Mary Faria, AOMA Graduate School of Integrative Medicine (36:50):

Yes, thank you very much.

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Amy Goldstein, Director, AACIPM (36:54):

Thanks to all of you. Thanks Ariana, for being a wonderful moderator and to all of you as panelists and presenters. And just as Ariana said, we keep saying this throughout the day, we are focused on a comprehensive approach to pain management, which includes all the evidence-based tools in the toolbox. And we are just diving deeper here in acupuncture, as she said, to really highlight some of the payer issues related to Medicare and et cetera, as we're looking at the underserved.