Issues in Coverage for Complementary and Alternative Medicine Services:

Report of the Clinician Workgroup on the Integration of Complementary and Alternative Medicine

The Environment Preceding the Clinician Workgroup on the Integration of Complementary and Alternative Medicine - CWIC

After years of escalating health care costs, the 1993 Washington State Legislature adopted, and the Governor signed, health care reforms to assure that consumers in Washington could buy health insurance even if they were sick or had changed jobs. Subsequently, the legislature passed a law[2] that prohibited insurers from limiting coverage for a pre-existing health condition for more than three months.

As part of the 1993 reforms, health care professionals sought legislation requiring insurers to include every qualified health care provider within their networks. Insurers were concerned that limiting their ability to select competent and effective providers could negatively impact quality and cost of care for their customers. As a compromise, the legislature required insurers to include every category of licensed health care provider in the health care networks (RCW 48.43.045),[3] with an original effective date of July 1, 1995, then re-codified with a new effective date of January 1, 1996. Appendix A includes relevant laws in Washington State. Appendix B lists professions regulated by the Washington State Department of Health.

The following year, the Legislature made significant changes to the reforms, repealing the requirement that mandates all employers provide health insurance. However, several provisions were maintained, including access to every category of licensed health care provider, the right to buy insurance even when one is sick, and permitting portability of coverage when a worker changes jobs or moves.

Beginning December 1996, Insurance Commissioner Deborah Senn convened public meetings with health care providers, insurers and consumers to discuss full implementation of the "every category of provider" provision of the health care reform law. Her goal was to clarify for providers, consumers, and insurers the expectations regarding the law's implementation. A series of legal challenges[4] followed which have helped clarify the degree coverage is available and in which types of plans. RCW 48.43.045 represents the first legislative mandate in the United States to require insurers include access to every category of provider in all health care plans.

Concurrent with the legal process, the Office of Insurance Commissioner (OIC) proposed that constructive discussion between insurers and providers outside of the adversarial political and legal arenas be pursued regarding coverage and integration of "complementary and alternative medicine" (CAM) services. A forum was established with representatives from all parties involved in the legal challenges.

[2] RCW 48.43.025 (1) Preexisting conditions.

[3] RCW 48.43.045 (1): Every health plan delivered, issued for delivery, or renewed by a health carrier on and after January 1, 1996, shall: Permit every category of health care provider to provide health services or care *for conditions included in the basic health plan* services to the extent that: (a) The provision of such health services or care is within the health care providers' permitted scope of practice; and (b) The providers agree to abide by the standards related to: Provision, utilization review, and cost containment of health services; Management and administrative procedures; and provision of cost effective and clinically efficacious health services.

[4] See "Factual Chronology of Legal Events" in Appendix C.

Multidisciplinary representation was sought and discussion was focused on the issues that made CAM coverage decisions so challenging.

Although labels can be limiting, the term CAM has been adopted for this document to characterize some of the professions licensed in the State of Washington that are subject to inclusion under the every category of provider law. Specifically, CAM refers to all health care professions that are regulated in the state and, within their scopes of practice, may care for patients with conditions that are covered by the Washington State Basic Health Plan (BHP),[5] that have not previously been reimbursable, or have experienced limited reimbursement under insurance benefits. It is fully recognized that some of the professions included in this work group do not consider themselves to be "complementary and/or alternative." Some of the included professions function in primary care roles and/or are providing services that are commonly incorporated within current conventional medical practice. In like manner, for the purposes of this report, the term "conventional medicine" (CM) is used to refer to allopathic and osteopathic (MD/DO) providers and their care generally. Again it is fully recognized that other professions, such as MD's and DO's, may function as and/or provide services that can be considered complementary and alternative.

January 1997: Formal discussions convened by OIC staff and legal counsel with CAM providers and carrier attorneys to discuss coverage options.
February 1997: OIC conception of workgroup for clinicians.
March 1997: Outside facilitation sought by OIC to plan first meeting of clinicians.
May 1997: First facilitated meeting of carrier and CAM clinicians.
October 1997: Review of facilitator proposal for 1998 plan of Clinician Workgroup on the Integration of CAM (CWIC). Agreement between parties to remove legal counsel from integration discussions.

Formation of the Clinician Workgroup on the Integration of CAM

In an effort to discuss the issues of CAM integration into the conventional medical health care system without the threat of legal challenges, the OIC reached an agreement with carrier attorneys that discussions could take place with their medical directors about outcomes studies, clinical protocols, and other clinically related subjects. The discussions would not create binding decisions by any of the parties and would be facilitated by outsiders who had expertise in the CAM environment. John Weeks[6] and Lawrence Jacobson[7] were identified as facilitators for the project. Initial facilitation was paid for by the OIC to begin the discussions and to decide if there was further work to be done in a collaborative way.

In the first meeting of the clinicians, all parties agreed that a great deal of constructive work could be accomplished. This led to an "agreement" of all parties that legal counsel should be removed from the discussions to allow a safe environment to develop without barriers to in-depth discussions.

The development of a collaborative and respectful environment within the workgroup was considered key to successful working relationships and discussion of potentially difficult situations. Hence outside facilitation

[5] For a definition of the Basic Health Plan, refer to RCW 70.47

[6] John Weeks is the Publisher-Editor of *THE INTEGRATOR for the Business of Alternative Medicine*, one of the nation's most authoritative publications on the business of alternative medicine, and is a widely respected national consultant on integration. His clients have included HMOs, health systems, provider organizations and government agencies at all levels, including a role as chair of the alternative medicine track for the National Managed Health Care Congress and has an ongoing relationship with Health Forum/American Hospital Association on their CAM initiatives. His experience from 1983-1993 as Vice President for External Affairs at Bastyr University, as a board member of the American Herbal Products Association, and as Executive Director for the American Association of Naturopathic Physicians has allowed him to bring an intimate understanding of alternative care approaches to the table. Weeks writes and presents widely in the peer-reviewed and industry press. Of particular significance to his involvement with CWIC is his expertise in strategic planning and problem-solving. His contributions to practical implementation and process assured that a potentially adversarial environment developed into a meaningful and constructive workgroup.

[7] Lawrence M. Jacobson , MSW, MPH, is founder of Managed Healthcare Resources Northwest. He has 23 years experience in health care managerial positions, experience in facilitation of provider-payer relationships for the purpose of optimizing care, service and delivery effectiveness, and the development of win-win strategies among diverse groups of healthcare constituencies. Jacobson has served as senior contract administrator for a major southern California HMO, has done numerous strategic planning projects for hospital and physician organizations and has developed three behavioral health networks. His experience in developing CAM networks for insurers in Washington State and his experience with market research and customer satisfaction assessment ideally positioned him to serve as co-facilitator of CWIC. His past experience as Director of Managed Care for the Washington Health Foundation and as Medical Services Contract Manager for Pacific Medical Center and Clinics contributed unique insight to both payer and delivery issues essential to the success of CWIC's effort.

would require both background and experience of interpersonal skills and specific expertise in the area of the CAM environment. The two facilitators, each had recognized competence and experience within the CAM community, as well as strong understanding of issues in managed care, health plan development and marketing. The facilitators invested their time and personal relationships with providers of all categories to be certain that the participants would be committed to the process. Since each of the facilitators had different backgrounds, the workgroup participants were diverse, yet devoted to the investigation of CAM integration into a conventional medical health insurance system. The use of their pre-existing relationships in the CAM and CM communities was helpful in creating a collegial environment for discussion.

An OIC health policy staff representative met with provider groups to identify those categories that would be most affected by this law. A series of informal discussions with health care practitioners helped identify those considered CAM, licensed by the Department of Health, and caring for patients with conditions covered by the Basic Health Plan. Simultaneously, facilitators conducted face-to-face and telephone interviews with potential participants to further refine issues of interest and concern.

Sensitivity to the somewhat adversarial and skeptical nature of the environment was high on the part of the organizers. As a result, several strategies were employed to encourage communication and understanding. For example, seating arrangements that fostered exchange, representation and proximity of the various conventional and CAM participants was used and potential participants were interviewed ahead of time. This, along with other small group processes, supported positive interaction and new relationships. Thus, when discussions and decisions occurred, participants were made aware of those who might be missing. Over time, more mutual understanding occurred, many tensions were defused, and trust was fostered. The need for assigned seating became unnecessary by the second year, as the group had much greater appreciation of the perspectives of all parties.

A pivotal point in the workgroup activities was the use of community organizing methods originally proposed by John Weeks, facilitator, and Richard Layton, MD, Medalia Health Care.[8] This theme led to the acceptance of the facilitator's proposal of activities for 1998.

The purpose of CWIC was to develop constructive working relationships between health insurance companies, provider-based systems, and complementary and alternative health care provider communities within the new regulatory framework presented by RCW 48.43.045. The expectation of the organizers was that this could be accomplished through communication leading to education, mutual respect, and understanding of the issues of importance to each participant. Criteria for participation in the work group included the requirement that representatives to CWIC must be health care providers, with the exception of the outside facilitators. As a result, the group was able to maintain a clinical focus rather than a legal one. Outside facilitation was used to assure non-alignment with providers, payers, or regulators and to help maintain the focus on issues of multidisciplinary cooperation, availability of legally allowed services to the consumer, and coverage issues appropriate to respective scopes of practice.

Careful consideration was also given to balanced representation by providers of associations and insurers, as well as the professional affiliations and credentials of the participants. An OIC health policy staff representative was assigned as an equal participant in the workgroup itself and accepted responsibility to coordinate and schedule meetings. Because outside facilitation required funding, an ad-hoc steering committee recommended to the committee of the whole that costs be equitably borne by each participating organization. A sliding scale, based on organization size, was adopted. However, it was decided that no organization would be excluded because of financial constraints. In addition, "in-kind" support was provided for meeting sites by some of the participants. Every effort was made to make the experience a collaborative one and to preclude alienation or loss of ground already gained. A limited amount of staff time and resource support was also provided by the OIC.

A planning committee was established by the group, which included one member from each type of organization, the facilitators, and the OIC representative. For obvious reasons, the early development of the workgroup and the planning committee necessitated adherence to maintaining balanced representation and the participants went to great lengths to not exclude or ignore needs, perspectives and opinions from any participant. Over time, relationships evolved so constructively that the need to account for each participant group became unnecessary.

Unfortunately, some groups were unable to participate consistently. Most of the conventional medical providers were insurers' medical director representatives. There were other CM representatives present at different times, but very few participated consistently in the meetings. From a practicing conventional medicine perspective, there was minimal significant input.

[8] Weeks J, Layton R. Integration as community organizing: Toward a model for optimizing relationships between networks of conventional and alternative providers. Integrative Med. 1998; 1(1): pp. 15-25, 1998

1998 CWIC Activities

An aggressive agenda for 1998 was developed by the facilitators and presented to the group for consideration. Topics were refined, modified and prioritized by the group. The agenda addressed coverage decisions, technology assessment, medical necessity, collecting data and the gathering of literature on costs and practices, wellness versus condition care, and integration of CAM services, among others. A variety of strategies for exploration were adopted, ranging from didactic presentations by outside experts or group participants, workshops and training, literature and survey research, group discussion, and/or facilitated decision-making. For obvious logistical and efficiency reasons, experts within Washington State were used. CWIC Meetings in 1998 were as follows:

January 1998: Inventory of existing standards for CAM practices
February 1998: Status of coverage and use of CAM services by carriers and physician groups
April 1998: Carrier procedures for technology assessment, medical necessity determinations, and coverage decisions
May 1998: Survey of CAM patients' views of perceived benefits
July 1998: Clinical guideline training
September 1998: CAM as add-on versus replacement of conventional care in high cost conditions
November 1998: CAM integration into conventional delivery settings

Inventory of Existing Standards for CAM Practices

- **facilitated group discussion and information collection**

The participating CAM provider groups obtained information regarding current standards for their services, including codes of ethics, peer review procedures, managed care committee activities, quality assurance and improvement programs, practice standards, clinical documentation standards, educational programs on standards, and clinical practice guidelines. A summary matrix provided in Appendix E indicates what standards were identified by the participants as of 1998.

The facilitators developed a survey to examine current practices regarding incorporation of CAM providers within the participating payer infrastructures. They also collected information from participants regarding providers' willingness to be observed by those with an interest in learning more about their practices. In addition, information regarding interest in participating in small group education exchanges was assessed. Participants' responses collected in 1998 are included in Appendix F.

Status of Existing Carrier Coverage for CAM Services, PCP Discussion

- **facilitated group discussion and information collection**
- **presentations by CM primary care providers and group discussion**

The facilitators collected information regarding the existing degree of participation and inclusion of CAM services within the carriers' existing programs. Processes and infrastructures for making CAM coverage decisions were identified. Responses from CM physician organizations and carriers can be found in Appendix G.

The facilitators and workgroup participants were able to identify a small group of CM primary care providers (PCPs) who would meet with the group to discuss communication and facilitate an understanding of PCP needs regarding potential relationships with CAM providers. This meeting identified core issues regarding relationships between CM primary care providers and CAM providers. James Bender, MD, Virginia Mason, gave an overview of Virginia Mason's managed care

program and emphasized the need for more information regarding specific CAM standards, better understanding of managed care systems by CAM providers, and the need for better self-regulation on the part of the CAM community. Better information between provider types concerning what interventions were risky or inappropriate under which clinical circumstances was suggested.

There was also ongoing discussion of the development of an educational program to support the group's desire to expand communication on better integration of CAM within the greater health care delivery system. There was recognition of the growth of "at-risk" and capitated primary care groups' use of a gatekeeper model to manage specialty and out-of-plan referrals. One local carrier, and some other plans, were incorporating naturopathic physicians as primary care providers who met basic availability and credentialing requirements.

Technology Assessment, Medical Necessity, and Coverage Decisions

-presentations by carrier participants
-facilitated group discussion

Presentations regarding the issues and processes associated with carriers' determinations of medical necessity and coverage decisions were made. Carriers and physician groups described their approaches and distinct needs in arriving at coverage decisions. Each insurer and physician group presented a general overview about how they approach determining medical necessity, how they perform or obtain technology assessments, and their processes for utilization review and management. The majority of carriers reported using the National Committee on Quality Assurance (NCQA) or Utilization Review Accreditation Commission (now titled American Accreditation and Health Care Commission/URAC) standards when credentialing providers. These standards also influence many of the carrier's approaches regarding which services and provider types are reimbursed.

Discussion from provider participants encouraged incorporating the use of CAM providers into their decision-making processes. Medical necessity and coverage decisions regarding CAM services should involve professionals that are trained in their respective disciplines in order to arrive at accurate and fair determinations, particularly as they relate to practice context, philosophy, and scope.

Discussion also occurred regarding distinctions between holistic health care approaches within the CAM communities, compared to the condition-based care paradigm of conventional medicine. Some CAM participants suggested that consideration be given to the ways consumers use CAM services to "create health." An issue arose regarding the variation in practice philosophies among the CAM professions as well as differences from conventional medical professions.

As an example, for an acupuncturist, medical necessity is informed by a different medical paradigm than that of CM. It is based on the balance of energy, known as qi (pronounced "chi") flowing through "meridians" or channels in the body. Thus, an acupuncturist may identify a condition of "imbalance" which warrants their intervention, though to a CM practitioner, the patient may appear outwardly healthy and without identifiable clinical signs or symptoms.

Although resolution was not reached, an understanding was conveyed regarding the fundamental basis of a conventional, insurance and health care paradigm contractually implemented and priced on condition-based utilization, prevalence, and clinical progress determinations. In addition, more clarity was conveyed regarding the range of alternative health care services that make care determinations and utilization decisions based on factors deemed useful within a holistic and wellness-based paradigm. One presenting review organization also indicated that CAM providers may need further understanding of the CM billing and utilization requirements.

Survey of CAM Patients' Views of Perceived Benefits

-development of survey for participant CAM providers' patients
- facilitated group discussion

Given the lack of an extensive research infrastructure that could evaluate CAM coverage and referral decisions, discussion occurred regarding focused consumer surveys to obtain patient self-report information. Because of the limits on time, personnel resources and funding, the group decided after some debate not to do a targeted consumer survey and instead reviewed some pilots done previously. In two cases reviewed, sample sizes were small and there was a great deal of discussion about the underlying reasons why consumers may choose CAM services and not tell their CM providers. These include wanting more attention and time, seeking more control over their care, broader, more participatory care options, and less use of pharmaceuticals and surgery as first options. Key literature is identified in the list of resources.

Discussion also occurred regarding how capturing utilization data from insurers and providers might be accomplished. The need for such information was emphasized as a component of making better coverage decisions in the future. The value for informing the conventional delivery systems and providers on the more appropriate use of CAM services was also shared.

Clinical Guideline Training by Matthew R. Handley, MD

A special training session open to all participants, but geared specifically toward CAM providers, was offered on development of practice guidelines. Early in the formation of CWIC, it became apparent that the language and needs of the conventional delivery and reimbursement system differed in several ways from that of CAM providers. A clear challenge was identified in clarifying clinical decisions regarding interventions and appropriateness in terms of conditions and outcomes used to drive coverage decisions. Although potential misuse of practice guidelines by either payers or providers continues to lead to controversy, the usefulness of written delineation of clinical considerations, thresholds, and their relationship to patient presentation was understood. It was decided that training in guideline development, including consideration of scientific evidence, clinical practice issues, and building consensus was appropriate for the group.

Matthew R. Handley, MD, Associate Director, Provider Education and Guideline Development and a family practitioner from Group Health Cooperative, presented a half-day workshop identifying the pros, cons, challenges and initial steps in guideline development. [9] Of particular relevance to CWIC was his recognition of and emphasis on the need to involve physicians and providers within the communities expected to use guidelines in their development. Much of Dr. Handley's guideline work has centered on complex and multi-factorial conditions such as hyperlipidemia and psychosocial factors of chronic disorders. Issues surrounding the evidence-basis for such conditions are similar to those associated with many of the models of interest to the CAM community, thus providing a good fit for the group.

In addition to technical and logistical insight to writing guidelines, the training emphasized their appropriate use by providers and offered tactics to assist in dealing with misuse or misrepresentation by non-providers. Strategies were discussed for incorporating input from not only the scientific literature and experts, but also with involvement and refinement by providers on the front lines, using them as a resource. Well-done guidelines can be helpful by synthesizing large volumes of scientific data into an understandable format. The ideal of guideline development is to help providers and patients better understand the care options available. Given the volumes of new scientific literature, and the pace of technology development in health care these days, guidelines can be an efficient way of identifying and synthesizing information into a reasonably manageable form. The importance of using systematic approaches to reviewing literature and incorporating and reconciling gaps between science and practice was emphasized. Implementation of guidelines should include opportunities for evaluation and refinement. In this way they can assist in continuous quality improvement to reduce variation in service delivery and outcomes.

[9] Dr. Handley has most recently been involved with the National Health Committee Guidelines Program of New Zealand to develop guidelines and criteria regarding recognition of "psychosocial yellow flags" associated with chronic low back pain sufferers. His expertise in developing and utilizing evidence-based guidelines is recognized worldwide. In addition to his contribution to guideline development, Dr. Handley has extensive clinical experience in family practice and sports medicine, so insight from the practitioner perspective balanced his managed care experience very well.

CAM as Add-on Versus Replacement to Conventional Care in High-cost Conditions

- **participant presentation**
- **facilitated group discussion**

Participating CAM providers presented information regarding one to three conditions for each discipline where CAM services appear to be effective. The purpose of this exercise was to describe treatment options that could be offered and provide information regarding the general cost associated with that care. Though the group agreed that professionally-approved practice guidelines did not yet exist for some of these conditions, presentations were made by midwives, naturopathic physicians, registered dietitians, chiropractors, and acupuncturists on conditions for which they have extensive experience and track records on cost-efficient treatment options available.

The CAM providers also requested information from payers regarding how their provider members might work more closely with PCPs and insurers when considering cost-effective options. Conditions such as chronic low back pain that may be conventionally treated with medication and rehabilitation might be equally efficient to treat with manipulation and/or myofascial work. Other examples such as; pain management in labor protocols by licensed midwives, otitis media treatment and prevention by naturopathic physicians, headache treatment by acupuncturists and tendonitis treatment by massage therapists, may prove to be cost effective or cost neutral, may lower side effects and risk, or simply provide patient choice. It was suggested that opportunities to work together on specific conditions might be pursued through research and outside the workgroup.

CAM Integration Into Conventional Delivery Settings

- facilitated group discussion

This discussion addressed some of the fundamental issues regarding the opportunities and barriers that currently exist to enhance coverage of CAM services within already existing benefits structures. The core issue most challenging to address is related to paradigm differences between the dominant condition-based health care delivery and financing system, and the holistic model of disease prevention and treatment, and wellness that are employed by CAM providers. There was a general agreement on the need to encourage more of a holistic health, and wellness, orientation into the existing health care system. Many of the CAM participants expressed their ability to contribute to this effort and inquired about what they could do to help facilitate it. Discussion regarding greater incorporation of prevention strategies and early identification of disease, with the potential to increase efficiency of medical delivery, occurred with CAM providers expressing that enhanced access to their services could potentially strengthen their disease management designs.

The session focused on interfacing with the conventional system. Peter West, MD, Premera Blue Cross, presented an overview of the condition/disease-based management program upon which insurers base their rate and premium structure, and as a result, their coverage decisions. The presentation provided examples of their programs focused on diabetes and cardiac disease, emphasizing that these programs were geared to more efficiently coordinate care rather than limit it. Similar approaches are used for other populations with similar illnesses. A core question was posed, given the organization of the existing insurance system: What services provided by CAM providers could be reimbursable under the existing condition-based model? This helped prioritize work on draft seed algorithm development by the CAM representatives for the 1999 agenda.

1999 CWIC Activities

1999 CWIC Activities

The second full year of CWIC meetings were directed primarily along two directions: exploration of existing successful integrated CAM/CM practices and development of draft clinical care pathways, algorithms, and protocols by participant CAM organizations. Participants, facilitators, and OIC staff worked to identify and invite representatives from numerous integrated clinics to present their approaches and experiences to the group. Presentations were scheduled throughout the year's meetings. In addition, dedicated effort was made to train participant representatives in written clinical care pathway development. Training was aimed at using both evidence review, as well as expert and community-based consensus development, to draft written protocols in a way that non-CAM providers could understand.

In addition, discussion and planning on potential future opportunities for the group was undertaken. One task identified in 1998, the exploration of the role CAM could play in high cost conditions, was abandoned for the year, due to inadequate and non-standard availability of actuarial claims data from the carriers. It was recognized that this topic remains important, but it will clearly require adequately funded health services research activity in order to be meaningful. As a result, and based on the recognition of the need for enhancing CAM research in numerous areas, the group directed the planning committee to explore potential future research activity in greater depth. Large group meeting agendas for the year included:

April 1999: Multidisciplinary clinic presentations (Seattle Cancer Treatment Centers of America, Center for Comprehensive Care, Seattle Healing Arts); discussion on insurable practices.
April 1999: Clinical care pathway and algorithm training.
June 1999: Multidisciplinary clinic presentations (Harborview Medical Center, Swedish Hospital Dean Ornish Cardiac Rehabilitation Program); CAM practices survey project presentation; discussion on high cost conditions.
June 1999: Research planning meeting with University of Washington and Bastyr University researchers interested in CAM; presentations from Bastyr University, University of Washington and CWIC participants.
September 1999: Multidisciplinary clinic presentations (Community Health Center King County); presentation of draft algorithms by participants.
October 1999: Multidisciplinary clinic presentations (Puget Sound Birth Center); presentations of draft algorithms by participants.
November 1999: Conclusion and summary of CWIC experience, review of material and information for inclusion in final report, and presentation by Deborah Senn, Insurance Commissioner.

Exploration of Approaches Used by Existing Integrated CAM/CM Clinics.

- **presentation by representatives from facilities throughout Puget Sound**
- **multidisciplinary clinic questionnaires**
- **facilitated group discussion at multiple meetings**

While planning the 1999 activities for the workgroup it was agreed that understanding how integrated clinics operate would be of benefit. The planning committee identified several clinics that marketed themselves as integrated or were known in the health care community for using a multidisciplinary approach. In order to help standardize the information participants were most interested in, each presenter was asked to fill out a survey developed by the group, highlighting key attributes of their clinical setting. Among the attributes for which information was requested were: focus of the clinic, patient triage protocols to and from CAM providers, inventory of provider types on staff, characteristics of

interdisciplinary communication at the facility and any available information about outcomes and satisfaction. In addition, information about reimbursement for CAM services and general acceptance of the CAM providers' work within the CM community was requested. This process resulted in development of a questionnaire and involved expert presentations by integrated clinic practitioners. Summaries of their responses can be found in Appendix H.

The presentations demonstrated that there are many ways to run an integrated clinic, and that no particular strategy seems to stand out as "the" most successful practice model. All but one of the clinics (a licensed birth center) had at least four different types of providers on the premises, whether or not they were either subcontractors or employees of the clinic. Several of the clinics indicated that low levels of reimbursement for CAM services were an issue, and that often reimbursement was delayed compared to reimbursement for CM services. Each presenting clinic indicated that there had been initial resistance from the conventional medical community and that resistance decreased as familiarity and communication increased. Most clinics also indicated that they had received referrals that were treatment failures of both CM and CAM interventions. Some presenters indicated that an integrated approach contributed to higher satisfaction on the part of patients and appeared to have enhanced successful outcomes from care. One presenter suggested that patients who do not respond within the standard modality time frames and exceed the ability of the third party payer to continue reimbursement could also be considered a failure of the system overall.

The presentations and questionnaires provided by the multidisciplinary clinics during 1999 were valuable. Care models presented concerning service delivery, effectiveness and gaps in coverage. This helped lay the groundwork for further study and for developing models of integrated care delivery. The presentations also clarified significance of integration across a range of provider types within the community.

Clinical Care Pathway and Algorithm Training by Robert D. Mootz, DC

- **in-service workshop training**
- **follow-up presentations and discussion by group**

Based on the 1998 discussions between carriers and CAM participants, it became clear that a fundamental requirement for understanding of CAM services would be the development of written care protocols. In recent years, clinical practice guidelines have grown in number and quality for conventional medical services. However, practice guidelines remain controversial and offer multiple challenges. In an ideal setting, guidelines should help providers and patients synthesize extensive amounts of scientific data and expert opinion into concise, meaningful protocols that can help patients and providers sort through various options in order to make the most informed decisions about how to proceed.

In reality, practice guidelines are subject to the limitations of evidence and human nature. Unscrupulous or ill-informed end users (be they payers or providers) can misuse or misrepresent a guideline's purpose, intent, or value. Guideline quality can also be highly variable. Recognizing these concerns, the group sought training to better understand the nature, strengths, and limitations of guideline and care pathway development. During the 1998 training, Matt Handley, MD presented methods for developing guidelines as well as steps to take in creating them for conditions addressed by CAM providers. Dr. Handley described purposes of clinical guidelines and how they differ from other types of guidelines. He described the importance of individual professions and disciplines being involved in developing their own guidelines. Dr. Handley also offered insight into who should be involved in the process and who should not. He also helped set the stage for developing strategies for sorting through vast amounts of information and working with groups to obtain consensus. Since the large size of the 1998 agenda precluded the ability to develop specific care protocols for CAM services, the group set this task as a 1999 priority. Specific disclaimer language can be found in Appendix I.

Robert D. Mootz, DC, Associate Medical Director for Chiropractic at the Washington State Department of Labor and Industries[10] provided a day-long workshop on care pathway and algorithm development. The session aimed to develop skills in writing condition-specific care pathways and clinical algorithms. Participants were provided with an extensive collection of published literature and numerous examples of such pathways and algorithms for both CAM and CM procedures. The group was also taken through decision-tree logic and worked through examples of algorithm writing. Because the health paradigm under which CAM providers function may differ from CM perspectives, the concept of insurable and reimbursable services described by carrier representatives in 1998 was expanded upon. An approach taken by the group was to consider initial care pathway

[10] Dr. Mootz is a chiropractic physician now working in a fulltime government health policy and research capacity and is editor of a clinical journal, *Topics in Clinical Chiropractic*, focused on the publication of clinical care pathways. He has been involved in several guideline and care pathway development efforts and served on the faculty of the Institute for Healthcare Improvement multidisciplinary training of large clinics, hospitals and employer groups to use continuous quality improvement methods to enhance patient outcomes.

development exercises to focus on "insurable practice descriptions" rather than "guidelines." Dr. Mootz encouraged the group to identify which services might interface with the clinical thresholds payers need to make reimbursement decisions. The importance of writing them in such a way that the respective disciplines philosophic basis would not be undermined was emphasized by all.

In addition, specific emphasis was given to developing disclaimers for specific work to help keep care pathways and guidelines in their proper clinical context. The importance of developing guidelines in a way that informs patients and providers about the options and decisions to be made was emphasized. Participants were cautioned against simply writing them "defensively," e.g., for the singular purpose of meeting a payer's actuarial need or to counter coverage decisions providers disagree with. Unless care pathways accurately reflect meaningful clinical decisions, they are more likely to be subject to misinterpretation or misuse.

Algorithm Presentations by CAM Providers[11]

This training set the stage for participants to establish workgroups, or engage in existing workgroups, within their respective disciplines to draft seed pathways to share with group at year's end. The presentations by the professions reflected a great amount of work and led to a much clearer articulation of the services and clinical rationales described. During the presentations, substantial constructive feedback occurred and this exercise contributed to a great deal of learning.

Not only did many of the medical directors with the carriers express their respect for the work, but the workgroups involved in the process communicated the intrinsic value of explicitly delineating the thought processes they go through in making clinical decisions.

The issue of the paradigm differences was often raised by the CWIC participants and has been commented on throughout the report. Using tools from the guideline training, and with a better understanding of the constraints under which carriers must function, the CAM professions were able to better delineate how their various paradigms impact clinical decision-making.

Some participants indicated that clinical steps in practice guidelines can reflect uniqueness of their practice philosophy, and ways of approaching this should be explored. Practice guideline development is a common tool that can facilitate improved communication between CAM and CM providers and carriers concerning clinical issues and activities within the context of respective paradigms.

Development of useable guidelines is time and resource intensive. Carriers observed an array of strategies for condition management used by different types of CAM providers when the CAM professions presented their draft condition-specific algorithm.

The experience was considered to be very useful and many CAM provider representatives indicated there is interest within their organizations and institutions in further refinement of these pathways and development of additional ones. Examples of the "insurable service descriptions" drafted in 1999 are included in Appendix I. It needs to be emphasized that these are presented for educational and illustrative value in this report. These algorithms are presented in draft form and should not be considered as definitive clinical management protocols endorsed by the CWIC, the OIC, or any of the CWIC participants and their respective organizations. None of the draft seed algorithms included in this report have been approved by any association, educational institution, or other professional societies or organizations.

Research Interests of the CWIC

When the CWIC was first established there was an expectation that research needs would be identified. By 1999, the group had identified a substantial number of research interests and had begun to initiate dialogue with various investigators involved in CAM research. Daniel C. Cherkin, PhD, Associate Director, Internal, Senior Scientific Investigator at the Center for Health Studies at Group Health Cooperative of Puget Sound, presented a preliminary report of the progress of a survey being conducted on selected CAM providers.[12]

He reported on a CAM provider survey project being done in collaboration with CAM providers, including investigators and consultants who are members of CWIC. Surveys similar in design to those used in the National Ambulatory Medical Care Survey were developed for acupuncture, massage, chiropractic, and naturopathic medical practices in several representative states around the country. The surveys obtained information from providers immediately following patient visits about patient condition, clinical evaluation and interventions used, communication and referral. The unique feature of

[11] Presenters of each profession are identified by an asterisk (*) next to their name in the participant acknowledgements pages iii and iv.

[12] Dr. Cherkin is a noted health services researcher who is responsible for numerous projects including the federally-funded Back Pain Outcomes Assessment Team, and has co-edited a US government report on chiropractic. He has also been an investigator on clinical trials examining chiropractic outcomes and is currently studying outcomes of care for low back pain comparing "usual care", chiropractic, acupuncture, and massage approaches. He is well-known for his work on patient satisfaction.

this work is it is collecting detailed information from four kinds of CAM providers about decisions and procedures used on patients at the time the provider is actually performing them.

Dr. Cherkin shared some early preliminary findings with the group and indicated that the project will be fully analyzed with completed reports sometime in the year 2000. The work was expected to be of value by the respective CAM provider groups in order to inventory what is being done in the field.

A separate meeting was held with research scientists from the University of Washington (UW) and Bastyr University that either had CAM research in progress, or who had an interest in CAM research. Presentations included a wide variety of research projects currently underway, such as the use of pulsed magnetic therapy for multiple sclerosis and the use of herbs for menopause. The meeting drew a great deal of participation and provided some framework for what could be done. Subsequent meetings identified potential funding opportunities with potential principal investigators from the UW and Bastyr, as well as to consider existing research underway. Although the CWIC as an entity itself would not be a source or recipient of CAM research funding, it represents a unique vehicle for communication and collaboration between providers, purchasers, and regulators within the health care industry. It was felt that the dynamics, work products and relationships established during the three-year project could be harnessed for future work. Consideration of further collaborations and research agenda identification continues by the participants.

Conclusion and Summary of the CWIC Experience

- review of material and information for inclusion in final report

-presentation by Washington State Insurance Commissioner Deborah Senn

During the last scheduled meeting of the CWIC time was scheduled to review the group's activities and accomplishments, identify specific value attained from the project, and explore next steps. The group established writing and editing committees to work with the OIC staff and facilitator to prepare the final report and recommendations. Insurance Commissioner Deborah Senn attended to express her appreciation for the collegial and collaborative nature of the group and its hard, principally volunteer work. She indicated that the group had achieved the objectives she had set. The Commissioner also commented that the communication and partnership established in the project was on the cutting edge in the industry. She also indicated that no decisions have been made on further involvement of the OIC on future work with CWIC but that more discussion would be forthcoming based on the requests of the members and needs of the community.