
ORIGINAL RESEARCH

INTEGRATION AS COMMUNITY ORGANIZING: TOWARD A MODEL FOR OPTIMIZING RELATIONSHIPS BETWEEN NETWORKS OF CONVENTIONAL AND ALTERNATIVE PROVIDERS

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The leading model for integrating complementary and alternative medicine (CAM) providers and services into health care delivery and benefits plans is through contracted networks of credentialed CAM providers. The CAM benefit is usually offered for an additional fee (an insurance “rider”) with management frequently contracted (“carved out”) to an independent specialty management firm. This model, viewed by many plans as a relatively risk-free method for entering the CAM arena, is principally market or consumer driven. The authors suggest that the incentives in this model work against both integrating CAM providers into basic service delivery and in gaining an understanding of the optimal role of CAM in the broader health care system, particularly regarding questions of effectiveness, cost-effectiveness, and appropriate referral patterns to and from conventionally trained physicians. The authors share a practical, network-oriented CAM integration strategy that was developed in 1996–1997 for a multi-clinic primary care organization servicing numerous insurance contracts, each of which included benefits provided by credentialed networks of acupuncturists, chiropractors, naturopaths, massage practitioners, and midwives. The strategy focuses on what the authors call “community organizing”: determining specific interests of the providers then building, based on the “grassroots” of physicians interest, an integration strategy. The use of interactive workshops and provider surveys, as well as outcomes, are described, together with a prospective workplan for an implementation of this integration approach. An information-gathering strategy based on what the authors call “compiling observation” is then presented as a means to gain some useful, initial understanding of questions relative to the patient satisfaction, effectiveness and cost-effectiveness of CAM integration, in this context in which more thorough data on CAM interventions may not be available. (Int Med 1998;1:15–25) © 1998 Elsevier Science Inc.

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Health plans in the United States show increasing interest in offering complementary and alternative medicine (CAM) products and services. Various motivations influence health plan decision-makers. These

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may include perceptions that health care may be more effective and cost-effective with appropriate integration of CAM into their service delivery.¹ Other executives of plans exploring these services suggest that the integration process may be part of the broader system’s movement toward health promotion.²

¹The monthly newsletter, *Alternative Medicine Integration and Coverage*, John Weeks, Executive Editor (St. Anthony Publishing, Reston, VA), documents such interest in most issues. Also see: Stern D. Fringe benefits: insurers begin covering alternative medicine. *LAN Magazine*, September 1997, page 104.

²Stern D. The building blocks of a complementary medicine program. *Healthplan*, January–February 1998;39(1):63–68.

Observers of integration activity, however, agree that the driver of this process is the consumer. One leader of a CAM initiative with a large national health system put it this way: "This [CAM] is not going away. People are saying it works. It's not a fad."³ As such, CAM integration in many leading plans is market-driven. A CEO of a Connecticut-based plan with a visible involvement in the field stated this case for developing CAM products succinctly: "You disregard the consumer at your peril."⁴

In this context in which the principal motivation for the health plan is to reach out to consumers to gain market advantage, development of the CAM product may not be structured around considerations of effectiveness, cost-effectiveness or optimal integration. Instead, one sees some or all of the following characteristics in the mainstream organization:

- *Lack of internal competency in CAM.* The plan decides to contract with an external network of CAM providers because it does not believe it has the internal competency to either deliver or manage the CAM services.⁵ Management is therefore exported to a specialty provider network that may do any or all of the following: credential, contract, bill, communicate, educate, set, and manage utilization guidelines.
- *Fear about assuming risk.* The role of the actuary in this moment of CAM integration is, of necessity, to "take a leap of faith."⁶ Utilization data are not available on which to make informed estimates about how much the CAM benefit will cost or if it will cost the system more than conventional care. The purchaser is therefore charged an additional amount, known in the industry as a "rider." If the plan contracts with an external network, this risk is frequently passed directly through to the external group, after an administrative fee is typically sliced off the total paid.
- *Desire to avoid confrontation.* Health plans may assume that their members will want direct access to CAM providers without the awkward step of gaining referral from a conventionally oriented physician who may know little about CAM and, in fact, have biases against CAM. A rider in which a member has direct access to CAM providers limits communication, and thus confrontation,

³"Columbia HCA Establishes CAM Task Force" in *Alternative Medicine Integration and Coverage* (St. Anthony Publishing, Reston, VA), September 1997, p. 4. Also Blecher M.B. Gold in *goldenseal. Hosp Health Netw*, October 20, 1997, p. 50.

⁴Lagnado L. Oxford to create alternative medicine network. *The Wall Street Journal* 1996. Oct. 7.

⁵Most outspoken on this point are executives with Blue Cross of Washington and Alaska who have stated, in numerous presentations, that a lack of competency was a major factor in their decision to contract with an outside network of acupuncturists, naturopaths, and massage practitioners under the Washington state "every category of provider" mandate in January 1996.

⁶Mathy, Sandra, then vice president, American Medical Security, in a panel discussion entitled "Build or Buy Strategies for Complementary Networks" at a conference entitled *Integrating Complementary and Alternative Medicine into Managed Care*. Institute for International Research, October 7, 1996.

between members and their physicians. The health plan may also save itself from pushing additional responsibilities on what may be viewed as a reluctant conventional provider group.

Although an economic, systemic, and even emotional logic is evident in the strategy of offering CAM through an external network or a rider, understanding of optimal integration may suffer from this choice. Table 1 looks at the disincentives to developing and understanding optimal integration that may be prompted in differing strategies for externalizing or exploring the CAM benefit. Just as certain chronic disease pathologies are determined in the presence of a cluster among a list of symptoms, so may the CAM integration process with too many of these characteristics be deemed chronically unhealthy.⁷ Motivation to look beyond mere issues of consumer or member interest, and of marketplace forces, may be suppressed by this reactive CAM strategy. Deeper systemic issues of cost, cost-effectiveness, and the ultimate role for CAM providers and therapies in health care delivery in the United States may be obscured.

The integration strategy described here does not question whether the CAM network is an effective way to integrate CAM providers and services into health care delivery. Rather, this delivery approach is accepted as an important structural element in U.S. Health care.⁸ The challenge, given this context, is to create a working model that maximizes understanding of the optimal role of CAM networks in health care delivery. Such an approach would mediate against the structural disincentives to understanding appropriate integration in the customary network model, while at the same time adding value to the CAM experience once initiated.

THE CONTEXT: MEDALIA HEALTHCARE, LLC AND WASHINGTON'S "EVERY CATEGORY OF PROVIDER" LEGISLATION

Medalia Healthcare, LLC ("Medalia"), was, at the time this project was engaged in 1996, a network of 330 primary care physicians (PCP) in 48 clinics serving the central Puget Sound geographic area of Washington state. Medalia is an independent entity, developed as a partnership between the Sisters of Providence Health System and the Franciscan Health System. Medalia is a PCP delivery system and not a health plan. The organization's PCPs service contracts with most of the region's payers, such as Blue Cross of Washington and Alaska, Regence Washington Health (a Blue Shield company), Providence GoodHealth Plan, PacifiCare of Washington, QualMed of Washington, and others. Some

⁷Paradoxically, the external network that most pleases a payer may be the greater carrier of this integration "illness." The perception may be created that CAM is externally handled and the plan therefore is not required to devote any additional energy to better CAM integration.

⁸The external network is used extensively for behavioral health and chiropractic care, two other areas where many health plans may feel they lack internal competency.

Table 1. Incentive Structure in External Contracting of CAM Integration

Decision	Healthplan Motivations	Incentive Structure
Contract credentialing to external CAM network	<ul style="list-style-type: none"> • Lack of internal competency/inexperience • Less start-up expense 	<ul style="list-style-type: none"> • Limits plan direct relationships and communication with CAM providers • Limits development of internal credentialing expertise • Less investment in CAM
Contract billing and management to external CAM network	<ul style="list-style-type: none"> • Lack of internal competency • Less start-up expense • Network assumes headaches for patient and CAM provider communication • Shifts potential conflict between healthplan and member over utilization 	<ul style="list-style-type: none"> • Plan is not gathering primary data • Plan will not invest in changes, to more adequately understand CAM, in its own information system • Less likelihood of analyzing outcomes proactively • Less development of internal CAM management skills
Grant members or policy-holders direct access to CAM network providers	<ul style="list-style-type: none"> • Avoids confrontation between member and PCP over utilization • Member has less hassle • Avoids conflict between plan and PCP 	<ul style="list-style-type: none"> • Communication between CAM providers and conventional providers is limited • Conventional provider may not be aware of a patient's CAM choices • Limits likelihood that plan will invest in education of conventional providers about CAM
Charge additional fees ("rider") to access services of CAM network providers	<ul style="list-style-type: none"> • Limits risk • Removes risk, if the benefit is fully carved-out 	<ul style="list-style-type: none"> • Without economic integration, less reason to bring CAM into core quality, case management and disease management initiatives • Less reason to analyze whether CAM is an add-on or replacement for conventional care

of Medalia's contracts are discounted fee-for-service, others capitated primary care, and others are accepted on global capitation.

The context for the project, which commenced in July of 1996, was the passage of legislation by the Washington state legislature that required all health plans in the state to "include every category of provider" as of the first of that year.⁹ Because most of the state's health plans already offered some access to chiropractic services, the brunt of the legislation was to include the state's licensed acupuncturists, naturopathic physicians, and massage practitioners.

The mandate had no direct effect on Medalia, which is not a health plan. Yet a variety of factors influenced the PCP system to proactively develop a strategy.

- All the plans serviced by Medalia had developed separate, and often quite different, strategies to comply with the mandate.
- Visibility of the mandate in the media upped the expectation that CAM would be covered. Medalia's PCPs, with varying degrees of personal understanding of CAM, increasingly faced patients who expected better integrated CAM care.
- The system's strategic interest in managing full capitation urged better understanding of how to manage CAM services and providers.
- Leaders of the parent firm who believed in the role of

spirituality in health were disposed toward a proactive strategy toward CAM in the PCP network.¹⁰

- A cadre of physicians within the larger network, including the medical director, promoted a positive relationship for Medalia with CAM providers as a good direction for creating better care and a stronger position in the market.

STRENGTHENING LEADERSHIP INTEREST

Weeks has written elsewhere of the role of bias and polarization, among both conventional and CAM providers, as perhaps the core obstacle to optimal integration of CAM services.¹¹ This experience-based thesis can be partially explained by theoretical views of the psychological impacts to both oppressed and oppressor of an unequal political-eco-

¹⁰Most outspoken was Sister Diana Bader, then with the Sisters of Providence Health System and now with Catholic Health Initiatives. Medalia already had in place a spirituality program in which a Jesuit priest with a masters in social work was serving four Medalia clinics.

¹¹Weeks, J., Operational Issues in Incorporating Complementary and Alternative Therapies and Providers in Benefits Plans and Managed Care Organizations, presented at a workshop entitled Complementary and Alternative Medicine: Issues Impacting Coverage Decisions, co-sponsored by the NIH Office of Alternative Medicine, United States Agency for Health Care Policy and Research, and the Arizona Prevention Center at the University of Arizona Health Sciences Center, October 9, 1996, pp. 59-68. Publication by the National Institutes of Health expected in mid-1998. Section on bias and polarization published as Managed Care Meets Alternative Medicine; Reflections on Overcoming the Polarization. *Altern Complementary Ther* 1997 Feb; 3(1):37-41.

⁹Revised Code of Washington 48.43.045.

conomic situation, such as typified the conventional physician/CAM provider relationship in the U.S. Health care system; and by psychological perspectives on the powers that may be embedded in the unknown or, in the term used by psychologist Carl Jung, the "shadow." Whereas this viewpoint is experience-based and nonscientifically derived, the perspective is widely accepted as an important force in the CAM integration dialog.¹²

Role of the "Agnostic" Physician

Medalia's medical leadership accepted this thesis as a given and the initial steps followed on this acceptance. First, a decision was made to not work through an ad hoc alternative medicine committee already present inside Medalia. The group consisted of advocates of greater integration who were known inside the system as true believers and therefore discounted by some physicians. Although their inputs remained critical in numerous areas, a separate working team was created that intentionally included "agnostic" physicians: physicians who were neither true believers in CAM nor opponents. They were respected medical leaders who could be expected to be open-minded and who perceived there was value in the exploration.¹³ The strategy was not to bring the organization's chief proponents of CAM and leading naysayers into one room. Rather, the move was toward creating working relationships through opening middle ground.

To create greater awareness of CAM among the organization's leaders, 30-min presentations were delivered to the executive committee and the regional medical directors. The presentations focused on the developing marketplace for integration, nationally and locally, and some basic information about the mandate and provider categories. The intent was less on convincing the committee members to believe in the value of CAM than to show that dealing with CAM deserved to be in their business plan. The goal was to create an openness to broader exploration and relationship building.

INTERACTIVE WORKSHOPS: MEDICAL DIRECTORS AND CAM PROVIDERS

The next major step involved bring together the system's medical leadership, including five regional medical directors, for a half-day focused workshop on CAM. The community organizing strategy became apparent with this initiative. Instead of presenting information about CAM

treatments in a didactic format, the initial workshop focused on creating relationships of trust between Medalia's medical directors and selected CAM providers.

In the Medalia strategy, the decision was made to focus the initial interactive workshop on a single provider category to limit the range of the discussion.¹⁴ The category selected, licensed naturopathic physicians, is paradoxically of special significance in Washington State, but is also, as was shown in a subsequent survey reported below, to be the least known or utilized by Medalia's PCPs.¹⁵ Part of the decision was based on the breadth of CAM understanding the naturopathic medical profession brings to the table. The naturopath, due to the breadth of the federally recognized education required to become a licensed, general practitioner of natural medicine, has familiarity with the other therapies and provider types of interest to the Medalia. The licensed scope of practice for a naturopath in Washington state includes physical manipulation, similar to chiropractic, and massage and other body work. Naturopaths are also taught the principles of Oriental medicine, and most refer for acupuncture if they are not independently credentialed in this field. In addition, these providers are licensed in Washington state as general practitioners, with some prescriptive authority. The naturopathic medical paradigm, although philosophically vitalistic, is taught with a strongly biomedical approach, including roughly similar course hours of training in conventional medical sciences. For these reasons, the category was deemed an ideal partner for an initial exploration of CAM integration.

The purposes of the workshop, preliminary preparation and outline are described in Table 2. The naturopaths were selected based on participation in credentialed CAM networks, geographical diversity, confidence in both their clinical skills and their limits, and strong interest in better-integrated relationships.¹⁶ Those known for strongly polarized views were not selected. Premeeting preparation included, besides the presentations noted above, and individual conversations with the naturopathic physicians, the

¹⁴While Medalia made the decision to use just one CAM provider category, the naturopath, the dyad-based interactive workshop format has subsequently been successfully used in a workshop in which the CAM providers were a mixed group of naturopathic physicians, acupuncturists, massage practitioners, chiropractors, midwives and dietitians. The program was developed by Weeks and Larry Jacobson, MPH, LCSW, Managed Healthcare Resources Northwest, for the Washington State Office of the Insurance Commissioner at a workshop on May 30, 1997.

¹⁵Naturopathic physicians in Washington State were included as part of the primary care matrix in the state's 1994 Health Professional Resources Plan. A local research and education institution founded by naturopaths, Bastyr University, was selected by the Seattle-King County Department of Public Health in 1996, following a competitive bidding process, as the primary sponsor for the nation's first publicly funded integrated natural medicine clinic. Bastyr had previously been selected, in 1995, as one of the first research centers funded by the NIH Office of Alternative Medicine.

¹⁶An additional factor was whether the selected naturopathic physician had at least one additional CAM provider type in their practice. This reflected an organizing principal in the network development strategy, described later in the article, which was to simplify Medalia's relationships with CAM providers by choosing to create relationships with multispecialty CAM practices.

¹²Weeks has offered this perspective, without substantial argument, to audiences in forums sponsored by such diverse organizations as federal agencies, the American Association of Health Plans, Pacific Northwest Chapter of the Employee Benefits Planning Association, National Managed Health Care Congress, National Acupuncture Alliance, and the American Association of Naturopathic Physicians.

¹³One was the chair of Medalia's utilization review committee, David Zieve, MD. Another was a widely respected family practice physician who was, at the time, the immediate past-president of the Washington State Medical Association, Peter McGough, MD.

mailing of a chart that took a somewhat whimsical view of the effects of polarization on the integration process.¹⁷

The room was set in two tables, with four naturopathic physician–Medalia physician dyads at each table. Where possible, the providers were paired geographically.¹⁸ Discussion began with some warm-up in which each provider described the nature of their practice and the types of providers with whom they shared space. The formal program moved in two rounds of three stages each. First, the group shared in dyads, with one partner speaking first and with the other listening, for 3 min. The roles were then switched. The four dyads at each table discussed their experiences. Two representatives from each table shared their findings with the full room. A balance between the conventional PCP and naturopathic groups was assiduously maintained, although in a spirit of lightness. For instance, the two providers selected by each table to report to the whole group included one from each camp; at one table the Medalia physicians were the first in their dyads to speak, while at the other the first speaker was the naturopath. The meeting was also facilitated by a mixed dyad.¹⁹

The content included two rounds of discussion. The group initially focused on the challenges posed by greater integration. The opportunities produced by greater integration for the providers, their patients, and for Medalia were then explored. Table 3 lists the concerns, opportunities, and potential models for collaboration and mutual learning identified in this process. They are presented in the informal language with which they were gathered during the workshop. Informal responses after the workshop from the participants indicated strong belief that the interactive workshop was valuable.

SURVEYING SYSTEM PHYSICIANS TO SET AN ORGANIZING DIRECTION

The next step in the process involved development and administration of a survey of Medalia physicians. The survey served a variety of purposes:

1. All Medalia physicians were given an opportunity to provide input into a process that was believed would be controversial for many.
2. Medalia gained baseline data on the perspectives of its providers relative to their knowledge of CAM, and the usefulness of the distinct provider types.
3. Medalia gained an internally derived, physician-focused sense of the directions that might be taken in the subsequent CAM strategy.

The survey, together with a subsequent survey of the selected CAM providers, discussed below, was developed to

¹⁷ See footnote 11.

¹⁸ Optimally, some thought will go into the seating arrangement and pairing of the dyads.

¹⁹ The cofacilitators were the project consultant, who was well-known to the naturopathic physician participants, and James Tufano, MHA, then a special projects consultant to Medalia's senior management.

Table 2. Model Interactive Workshop for Conventional and CAM Providers

Purposes	
<ul style="list-style-type: none"> • Develop relationships of trust between selected providers • Identify opportunities and challenges in integration • Clarify utilization and management issues • Explore assumptions about values • Seek guidance for integration strategy 	
Preparation	
<ul style="list-style-type: none"> • Hand-picked CAM providers in geographically-matched dyads with conventional MDs • Small group approach, with four dyads per table, two tables in total • Some prior preparation and agreement on ground rules • Commitment of system leadership to the process 	
Structure	
Welcome/Opening Remarks/Goals	10 min
Provider introductions (by table)	10 min
Partnering Session I	45 min
Concerns	
Partners free-speak (3 min each)	
Table talk (15 min)	
Group share (15–20 min)	
Partnering Session II	45 min
Opportunities	
(Repeat process in Session I)	
Next steps	30 min
What do you want from each other?	
What do you want from the administration?	
What do you want from insurers/plans/purchasers?	

provide a map that would lead the community organizing strategy. The four-page survey focused on five licensed provider categories: acupuncturists, chiropractors, naturopathic physicians, massage practitioners, and midwives.²⁰ Questions focused on knowledge of educational standards and scope of practice for each category; perceptions of clinical value; referral experience and patterns to CAM providers; specific CAM providers the PCP believes should be in a Medalia network; professional or personal interest or training in CAM; CAM services the PCP felt competent to provide or teach; clinical conditions for which exploration of CAM was deemed valuable; specific CAM therapies that should be explored for specific conditions; specific areas in which CAM integration might lead to savings under capitated contracts; and general perceptions of the impact a better Medalia integration strategy would have on the effectiveness, cost-effectiveness, and patient satisfaction of better integrated CAM care.

Physicians were given the option of signing their surveys. A substantial majority of respondents (75%) chose to do so. Three-fourths of all returned surveys, therefore, cre-

²⁰ Although the survey was used to elicit information regarding the midwife category, the scope of work on the consulting contract focused only on naturopaths, acupuncturists, and massage practitioners.

Table 3. Informal Outcomes of the MD/ND Interactive Workshop

Concerns	Opportunities	Structures for Ongoing Collaboration
Different practice philosophies	Increase range of service offerings to patients	Grand rounds
Cost and regulatory concerns detract from patient focus	Growing “comfort zone” for discussion with patients	Case discussion
Shrinking dollars—turf issues	Increase wellness/prevention services offered	MD visit an ND office
MDs lack of knowledge of ND practices	Increase of mutual control through better communication	CMEs/workshops involving both provider types
Patient as communication link is limited source of information	Co-managed studies of clinical cost and patient satisfaction might be developed	Learning more about practice philosophies and education
Wide range of provider attitudes and prejudices	NDs will increase knowledge of managed care and capitation	Identify “ideal” patients for comanagement
MDs have little or no experience of natural medicine	MDs will increase knowledge in areas such as therapeutic nutrition and botanicals	Establish a dedicated group or committee within Medalia to focus in integration
Little MD understanding of ND rationale for time intensity required for ND diagnostics	MD PCP to ND PCP comanagement may decrease need for higher priced specialists	Select and educate a designated “CAM Expert” at each Medalia clinic
Time-intensity of the cross-referral process	Better dissemination of knowledge	Build on current referral relationships
Lack of ND knowledge of managed care systems and requirements	Increased contracting and leveraging opportunities	Attend each other’s regular group meetings
Why would NDs willingly embrace managed care?	Decrease medication usage in patients	Collaborate on joint care management strategies
Rigor of efficacy standards imposed on NDs by MDs exceeds that historically imposed on MDs	Decrease costs of care	
Lack of uniform clinical practice standards in the ND community	Marketing opportunities for the system Increased access to providers for patients	

These lists were developed rapidly and informally based on the reports from the two tables of dyads and ensuing discussion. They are not meant to be definitive, but representative of the product of this interactive process as recorded on poster paper while in process. In a few instances, minor clarifying edits from the original have been made.

ated an individualized profile of a specified provider’s interests in CAM. For those who signed, the system was able to see such things as:

- physician X believes that better integration of CAM can lead to more cost-effective care, and she believes a good place to start is to work with acupuncturists on migraines
- physician Y has no personal interest in CAM, except to know that another physician in his clinic has some education or expertise in the arena and can be a resource, based on the physician’s belief that better integration may create some perceived increase in patient satisfaction; or
- physician Z is already referring extensively to chiropractors and massage therapists for certain conditions and may be an internal resource in educating other providers about these relationships.

The focus was not on developing pure research data but rather on useful information that Medalia could use in shaping its strategy.

PCP SURVEY METHOD AND FINDINGS

To increase the level of physician response, the survey was distributed to clinic managers in the clinics, who were then

responsible for distributing them to clinic providers. Surveys were distributed subsequent to presentations on CAM developments, by the consultant, at regional physician meetings.²¹ Follow-up calls were made to clinic managers to ensure that surveys had been distributed and to request that the manager make a point of asking providers to complete them. An estimated 270 physicians received the surveys. Of these, 110 were returned, a 41% response rate. Twenty-seven of the responses (25%) were not signed, yielding 83 individualized profiles of Medalia physician perspectives on CAM.

Tables 4 and 5 show outcomes of these questions. Each statistically reported response represented answers of between 102 (93%) and 109 (99%) of respondents, except in the question regarding potential benefits from greater CAM integration under capitated arrangement, which was answered by only 81 (74%) of respondents.

The conditions for which at least three PCP respondents believed CAM should be explored were allergies, anxiety (stress management), back pain, neck pain, fatigue, fibro-

²¹Survey responses were highest from those regions where the greater percentages of the physicians had heard the initial briefing on the growth of the CAM integration movement.

Table 4. PCP Perceptions of, and Referral Patterns to, CAM Provider Types

Provider Type	Knowledge of Educational Requirements	Knowledge of Scope of Practice	Usefulness of Services	Believe CAM Services Are Useful*	Have Ever Referred a Patient [†]	Have Referred >10 Patients [‡]
Naturopath	2.14	2.16	2.41	16%	37%	5%
Chiropractor	2.58	2.80	3.24	40%	73%	25%
Acupuncturist	1.92	2.40	3.38	36%	44%	12%
Massage Practitioner	2.24	2.60	3.30	40%	65%	17%
Midwife [§]	2.70	3.24	3.63	58%	20%	4%

Responses were on a 1 to 5 scale with 5 signifying “highest” or “most.”

* Marked “4” or “5” on the scale.

[†] The data do not capture whether the referral was patient driven or physician driven.

[‡] An attempt to indicate the percent of PCPs who may proactively refer from time-to-time.

[§] Category includes both certified nurse midwives (CNM) and licensed, direct-entry midwives. Regional data from the survey suggests that a CNM birthing program associated with one portion of the system shifted responses toward the positive.

Note: The findings reported in Tables 4 and 5 are not presented as a scientific analysis of PCP perspectives, practices and opinions. Rather, they are offered as representative information one PCP organization developed as a basis for developing the integration strategy discussed below.

myalgia, headache, pregnancy, menopause, and somatic conditions. Leading interest was noted for chiropractic or acupuncture, and to a lesser extent massage, for acute or chronic back and neck pain; naturopathic physicians for allergies²²; massage practitioners for fibromyalgia; naturopathic physicians for fatigue; and midwives for pregnancy. Those conditions for which PCPs believed appropriate referrals might save the system money under its capitated contracts reflected the responses regarding productive areas for exploration. However, some responded with more general comments. Examples were:

- “try utilizing them in high-utilizing patients”
- “some of our traditional therapies are not very helpful, perhaps these providers are”
- “contract providers who develop care plans for specific conditions”
- “we can limit referrals to high cost specialists,” and
- “some patients respond psychologically better to alternative medicine.”

SURVEY OF THE “COMMUNITY COMPLEMENTARY PARTNERS”

A decision was made early in the project to create a limited, geographically based directory of “Community Complementary Partners” (CCP) around which the system would organize its CAM organizing activity. The logic was based in the desire to build relationships, which was perceived to be easier if attention was focused on a relatively small network. Because two of the major payers for which Medalia’s PCP contracted to deliver services had chosen to offer acupuncture, naturopathic, and massage services through an external network of credentialed providers, Medalia moved forward by creating a subset of this network, or a network within the network.²³

²² An interesting side note is that while some MDs showed interest in naturopathic care for “allergies,” the naturopathic physicians tended to note specific conditions that they perceived may be related to food sensitivities, such as otitis, sinusitis, and digestive disorders.

²³ Alternare of Washington (Seattle, WA) was the external group.

All of the CCPs selected were therefore previously credentialed. Because the system already had a chiropractic network and did not choose to focus on midwives, the provider types for the directory were limited to acupuncturists, naturopaths, and massage practitioners. Other factors influencing selection included geographic distribution; recommendation by a PCP in the PCP survey; expressed interest, determined through phone interview, of the CAM provider in working in a more integrated environment with PCPs; and priority was given to CAM clinics with more than one provider type, to simplify Medalia-CCP relationship building. Contact was initiated by the consultant, who had widespread contacts inside the local CAM provider community.

The resulting directory included just 40 providers from 20 clinics representing 19 naturopathic licenses, 14 massage licenses, and 12 acupuncture licenses. Some practitioners held dual licenses. The directory was to be expanded if this limited group could not support referral activity. Each listing included a brief, 25-word description of the practitioners’ practice philosophy.²⁴

All of the CCPs were required to fill out a survey, the goals of which were to provide information for the directory (current insurance contracts, educational background, and current licenses); and to gather information that would support the organizing strategy. The latter included questions on:

- three health conditions with which the provider believes he or she is successful
- two conditions which the provider would benefit from closer MD relationships
- five conditions where the provider’s services would, if patients were referred directly to him or her, save the organization money on its capitated contracts

²⁴ Although the early intention was to include CAM provider photos in the directory, to increase the humanness of the CCPs to the PCPs, the initial directory ran without the pictures.

Table 5. Perspectives and Specific Interests of System PCPs Regarding CAM

Measure	Response
Perception of Value of Increased CAM Integration	
Believe better integration will lead to more <i>effective</i> care*	38%
Believe better integration will lead to more <i>cost-effective</i> care*	30%
Believe better integration will lead to more <i>satisfied patients</i> *	71%
Believe some CAM can lead to cost-savings under capitated contracts [†]	69%
Personal or Professional Interest in CAM	
Have personal or professional interest in CAM	35%
Have taken at least one CE course on some CAM aspect	35%
Could teach in some CAM area	6%
Potential providers of CAM services among PCP respondents	3%
Areas of Interest in Future CAM-Related Education	
Request more CMEs in CAM [†]	61%
Wish to have CAM providers meet with clinic doctors [†]	54%
Interested in joint case review with CAM providers [†]	43%
Would like to have a trusted CAM provider on-call [†]	35%
Interested in collaborating with CAM providers on care pathways [†]	33%
Would like knowing that at least one MD in my clinic knows about CAM [†]	40%
Interested in observing a CAM practice to gain more understanding [†]	25%
Were interested in seeing CAM provider as a patient for more education [†]	20%
Specific Suggestions for CAM Integration	
PCPs who recommended at least one CAM provider for the CAM network	21%
Total number of CAM providers recommended by at least one PCP	70
Total conditions for which at least one PCP believed CAM should be explored	36
Conditions for which at least three PCPs believed CAM should be explored	9

*Checked "4" or "5" on 1–5 scale.

[†] Respondents could list more than one means of gaining CAM education.

[‡] Only 81 respondents (74%) answered this question.

- other providers from who the CCP regularly received referrals
- providers, by type (conventional and CAM) to whom the CCP regularly refers
- areas of educational interest to work more effectively in managed care, and
- a series of questions about the CCP's office management given the context of increased involvement with health plan reimbursement.

Findings of the CCP Survey²⁵

The CCPs expressed strong interest in educational programs that would better prepare them for working in an integrated environment. Ninety-three percent expressed an interest in such education. The most frequently noted were: referral procedures (63%); utilization management (59%); how insurance works (52%); capitation (48%); medical records (48%); medical necessity (37%); and the role of the PCP gatekeeper (33%).

While CCPs created a list of over 100 conditions in which they believe they could save the system money by receiving

an early referral under capitated arrangements, responses tended to cluster around specific conditions. Fifteen broadly defined conditions were named by at least four providers each. Responses clustered most frequently as follows:

- Acupuncturists—back pain, digestive complaints, fibromyalgia, pain, migraines, some women's conditions
- Massage practitioners—carpal tunnel/tendinitis, fibromyalgia, musculoskeletal, sprains/strains
- Naturopathic physicians—arthritis, digestive complaints (from constipation to irritable bowel to colitis), chronic infection (especially otitis and sinusitis), hypertension, fibromyalgia, chronic disease, and numerous women's health conditions (PMS, menopause, endometriosis, etc.).

Notably, from the community organizing perspective, a number of respondents used a "comments" section at the end of the survey to recommend relationship-based strategies for moving forward. One suggested one-day specialty clinics ("well child", etc.) in which a CAM provider and a system physician work together. Others supported face-to-face meetings in each other's offices.

DISCUSSION OF SURVEY FINDINGS: USE-VALUE FROM A COMMUNITY ORGANIZING PERSPECTIVE

A critical perspective on the findings of the PCP survey reported here might include the following comments: less

²⁵ Like the data presented from the PCP survey, the findings of these surveys are not to be viewed as definitive about CAM provider perspectives, but rather, the data are offered here as an example of the kind of intelligence the survey allowed one conventional organization to glean as it embarked on its CAM strategy.

than half of PCPs believed that better CAM integration would lead to more effective or cost-effective care; little direction was given regarding the value of any single CAM intervention for a specific condition; any apparently positive findings on CAM were probably overstated, given the likelihood that the PCP sample that completed the survey selects for those with an above-average interest; and, finally, all it shows is that some 30–50 physicians, in a system of over 300, believe that better integration of *some* CAM can produce more effective or cost-effective care.

Assumptions in the Community-Organizing Perspective

The community-organizing perspective does not argue with these criticisms but turns them on end. It does so based on some assumptions about the future of CAM in health care in the United States:

- integration of CAM into mainstream delivery, and various coverage schemes, will increase for the foreseeable future,
- understanding of, and interest in, CAM among individual, conventionally trained physicians will continue to be uneven, both in the extent of their exploration and the types of CAM that are of interest to them,
- many conventional physicians will increasingly explore some CAM modalities for the purposes of integrating them into their practices (rather than through referral),²⁶
- integration will continue to be consumer driven, and frequently lack an ideal evidence base, and
- finally, implicit in the above, the movement of CAM into the mainstream of health care will continue to be characterized by a grassroots process.

From the community-organizing perspective, these findings are the grassroots that can flourish to greatest benefit by appropriate attention. A solid body of 30–50 physicians is identified who show some level of intrigue with CAM. The details of their specific interests and beliefs become the foundation of the organizing initiative and give specific guidance for the activity ahead. Interests of a second, broader group of respondent physicians, who may not have as much belief in the value of CAM care but wish to become better educated or have stronger support systems in dealing with CAM issues. This interest is registered by interest in continuing education (61%), having a CAM provider visit their clinic (54%) and, to a lesser extent, knowing that a colleague is knowledgeable about CAM (40%).

A Practical Strategy for Putting the Findings to Work

Table 6, and especially the section entitled “Relationship Building and Education,” describes a work plan that fo-

²⁶This includes both the new physicians who may have availed themselves of the CAM training that is increasingly offered, though very unevenly, in medical schools, and currently practicing physicians who will seek to add to their understanding.

Table 6. Tasks of the Community Organizer for CAM Integration Inside a Plan, Network, or Delivery System

Relationship Building and Education

- Contact the physicians who wish to have a community complementary partner (CCP) meet with clinic doctors (54%), select appropriate CCP and arrange meetings.
- Contact physicians who wish to observe a CCP (25%), find out which provider types, and begin making arrangements with nearby CCP.
- Contact physicians who want to go to CCP as patient (20%), find out which provider types, and begin making arrangements with CCP.
- Create, disseminate, and evaluate forms, and initiate some follow-up interviews with involved PCPs and CCPs, which can be used to evaluate and refine the usefulness of the three activities above.
- In response to the interest of PCPs in knowing at least one clinic PCP was educated in CAM (40%), identify these CAM Resource PCPs and develop the educational strategy, immediately below, around their interests and felt needs.
- In response to PCPs wishing additional education in CAM (61%), and the needs of the Core Resource PCPs (above), organize a system-wide and/or regional CE program.
- In response to expressed educational interests of CCPs, create an educational program or strategy.
- Create brief reports on developments for internal newsletters to move the discussion out into the system.
- Oversee changes to the CCP Directory.
- Work with the internal CAM committee.

Compiling Observation*

- Identify dyads of PCPs and CCP who are interested in compiling observation on referrals around a CAM approach for a condition of interest (i.e., acupuncture for migraines).
- Develop simple survey forms which will be filled out by the patients, PCPs and CCPs.*
- Work with the dyads to compile the observations (surveys) into brief reports.*

*Except where marked, the services could be provided by a person with good communication abilities and basic administrative skills. Those work components with asterisks would require higher level professional support.

cuses on these identified physician interests. Based on the data gained in the surveys shown in Tables 4 and 5, the community integration organizer would work in three areas: relationship building, education, and compiling observation. The principal investment is in a community organizer for CAM integration (COCI). The COCI’s core responsibility is to implement the requests and interests identified in the PCP and CCP surveys. This individual would optimally have some passion for the integration undertaking, good communication skills, basic administrative, writing and reporting abilities, and perseverance. Use of a retained, external contractor on an hours-per-month basis could might serve the dual purpose of limiting expenses and maintaining focus on the project.²⁷ The COCI organizes and

²⁷The implementation phase proposal for Medalia offered an externally contracted organizer at \$20/hour and 30 hours a month, or a \$7200 base budget for staff. The paradox of contracting out the services that are to enhance internal CAM competency is noted.

builds upon the existing interests in CAM integration, documenting and responding to other signs of interest that may be expressed by additional physicians as the integration program unfolds.

“Compiling Observation”

The second component of the COCI's work is to assist with information gathering on the clinical experiences of those who are parties to the integration effort: the referring conventional provider, the CAM provider, and the patient. This strategic component requires development of some simple, short survey instruments, and a structure for information gathering and internal reporting. The COCI would need to be supported in this work by a higher level professional.

We use the term *compiling observation* for this activity, to distinguish it from more formal research. The focus in compiling observation is to create a middle ground between individual observation, belief or perception, of either the physician, CAM provider, or patient, and the kind of scientific evidence normally desired as a basis for decision making in formal technology assessment, medical necessity, and referral processes.²⁸ The experience of CAM integration for limited, consecutive sets (5, 10, 15, etc.) of referred patients with specific conditions is captured. The documentation focuses on a single PCP/CCP dyad in which each professional perceives that the investigation is of some interest and may be valuable from the perspective of optimizing patient care.

The proposed role of the COCI in facilitating the compiling of observation around referral for one condition for a PCP/CCP dyad is described below:

1. The COCI contacts a PCP who perceives potential value in a specific CAM provider type for a specific condition, as identified in the PCP survey, and initiates discussion of the project.
2. The COCI identifies a CCP who believes that CAM services may be useful for the condition and sets a meeting, or meetings, of the PCP/CCP dyad to test their compatibility, discuss the compiling observation project, clarify specific questions that may be of interest, and describe the use of the survey forms.
3. The referring PCP provides a brief assessment of the condition of the patient at referral, including past treatment for the condition, expected course of treatment, medications, and any future services, which might be anticipated if the course of the condition is not reversed or slowed.
4. The CCP agrees to maintain more extensive, focused records of the CAM treatment plan and perceptions of the patient's progress than are generally recorded.
5. The PCP/CCP dyad agrees to work to ensure patient participation in the project, which includes surveys

prior to referral, immediately following the conclusion of treatment, and a survey at some future date (6 months, 1 year, etc.).

6. The COCI is responsible for administering the project and compiling the observations. This administration may include post-project interviews with the PCP/CCP dyad in their experience and suggestions.
7. The COCI, should the system be interested, may be responsible for requesting corroborating information of the experience of the patients that may be available in the utilization data compiled electronically by the system or health plan.

The compiled observations may have a variety of uses to the physician network, delivery system, managed care organization, or other party that is sponsoring the project. The system acquires perceptions of usefulness of the CAM services for specific conditions, from three distinct perspectives, for a consecutive set of patients. Estimates of the costs incurred, or saved, may be made. The PCP/CCP dyad may be made available to other providers to make presentations on their experience. Appropriate use of the CAM provider may be clarified. Simple write-ups of the integration experience may be created as a resource for other system PCPs and CCPs.²⁹

The compiled observation may be used as a basis for shaping a more thorough research proposal, or for refining the survey instruments used for compiling observation in work with other PCP/CCP dyads. Finally, depending on how conclusive the compiled observations may seem, the system can make recommendations for or against additional exploration, or for or against such referral in the future.

CLOSING COMMENT: FINDING A PRACTICAL MIDDLE GROUND

The shift toward coverage and integration of CAM in the United States has commenced at the very time that the broader health care system is working to move coverage decisions from physician belief to an objective, evidence base. In general, the new standard is applied most frequently to new procedures or therapies. Many commonly used conventional therapies and procedures have, effectively, been grand-parented, particularly those in the relatively noninvasive and inexpensive general practice arena. Previously uncovered CAM approaches, although they may have been in use for millennia, are, conceptually at least, pushed into the new-and-unproven category.

These concurrent shifts in the system—each called a paradigm shift by its advocates—create clashes. CAM advocates argue that their routine approaches are being held to a higher standard than grand-parented, routinely provided conventional services. At the same time, the market

²⁸It is worth noting here that an evidence-base for such decisions is also more the exception than the rule for decisions on conventional treatment.

²⁹Attention must always be given to contextualizing the compiled observation as merely suggestive.

is driving many payers to make CAM an exception to the new rule on evidence-based coverage decisions. The most common method, as described at the outset of this report, is to outsource CAM services to an independent entity and to pay for such services through requiring an additional fee. As argued above, the incentives in this coverage and inclusion method do not promote discovery of more basic answers, of interest to the system, regarding questions about either the effectiveness and cost-effectiveness of CAM, or of a proactive integration of CAM into mainstream care delivery.

The community-organizing strategy described herein is offered as a method for beginning to discover how to optimally integrate CAM providers and services given the inherent conflicts between broader system priorities, on the

one hand, and the reality that coverage and integration of CAM is expanding without the presence of an ideal infrastructure, on the other. At the most basic level, enhanced communication and relationships between CAM providers and PCPs, the thrust of the community-organizing approach, would be expected to foster safer, more appropriate, and more effective patient care. This approach also carves a middle-ground on the role of practitioner belief versus research evidence as a basis for referral or coverage decisions. The focus here includes conventional physician perceptions of the potential value of CAM, rather than merely relying on the perceptions of CAM advocates. In addition, the program to begin compiling the observations of PCPs, CAM providers, and patients honors the system-wide need to develop a better evidence-base for coverage and referral decisions.