Integrating CAM Into a Group Practice: The Experience of The Permanente Medical Group in Northern California

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Introduction

Dr Ballance: One day, a patient came in and told me, "I don't take medicine." Before I moved on, I asked, "Do you take anything else?" She said, "Oh yeah," and pulled out a large bag of supplements—to which I replied, "Well, so I see: If the FDA will approve it, you won't take it; but if they don't approve it, you will." Then she laughed and said "Well yeah, something like that." What I considered medicine, she didn't.

Terminology has been a real challenge for our organization, just as it is for patients. Our CAM Advisory Group wanted to use the phrase "integrative medicine," but we decided not to do that because it might confuse the issue with the principle of Kaiser Permanente (KP) being an integrated model of medicine. Because we didn't think we would get the term "integrative medicine" accepted in our integrated medical group, we had to continue with "complementary and alternative medicine."

I'm going to talk about complementary and alternative medicine within The Permanente Medical Group (TPMG) in Northern California. You should know that we have about three million patients and about 4000 physicians. A major challenge for us is to manage CAM in such a large patient population and with such a diverse practitioner population.

The History of CAM in TPMG

When I came to KP Vallejo in 1980, I found that an acupuncture service was already in place. I am told that in 1976, an emergency department doctor from Walnut Creek, Forrest Cioppa, returned from a two-year study in England with Felix Mann and taught 35 Permanente physicians how to do acupuncture. Two of them that I know of adopted the skill in their practices. One was Russ Erickson, a pediatrician at the KP Richmond facility; he is still very active in the American Academy of Medical Acupuncture. The other was Howard Liebgold, Director of the KP Vallejo Rehabilitation Unit, which is the KP rehabilitation unit for all of Northern California. When I arrived in 1980, it was mainly Dr Liebgold who was using acupuncture. A Chinese-trained radiologist also had a small acupuncture practice within the facility.

When Dr Liebgold retired, his successor expanded the acupuncture practice in the Rehabilitation Department and created an Alternative Medicine Clinic at KP Vallejo. This event created something of an uproar because it attracted publicity through the local press and in at least one national magazine. We started to get letters from all over the country wanting to know if people could come and use the service; if we had housing facilities so they could stay with us; and if we treated all sorts of maladies. This was the reason we decided to create the position of KP Vallejo Chief of Alternative Medicine. Soon thereafter, the KP Northern California Region created the Regional Director of Alternative Medicine position and appointed Dr Harley Goldberg to it.

Early Alternative Medicine Activities of The Permanente Medical Group

We needed to respond to several problems developing regionally. First, we had to respond to the mandate for chiropractic coverage for Medicare patients. And how would we manage the issue of acupuncture, which was being provided for almost anybody with any diagnosis? Very important, if we did acupuncture at KP Vallejo, were we going to provide it also at KP Walnut Creek? At KP Redwood City? We knew that many patients and members were coming to us for advice about nutritional supplements and about other treatment modalities. How should we respond to that need?

A 1996 survey of Northern California Health Plan members and clinicians by Nancy Gordon of our Department of Research and David Sobel of Regional Health Education revealed that a large number of both members and clinicians were using alternative modalities and wanted their health care system to incorporate such modalities.[1]

The State of California Department of Managed Care required that if we provided a service at one location, we would have to provide this service consistently to our three million health plan members in Northern California. This was one of our earliest challenges. We developed method-

ology based on safety, effectiveness, and quality before we considered practical issues of implementation. Workgroups evaluated the evidence for acupuncture, manual medicine, herbs, and mind-body interventions, and this was a major task. The workgroups collected relevant literature, reviewed the evidence, and created evidence tables. In our reviews, we first considered safety because if something was unsafe, why go further and assess effectiveness? Opportunity always exists to disagree about efficacy, because results are not always clear.

If we believed that something was safe and probably effective, we then considered whether The Permanente Medical Group could provide it to members and patients in a high-quality way. This project did result in several recommendations to the medical group. We then created two additional committees: an education committee and a research committee. Expanding from the original committees, we have identified a CAM representative at each major KP Northern California facility. The CAM representatives meet regularly to guide implementation of CAM programs and are the on-site contacts at their home facilities.

We have developed several guiding principles for our medical group as we considered alternative medicine. Probably the most important is that we must be consistent across the KP Northern California Region: If we're going to do acupuncture at KP Vallejo, then we must have comparable services with comparable standards at all the major KP facilities—whether the service is offered internally or referred out of plan. This rule is intended to prevent a patient being offered acupuncture for an indication at one facility and then hearing that their cousin or neighbor was refused the same request at another facility. We needed to have consistency.

Early Challenges as CAM is Extended Regionwide

For us, the major challenge was to provide CAM services in a consistent, high-quality way across all KP facilities. For example, after the herbal therapy workgroup approved six herbal and supplement products, the next question was how we should manage availability of the products: Should they be placed on the formulary? Where should they be made available? Most important—and this reflects the issue Dr Low Dog raised—how do we recommend something if we don't know the quality of the product?

We asked the pharmacy services department to evaluate several manufacturers so that we could be assured that the products were of good quality. Pharmacy Services conducted site visits to review manufacturing quality and developed a short list of products from which we purchased specific products. The USP Verification Program (USP-VP) now is available and has been presented in Northern California. We have agreed to use the USP-VP standard in the future for products we purchase. However, USP standards did not exist for herbs and supplements when we began this project.

Framing the Clinical Discussion of Alternative Treatments

A recent series of articles in the *Annals of Internal Medicine* has been edited by Eisenberg and Kaptchuk and is well worth your attention.[2-13] The articles address basic questions: What is alternative medicine? What are its major treatment modalities? How should we address the questions of malpractice and integration? Eisenberg has ingeniously defined three categories of use: To approve, to accept, and to discourage. Working in musculoskeletal medicine, I often accept—or even encourage people to consider—the use of glucosamine. It appears to be very safe and seems to be about as effective as NSAIDs. The quality issues have been addressed by our pharmacy and by national organizations such as *Consumer Reports* and ConsumerLab.com. Glucosamine is an over-the-counter product, so it's not on our formulary. People are going to pay a dollar a day if they buy it from a warehouse store or a little more than that if they buy it from us (because we don't stock the volume that the warehouse stores have). But to me, nonsteroidal anti-inflammatories are inherently risky when used by older people, especially to treat chronic conditions; and even the safest NSAIDS carry a fairly high risk of gastrointestinal bleeding. So, I often find myself encouraging patients to give glucosamine a trial.

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For intermediate categories, Eisenberg talks about condoning or accepting CAM use. Many CAM options seem pretty safe but do not show evidence of efficacy or quality—for example, use of valerian for sleep or chiropractic for "tennis elbow." You might say to somebody who wants to try these, "I have no evidence that they will work, but I think it probably wouldn't hurt, so it sounds reasonable to try it; come back and tell me what happens." This approach assumes that you have evaluated the problem and have offered the patient the standard options that you have available.

An example of something that I would discourage today would be the use of kava for anxiety. Although this use has shown pretty good efficacy, recent European reports of liver failure make me hesitant to condone use of kava until more is known. Eisenberg talks about accepting, condoning, and

discouraging use, and I think that that is a very good framework for clinical discussion.

Future CAM Research at TPMG

We believe that anything we bring in must be evidence-based. We have to agree at some level that the substance is effective or safe, or else we have to make it a research project. If one of our staff comes to us believing that an alternative modality offers great benefit, we ask them to set up a clinical study to see if they can prove that to be the case. We are moving to create an infrastructure that will support reasonable pilot studies for research projects that people want to do. We believe that we have the population of patients and interested physicians to be in an excellent position to do cutting-edge research. We have a standing CAM Research Committee in association with our Division of Research and have a growing number of research projects underway. Our Research Committee coordinator is available to consult with clinicians interested in developing research trials.

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Education and CAM

Another guiding principle has been the importance of educating ourselves and our fellow practitioners as well as our healtlh plan members and patients about the safety, efficacy, and quality of CAM interventions. We have sponsored a series of regional teleconferences on various CAM issues. We have worked to make CAM resources available in the Clinical Library and in the Permanente Knowledge Connection (PKC) so that our clinicians can now access the most up-to-date information from the desktop. Patient tipsheets have been developed for the herbs and supplements that have been approved for use, and Frequently Asked Questions (FAQs) have been prepared for acupuncture and chiropractic. Where possible, CAM modalities have been included in patient educational material such as the menopause guidelines.[14] Classes in such practices as yoga, tai chi, qigong, and Feldenkrais movement have been instituted at most of our facilities.

Conclusions

We believe that CAM options that have been proven safe and effective should not be distinguished from mainstream methods of care. I shouldn't have my own practice where people come and talk about herbs while other physicians tell patients that they don't know anything about those things and that they should go and talk to Dr Ballance! The solution to this problem is best stated in a quote from my Chief of Medicine, who recently retired after 25 years. He said, "What's all the fuss about? If it works, everybody should do it; if it doesn't, no one should." The spirit of this quote probably best characterizes integration of CAM into the practices of TPMG physicians.

I will stop here and answer any questions during the panel discussion. Thank you. ❖

References

1. Gordon NP, Sobel DS, Tarazona EZ. Use of and interest in alternative therapies among adult primary care clinicians in a large health maintenance organization. West J Med 1998 Sep;169(3)153-61.
2. Eisenberg DM, Kaptchuk TJ, Laine C, Davidoff F. Complementary and alternative medicine—an Annals series. Ann Intern Med 2001 Aug 7;135(3):208.
3. Kaptchuk TJ, Eisenberg DM. Varieties of healing. 1: Medical pluralism in the United States. Ann Intern Med 2001 Aug 7;135(3):189-95.
4. Kaptchuk TJ, Eisenberg DM. Varieties of healing. 2: A taxonomy of unconventional healing practices. Ann Intern Med 2001 Aug 7;135(3):196-204.
5. Kessler RC, Davis RB, Foster DF, et al. Long-term trends in the use of complementary and alternative medical therapies in the United States. Ann Intern Med 2001 Aug 21;135(4):262-8.
6. Eisenberg DM, Kessler RC, Van Rompay MI, et al. Perceptions about complementary therapies relative to conventional therapies among adults who use both: results from a national survey. Ann Intern Med 2001 Sep 4;135(5):344-51.
7. Vandenbroucke JP, de Craen AJ. Alternative medicine: a "mirror image" for scientific reasoning in conventional medicine. Ann Intern Med 2001 Oct 2;135(7):507-13.
8. Goldman P. Herbal medicines today and the roots of modern pharmacology. Ann Intern Med 2001 Oct 16;135(8 Pt 1):594-600.
9. Ernst E. The risk-benefit profile of commonly used herbal therapies: Ginkgo, St John's wort, ginseng, echinacea, saw palmetto, and kava. Ann Intern Med 2002 Jan 1;136(1):42-53.
10. Meeker WC, Haldeman S. Chiropractic: a profession at the crossroads of mainstream and alternative medicine. Ann Intern Med 2002 Feb 5;136(3):216-27.
11. Kaptchuk TJ. Acupuncture: theory, efficacy, and practice. Ann Intern Med 2002 Mar 5;136(5):374-83.
12. Cohen MH, Eisenberg DM. Potential physician malpractice liability associated with complementary and integrative medical therapies. Ann Intern Med 2002 Apr 16;136(8):596-603.
13. Kaptchuk TJ. The placebo effect in alternative medicine: can the performance of a healing ritual have clinical significance? Ann Intern Med 2002 Jun 4;136(11):817-25.
14. Kaiser Permanente of California. Regional Health Education, Northern California. Menopause: a Kaiser Permanente guidebook for women. [Oakland (CA)]: The Permanente Medical Group; 2002. Available from: URL: http://clinical-library.ca.kp.org/clib/health_education/core/kaiser/menopause_booklet/menopause_full_text.pdf (accessed September 26, 2002).