What Next ? and Why So Slow ?

It has been some time since the California Coalition on Somatic Practices (CCSP) distributed the "Results of the 1995 Survey" and the special report "Why Now is Not a Good Time to go to Sacramento." Both documents previewed plans for how we intend to contribute to the development of the emerging field of somatics. It seems timely to explain what we are doing now, as well as why it seems to be such a slow process.

California Coalition on

Somatic Practices

This may be your Last Mailing please see pages 14–15

"We would like to acknowledge the following associations for their participation in CCSP and generous use of the mailing lists in order to distribute this document. Special thanks to those that also have made financial contributions.

Associations which have submitted their mailing lists (and some donations) for distribution of this document: (they all are service marked)

American Oriental Bodywork Therapy Association
(AOBTA)

American Polarity Therapy Association
(APTA)

Association for Hanna Somatic Education, Inc.
(AHSE))

Association of Humanistic Psychology-Somatics Community
(AHP-Somatics)

Aston-Patterning Training Center

California Chapter-American Massage Therapy Association
(AMTA-CA.)

California Federation of Massage
(CFM)

Feldenkrais Guild of North America
(FGNA)

International Society of Movement Education Therapy Association
(ISMETA)

Hellerwork Practitioners Association

Lomi Method School

North American Society of Teachers of the Alexander Technique
(NASTAT)

Northern CA. Chapter–American Dance Therapy Association
(N. CA.–ADTA)

Reflexology Association of CA
(RAC)

Rosen Method Professional Association

Rolf Institute

Touchpro Institute

Trager Institute

Zero-Balancing Association

(We would also like to thank ABMP for printing notice to their members as to how to receive this document).

Remember us?

CCSP is an "unincorporated non-profit organization" with no formal organizational structure. We have considered various types of formal structure, including incorporation as a non-profit professional association, or becoming a satellite of an existing non-profit. Thus far, we feel that our informal structure has served us well, allowing us to focus on projects and to make rules and policies as needed. This is not to say we will always be informal. In fact, we revisit the issue often.

CCSP provides a unique voice in California, with our commitment to recognize and respect the diverse aspects of our field, and to try to do no harm to those affected by our actions. We are a network of organizations, schools and individuals,–committed to communicating issues throughout the field of somatics, and to representing the field as a whole.

In October, 1997 CCSP updated our mission statement, both as a guide for the future and as a reflection of what we have been actually doing.

Mission Statement (10/1/97):

Whereas: A broad communication forum is needed in the somatics field which gives different voices a chance to be heard and provides a common voice for our diversity

Whereas: we are committed to being an open, inclusive com munity of individuals and organizations; and Whereas: we share a common goal of supporting the development of the field of somatics in California

Whereas: we share a common commitment to protect the right of each modality to practice;

The Mission of CCSP is:

1. *To find a common ground for distinct somatic practices, while recognizing and respecting their inherent uniqueness.*
2. *To monitor and respond to opportunities and potential threats which affect somatic practices in California, and to trends nationwide.*
3. *To be a resource for other professions and the community at large.*

HISTORY:

Our original mission was to create an informational survey to educate and question massage and other somatic practitioners in California about issues of regulation and professional identity. The survey was intended to help practitioners make informed choices so that decisions could be made from the grassroots rather than by an elite group of self appointed leaders. In early 1995 we distributed over 22,000 of these 40 page packets. One year later we published and distributed the survey results.

Survey respondents most favored private professional regulation, possibly leading later to state law. After further study of regulatory conditions and issues in California, we felt it wise to take an active position against attempts to introduce state law at this time, as explained in our most recent document "Why now is not a good time to go to Sacramento ". (This document and the survey results are both available upon request or from our web site.).

Support for state licensing is found primarily among massage therapists and others subject to onerous local ordinances which regulate massage as a vice issue. This is a complex issue. In "Why now is not a good time to go to Sacramento" we explained why state licensing is not the best solution to this problem. It is neither feasible nor will it override the local regulations in California. Unfortunately, there is no way around the need for groups and individual massage therapists to work with each city to improve the laws.

CCSP has neither the manpower nor other resources for direct involvement in local regulations of massage. While we may be able to offer some support and advice, it is up to the practitioners affected by these regulations to work at the local level.

RECENT ACTIVITIES:

Responding to the survey support for self-regulation, we began to examine the idea of some type of council which would recognize the various existing private certifications. In early 1997, we were contacted by a company intending to establish a network of "manual therapists and somatic educators" for inclusion in managed care programs. Other inquiries regarding participation in managed care networks continue to come in. This area of activity was unanticipated,

but has proven to be critical in our development and direction over the past year, and clearly into the future.

These projects–integration into the evolving healthcare system including managed care, and possible creation of a council to recognize private certifications–have been our primary focus during this last year. With further study and new information we have now defined more specific projects and goals, which will be summarized below.

PROFESSIONAL CLIMATE:

The somatic practices need to be represented in policy forums relating to healthcare and managed care. Increasing attention is now focused on complementary and alternative medicine (CAM), usually defined to include massage and the other somatic practices. There are several journals on complementary care, some dominated by medical practitioners. The National Institutes of Health has an office of CAM devoted to the field. Serious discussions and studies are occurring around definitions, training, credentials and regulations of CAM in a number of different venues.

Last year California State Senator John Vasconcellas introduced a bill which would have created a group to study the certifications, training and licensing necessary for alternative and complementary practitioners to be eligible for payment by insurers and workers comp. Potentially this could have led to a group of bureaucrats creating standards for our practices. In fact, concerns over medical billing apparently led to a state law some years ago regulating occupational therapists. Although some of us may have no interest in being part of the healthcare system, we will be affected by policy regarding the emerging system of integrated healthcare.

Although the Vasconcellas bill was vetoed by the Governor after passing the legislature, the issue is not dead. If and when the state begins to seriously study us, we need to have at least one objective, inclusive source of information for them to access. Otherwise, they will get information from only the largest, most powerful groups, or even worse, base decisions on inappropriate models from other states or other professions.

Layout, Production, and Mailing of this report by:
Brian Parks - Somatic Practitioner

A recent British study on integrated healthcare included discussion of somatic practices widely used in England: massage, bodywork, reflexology, shiatsu, and Alexander Techniques. The study is relevant here as well. A major point addressed was the lack of outside review for most existing somatic certifications (each specialty having its own standards reviewed by no one else). There is concern over the lack of clearly defined standards, training, scope of practice, ethics, and other features necessary to allow consumers to make educated choices. Other problems noted were fragmentation and poor infrastructure of these groups, although the study does support recognizing the field in its diversity.

There is a need for an unbiased voice to speak accurately for and represent the profession in discussions of these issues. This has become a driving force for CCSP. At the least, we need to be able to define the terms we use to describe our work and our credentials.

WHY SO SLOW:

What we are doing is new, creating a system based on a more democratic vision of service. Slowness seems to be inherent in the nature of the task and the resources we have to apply to it. We are dealing with an ill-defined problem that we have to conceptualize as we go along. That would take time even with a full-time staff working on it, but when it's being done by part- time volunteers, it is bound to be slow. At the same time, we don't seem to be faced with critical external deadlines yet, so there's no harm in that.

Our group functions by consensus, taking time to research and analyze information and issues. We actively seek and consider multiple perspectives, so that we may respect and reflect diverse interests and viewpoints. Our definition of consensus means a decision that, although may not be considered by all to be the best choice, everyone can agree to live with and not undermine.

As with any healthy community, we try to balance task with process. Process requires allowing participants time for introspection, to identify the sometimes intangible concerns which can lead to conflict. We understand that a healthy community is not one without conflict, but rather is one that supports recognition of conflict, and addresses it with honesty and integrity.

CURRENT PROJECTS:

CERTIFICATION CHART & PRACTITIONER DATABASE:

Our study of private regulatory options led us to develop a comprehensive chart comparing current certifications in the field of somatic education and manual practices.

In an emerging field it can be difficult to understand the terms used to describe credentials. This can be a problem in the eyes of the public, as well as bureaucrats, health care practitioners, insurers, and others. Our chart allows for comparison between certifications, and clearer definitions of terms. It makes no judgments as to worthiness or credibility of the certifications. It simply presents information in a format which makes it easier to understand the various credentials practitioners have.

We initially considered setting up some sort of council or similar organization to approve existing certifications. Ideally, we would want such a body to be eligible for approval by an agency which recognizes the standards and processes of certifying organizations. We came to realize that this was an extremely demanding process in terms of time and financial and human resources, and beyond the scope of our current capabilities..

We then considered establishing a voluntary registry for somatic practitioners, but decided that the term "Registry" implied some verified set of professional standards. We concluded that establishing such standards and verifying that practitioners met them was beyond our scope and capability.

We are currently considering establishing a database of information about somatic practitioners in California, open to any practitioner who chooses to be included. The database would include information about the listee's professional identity, professional education and experience, the modalities they practice and private certifications they have received, and other pertinent information. Inclusion in this database would be voluntary (though we would encourage all practitioners to sign up). We currently see more value in a larger database of

practitioners whose qualifications are presented accurately rather than one limited by determining a minimal level of training for inclusion. Initially, at least, we would make no attempt to verify data submitted. For discussion purposes, we are calling this database the "California Somatic Practitioners Database" (CSPD), and referring to practitioners in the database as "listees."

The CSPD would provide information about the community of somatic practitioners in California which does not now exist, which could be used in various ways to benefit that community. It could provide profiles, for example, showing the range of modalities practiced, variations in education and experience, the extent of various forms of private certification, etc. Such profiles would be interesting in their own right, and could be important in any discussions of policies affecting the somatic community. Individual practitioners would not be identified for such profiles.

We can also envision purposes for which the identification of individual practitioners would be required. When Consensus Health (CHC) began to set up their network of somatic practitioners within the managed care system, for example, they asked CCSP for help in contacting practitioners who might wish to join the network. We directed them to practitioner organizations representing various somatic modalities, through which they contacted members of those organizations. If the CSPD had been in existence, we would have been able to direct them to practitioners who had authorized release of their identities for such purposes. In setting up the CSPD, we will need to define and allow listees to specify various purposes for which information about them might be released.

The data collection and entry involved in setting up and maintaining the CSPD is beyond the capabilities of an informal organization like CCSP, and we would expect to contract those tasks out to a cooperating organization.

While the practitioner database may be a reasonable next step toward professional growth and self-regulation, managed care is an issue which is necessarily commanding a great deal of our time and attention.

MANAGED CARE

In fall of 1996, we were contacted by Consensus Health (CHC- formerly known as Complementary Healthcare). This new company wanted to provide information to somatic practitioners about the practitioner network they were creating. With our help, they were able to reach members of most somatic associations in California, including those on our own non- affiliated practitioner list. CCSP has not taken a position on inclusion of somatic practices in managed care, feeling that decisions regarding participation should be left to practitioners. CHC later asked us for input on the contract and manual they were preparing. We hired Jerry Green, a lawyer who has been involved in CCSP, and specializes in issues such as this, to help us in suggesting changes.

While we have concern about some aspects of the CHC program, including the use of one contract for both licensed and unlicensed practitioners (acupuncture and soon chiropractic being in the same network), we feel that the current program recognizes somatic practices in an acceptable manner, legally and philosophically.

As of January of this year, Blue Shield has made this network available to all 1.6 million of their California members through their "Lifepath" program. Blue Cross of Calif. is developing a massage network. Alternative Healthcare of Thousand Oaks administers a similar program which includes at least massage.

These programs are currently what is called "access", or "non-benefited" options. This means that the client chooses your services, pays you directly at a discounted rate. While there is no need for the paperwork involved in billing and no wait for payment, the discount can be significant. Blue Shield requires that you discount 25% off your usual fees. In return, you get inclusion in their participating practitioner directory and access to the large potential client base the program provides. Hopefully this will lead to greater public and medical awareness and use of our services. The practitioner directory includes a short definition of each modality, increasing public awareness of the many specialties and styles of work. CHC, the network provider for the Blue Shield network, will analyze data on utilization by clients. This may help document, at least anecdotally, whether regular use of somatic practices contributes to lower health care costs. For any of us in that network, it will be useful to submit the minimal client utilization questionnaires which CHC is requesting.

We have identified three models of healthcare which have relevance for the integration of somatic practices into managed care programs. They are:

1. Medical model

This model has clear legal parameters under the medical practices act or other acts specific to limited medical practices (i.e., physical therapy)

The medical model focuses on the diagnosis and treatment of pathology, i.e., on classifying a presenting problem within a system of identified pathologies (diagnosis) and then applying a medically accepted intervention to that pathology (treatment). This conceptual framework lends itself nicely to managed care, since it allows specification of the conditions (diagnoses) and the interventions (treatments) for which reimbursement will be provided.

This model has serious shortcomings for most Somatic Practices. The legal definition of "practice of medicine" is highly restrictive, and permits "treatment" to be performed only by a licensed practitioner (MD, PT, etc.). Much of what we do is not "treatment" aimed at a particular pathology. Rather it is a more systemic intervention aimed at enhancing the overall health and well-being of the client. This may lead to an improvement in the presenting condition, even though it was not directly targeted at that condition. This fact is recognized in the following two models.

2. Non-treatment (Adjunct) Model

This model recognizes that some dysfunctions result at least in part from systemic conditions which can be improved by non- specific somatic intervention, i.e. back problems or stress related conditions associated with chronically high levels of muscle tension throughout the body, which benefit from techniques producing a reduction in systemic tension. As another example, interventions leading to better balance and body alignment reduce mechanical stress throughout the body, lessening vulnerability to a wide range of conditions and injuries.

This model need not require a finding of "medical necessity". Instead, it can use the medical condition as the criteria for coverage without considering the covered intervention as "treatment." For example, the insurer provides coverage for the condition of carpal

tunnel syndrome, as evaluated by the primary care provider. Based on the presence of the insured condition, the provider refers the client for the adjunctive (ancillary) service to address the person in a holistic manner. The somatic service can complement or enhance the primary treatment or be independent (if the condition is non threatening), so as to reduce the need for medical intervention. Somatic education techniques aimed at improving mobility would constitute one example. Soft tissue work on areas compensating for the symptoms of carpal tunnel syndrome might be another.

3. Wellness or Health enhancement model

This model would require a broadening of managed care coverage to include preventive and health enhancement services, to promote a generally higher level of health and functioning in the population served: individual customers and businesses providing employee healthcare.

Findings:

Somatic practices aimed at enhancing overall health and well- being do not fit within the existing medical model because no specific pathology is being addressed. Somatic practices which do target a specific condition are not generally classified as medically necessary "treatment," and if they were, could not be legally performed by a non-medical practitioner. The latter two models above support these philosophical distinctions.

Consensus Health and Blue Shield may make manual and somatic practices a paid benefit in the future, as a rider to policies purchased by employers. This would most likely be done under an adjunctive model, but not the wellness model. How this might look can be seen in the coverage for acupuncture, which has been set up to be both benefitted and access. (Note: As of early May, 1998, state approval of acupuncture as a paid benefit under the CHC/Blue Shield program is still pending. Currently acupuncture is only available under the access discount program).

Under the benefitted program, if a Blue Shield member covered under a rider for acupuncture goes to a participating acupuncturist for a covered condition (which are defined), the acupuncturist does an evaluation and submits a proposed treatment plan. Authorization is then given for the approved plan, according to established treatment protocols. The acupuncturist must keep adequate records, bill for services, and wait for

payment. Further treatment means submitting further requests. Unapproved sessions can be paid for directly by the member, but at the discounted rate of the access program. (CHC will use advisory committees of practitioners to establish treatment protocols when the time comes).

Wellness or health enhancement programs are not generally paid for by the insurers. Currently, some insurers pay for Dr. Dean Ornish's Healthy Heart program as an alternative to bypass surgery but only after a diagnosis of heart disease requiring surgery. Certainly many individuals with high blood pressure or other signs of potential heart problems which have not become urgent yet would be helped by the program, but insurers will not pay prior to pathology.

This seems to rule the health enhancement model out of the benefitted program, as it is currently constituted. Medical treatment is out as well, due to scope of practice issues (not to mention philosophical concerns of many of us). Adjunctive non- treatment models are therefore the primary ones we need to consider now for our own possible inclusion in benefitted programs.

The inclusion of somatic practices within managed care is viewed positively by some and negatively by other, but the evidence available to support either conclusion is sparse at present. CCSP hopes to contribute to increasing that evidence by following and monitoring the managed care networks now getting underway.

We intend to begin within this year, with surveys of practitioners involved in the Blue Shield/CHC network. CHC has agreed to give us use of the Blue Shield practitioner network list and we hope to gather information on the other programs as well. Results of these surveys will be distributed to respondents and associations, through newsletters and our web site. Our objectives in such monitoring are to assess the program, provide information to the somatic community and to Consensus Health and the other programs.

Types of data we intend to collect include: volume of referrals, practitioner originated comments and complaints, effect on prices/ length of sessions by participating practitioners, perceived effect on prices/ length of sessions by local non- participating practitioners, affects on relationships with clients, quality of care, client access to your work, and the affordability of somatic work. We also want to access utilization data and client experience, such as the specialties represented.

SUMMARY

As a volunteer organization with limited resources, we must take care not to overcommit ourselves. In particular, we are not yet sure that we have the resources to create a comprehensive database of practitioners and their certification information. The issue is not necessarily database yes or no, but database now or maybe later. We need to continue the network provided by the coalition , and to strengthen our ties to associations and schools. Monitoring the managed care networks which are including our services is a priority for us. The certification table is important, and the information it contains may need to be expanded.

We probably have the resources necessary for the certification table, creating a better network of internal communication, communicating with practitioners, and monitoring managed care. We have done some preliminary planning on the practitioner database and putting out the word that we may establish one may bring in additional resources to achieve it, or may lead to other creative means of achieving the same purpose.

We feel it important to send to practitioners at least annual reports on the issues and activities we are considering, with updates through association newsletters and professional journals, as well as our web-site.

While we need to pay attention to the "outside world" and how it impacts us, we also need to develop on our own terms, and not buy into a system of professional growth that doesn't support the best possible ability of each of us to work with our clients. This brings up difficult issues–we may need to create a new model rather than automatically accepting traditionally recognized programs as superior to others appropriate to our field.

How quickly these things get done, and what else we can do beyond our basic priorities, will depend on the resources available to us in the coming year. Those resources consist primarily of volunteer energy and commitment, which are always uncertain in an informal organization with a constantly shifting membership. If you feel, as we do, that this work is important, we encourage your participation and support..

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