Industrial Insurance Chiropractic Advisory Committee (IICAC) Meeting Minutes
Date: December 20, 2007

Final

Present: Robert Baker, DC
Clay Bartness, DC
Roger Coleman, DC
Linda DeGroot, DC
Michael Dowling, DC, Chair
Lissa Grannis, DC
Jay Lawhead, DC
Bill Pratt, DC, Vice Chair
Ron Wilcox, DC
Bob Mootz, DC
Neal Schanbeck
Joanne McDaniel
Janet Blume
Carole Horrell

Absent: La Vonda Mccandless
Guests: NA

General Business

Minutes:
In the 12/13/07 IICAC minutes, the second page of the Evidence Based Practice and Policy discussion notes were missing.

Moved, Seconded, Carried: Unanimous vote to approvethe minutes as written

Bylaws:
Bob Mootz distributed the final bylaws signed by Mike Dowling, DC, IICAC Chair and Judy Schurke, L&I Director.

IICAC Subcommittee Structure
Bob Mootz shared a two page spreadsheet of the prioritized topics that resulted from last month's discussions. He proposed two subcommittees:

- Evidence-Based Practice and Policy (EPP) to research and develop new information
- Provider Education and Outreach to distribute the new information

After discussion, IICAC members chose their subcommittee:

- EPP Subcommittee Members:
  - Bob Baker, DC
  - Roger Coleman, DC
  - Linda DeGroot, DC
  - Jay Lawhead, DC
  - Mike Dowling, DC, Chair
  - Bob Mootz, DC, staff

- Provider Education Subcommittee Members:
  - Clay Bartness, DC
  - Lissa Grannis, DC

- Bill Pratt, DC
- Ron Wilcox, DC
- Mike Dowling, DC, Chair
- Joanne McDaniel, staff

We'll spend the entire February meeting developing the goals, priorities, and assignments of these subcommittees.

IICAC projects were listed per subcommittee according to these criteria:

- "**Current Work**" = We already have resources or a process in place to accomplish the work. (All fall under the Provider Education and Outreach Subcommittee)
  - Biennial Chiropractic Consultation Seminar
  - Other L&I seminar ("Practice Headaches. . ." and special projects)
  - Attending doctor mentoring (available by phone/e-mail to answer questions)
  - Chiropractic Consultation Program
  - Troubleshooting claims problems/formal complaints
  - Claims suppression/directing care complaints
- "**Special Project**" = New resources, funding, procedures, etc. are necessary.
  - Provider Education Subcommittee:
    - Biennial Chiropractic IME seminar
    - Identify additional provider education opportunities IICAC may contribute to and develop course syllabi, for example:
      - Presentations at WSCA's annual conventions
      - Stand alone programs for WSCA
      - Collaborations with COHE CE efforts
      - Participation in annual E WA chiropractic meeting
      - Presentations at regional/county society meetings
    - Academic detailing in doctors' offices
  - EPP Subcommittee:
    - Contribute to revision of "Chiropractic Physician's Guide"
    - "One-page" tip sheets on common workers' compensation problems for WSCAs "Plexus" or website
    - Evidence-based Clinical Practice Aids for common occupational health conditions seen by DCs. This will require:
      - Literature summaries, bibliographies
      - Clinical management summaries and best-practices resources
    - Chiropractic Care Visit code service descriptions and components of care/documentation project
      - Payment policy information/criteria
      - Assess current code use, test and refine documentation/audit criteria
    - Develop condition-specific evidence-based indications information for use of chiropractic services
    - Develop resource materials and practice aids for specific clinical topics (anticipate approximately 1 per year)
      - Upper extremity peripheral entrapment syndromes (median, ulnar nerve)
      - Shoulder injuries
      - Neck injuries
      - Mid back pain and injury
      - Low back pain and injury
    - Pilot test and refine practice aids in specific settings (e.g. COHE providers)

Evidence Based Medicine

Bob Mootz provided an hour of education on evidence-based medicine, how is it accomplished, and why it's important.

The goal is effective care of patients. We need to obtain the information, implement it on a small scale to make sure it is useful, then roll it out to the community.

Higher quality evidence, such as randomly controlled clinical trials, is much more important than lower quality evidence. Anecdotal evidence may have currency only at an advocate or political level, not in evidence based medicine. It cannot be used on a community based level to establish quality care.

Technology assessments are rarely performed on existing, diffuse services. Emerging and high cost technologies get that attention. Insurers begin at "non-coverage" and must be convinced to cover and purchase the new technology services.

For new services, the burden of proof typically falls on proponents. Few companies want to pay the expense of clinical trials that are necessary to prove efficacy of the new service. Therefore, it's difficult to obtain approval.

The social context of evidence based medicine:

1. Does it work? (effectiveness)
2. Is it needed? (appropriateness)
3. Is it wanted? (informed decision making)
4. Should the public pay for it? (insured services)

What is the procedure for new technology assessments (devices, procedures, etc?

1. Application by proponents, utilization triggers, or legislative request
2. Staging: coverage and situation specific evidence is necessary
3. Policy analysts review the outcomes. Most are increasingly evidence-based medicine trained (MPH, MPAs, or similar)

"Standard of Care" is a legal term. It is determined by the Trier of fact (judge, jury, commission, etc., not by the provider community.