Dynamic Chiropractic

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Missed Opportunities?

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I used to just glow with pride when I would see a workers' compensation (WC) study compare how chiropractors stack up to other providers. We always seemed to come out with lower patient costs and return people to work sooner than our competition.[1] Sure, there were some design problems with the Manga report.[2] The recommendations only made sense for Ontario or some other jurisdiction that did not already cover chiropractic care very well, but it really was great to be a part of a profession that was doing a "better job."

These days, I'm getting a little nervous. The sophistication of research on costs of care is getting better and more accurate. Many of the design problems that exist with simplistic actuarial reviews are being overcome with approaches that encompass more than error-prone administrative databases. While it is true that actuarial reviews showing up in the next year or two, e.g., the recent Florida study,[3] will still show us coming out on top, new prospective studies and studies using better analytical methodologies may report less favorable results.

A recent study in California, using economic analyses that adjusted for case mix, demonstrated that the costs were fairly equal between cases managed by MDs and those managed by DCs.[4] Chiropractors still had a slight edge when it came to disability days, but overall it was a wash. The argument can be made that medical or chiropractic management are, at worst, substitutes. However, I have also reviewed current Washington state data (which is still too early to publish, and uses only the old-fashioned actuarial analysis approaches), and the early trends are not like the old days. These studies account for surgery rates of those managed by DCs versus MDs (which are about equal), severity of condition, and PT usage. The margins of advantage for chiropractic care are virtually gone.

There is a nationwide prospective study now out of Arizona State University collecting detailed claims data and interviewing patients that will compare in greater detail chiropractic and medical management using the best research design yet attempted for the question. It will cross state boundaries and assess patient-reported outcomes, have complete detailed billing information, and follow the cases over time. This promises to be the most meaningful WC study done to date, and I look forward to seeing what the results will reveal over the next few years.

What happened to those wide margins of cost and time-loss benefits over medical care? What has changed? What hasn't changed? For the most part, medical management of back conditions has improved dramatically since the days when the best medical, conservative care consisted of bed rest and prescribing devastatingly toxic NSAIDs. Throw in poor patient selection for aggressive back surgery, and we chiropractors had some fairly easy competition to beat. Today, early activation, less toxic drugs, and better patient selection for surgical procedures have resulted in lower costs and better outcomes in most settings. There is still a lot to be desired with run-of-the-mill medical approaches for back problems, but they are dramatically better than what the norm was 20 years ago. Chiropractors have been mostly content to rest on their laurels; some even promote extending care in injury settings regardless of outcomes (with resultant higher costs).

Spiraling health costs, superimposed on not-so-rosy outcomes, brought draconian measures in the form of managed care. However, two worthy lessons can be extracted from the experience: quality improvement initiatives and evidence-based health care have offered vehicles for improving patient outcomes.

On the medical side, I have long believed that a substantial narrowing between chiropractic and medical costs in WC settings would occur when the studies documenting chiropractic's effectiveness made the reading lists of health care planners. I recall a complaint filed against me by several students for being "antichiropractic" in my mid-1980s faculty days when I suggested that medical and physical therapy care were also improving back care, and we needed to be prepared for more effective competition.

This leads me to the other side of the equation: If medical care can improve, why can't chiropractic care? Why can't our already decent outcomes and high satisfaction become better? What is stopping development of better and more efficient chiropractic methods? I suspect it's inertia. For the most part, our academic institutions and practices have functioned in relative isolation from practice changes in the rest of health care. Patient care is our first concern, but we've also been motivated by business and political survival. Given our already high effectiveness and satisfaction marks, quality improvement has just not been on our radar screens. To survive another generation, however, we need to do even better; we need to do the job more efficiently, at a lower cost, and with higher levels of concern for our patients' interests. At all costs, we have to do at least as well as the competition.

Some of that improvement can come from better clinical techniques, from better adjusting skills, and more alert diagnostics. That, however, can take years of research. We can benefit from improving our general injury-care-management strategies and more attention to patient motivation; psychosocial barriers to recovery; and being able to constructively work within the system. In WC, that includes early (but appropriate) return-to-work, preventing adversity that invariably places the patient etween players often more concerned with their own agendas (e.g., closing a claim or winning a judgment), and promoting self-reliance. Several studies have documented that the best occupational health management practices help doctors reduce time loss, yet none of these practices involve any direct financial incentives or disincentives for doctors.[5]

Things Chiropractors Can Do in WC Cases to Help Prevent Long-Term Disability

Within the first month or two following an injury:
• oral "contract" to delineate patient responsibilities;
• appropriate, passive care to avoid treatment dependency;
• early activation.
• early return-to-work (include learning job demands).

More than a few months of time loss:
• coordinated identification/coordination of resources used and other potential options;
• seek additional clinical expertise or second opinions as appropriate;

• avoid repeating prolonged use of passive interventions that may create treatment dependence.
• assure good communication and coordination with system resources, particularly new participants who are more likely to become involved (e.g., vocational rehabilitation providers, attorneys).

Within the first six months of an injury involving prolonged time loss:
• identify if disability risk factors exist (e.g., psychosocial yellow flags; age; diagnosis; motivation; missed appointments; workplace organization and support; identification of system issues);
• assure that interventions promote worker control and self-reliance;
• if clinical progress is stalled or plateaued, consider other opinions;
• re-explore employer issues in depth (job-satisfaction, workplace support, fear of job-loss);
• re-explore lifestyle issues in depth (depression, demotivation, personal problems).

Conclusion

There are things practicing chiropractors can do right now to do a better job in WC settings that will improve our medical cost and time-loss experience with injured workers.

Aside from the obvious benefit to helping injured workers recover faster and avoid spiraling into long-term disability, what I've outlined here will help chiropractors be more effective, and improve how we stack up to the competition - if not for our patients, then for ourselves.

Author's note: I discussed strategies for preventing chronic disability in injured workers in much greater depth in a recent article.[5]

References

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