Dynamic Chiropractic

PHILOSOPHY

Visibility and Responsibility

In the last two months I have made invited presentations to two very different non-chiropractic audiences. But the more I reflect on the experience, the more I see interesting parallels. Chiropractic has reached a new level of visibility in society, but more specifically, it has appeared on the radar screens of two different kinds of health professionals, both having much to do with the potential future of chiropractic.

The first speech was to the American Association of Preferred Provider Organizations (AAPPO). Just as it sounds, the AAPPO is basically a trade association of PPO owners and administrators who have banded together to promote and enhance their brand of economic response to the rapidly changing health care industry. Industry is a good word to use with respect to the AAPPO, because many of their members are not clinicians of any stripe, but businessmen and women. Lest we look down our noses too quickly, it should be added that although they are clearly interested in the bottom-line, they realize that quality is part of the health care commodity equation. What PPOs and other managed care organizations want to deliver is value. Value is defined as quality divided by cost. The AAPPO wanted me discuss the integration of chiropractic into managed care, should it be done, and how could it be done.

The next presentation was to the Institute for Health Policy Studies, which is attached to the medical school at the University of California, San Francisco. The Institute for Health Policy Studies is composed of health services' researchers, economists, and policy analysts. Health services researchers are potential friends of chiropractic because they don't necessarily take sides in "turf" wars. They are interested in the bigger picture. Their goal is to study the entire health delivery system and help decide how to get the most bang for the buck. Rather than interest themselves in the biology of individual patients, they care more about the health of whole populations at a time. Needless to say, recommendations emanating from health services' researchers carry a great deal of clout with policymakers in both the private and public sectors. In fact, the U.S. government supports an entire agency devoted to health services research, the Agency for Health Care Policy and Research (AHCPR). The AHCPR guideline on acute low back pain is a good example how health services research can support the chiropractic profession.

What always strikes me about these relatively well-educated audiences is just how little they actually know about the chiropractic profession. They do not understand the education or the licensing process, and they generally do not know where we stand with respect to other health care professions. The little lesson here is that we simply need to be there, and there on a regular basis.

In both settings I was able to raise more than a few eyebrows by talking about the size of the chiropractic economy, which is somewhere around $6-7 billion annually; and about our growing inroads in the health care marketplace. A recent survey suggests that almost one in five Americans seeks chiropractic care every year. Furthermore, somewhere between 30 percent and 40 percent of all patients with low back pain seek care from a DC, very often in a primary care mode. When these figures clearly show just how important chiropractic seems to be to the American public, policy analysts have a tendency to wonder how they missed it. Now, they will scramble to study it, and this is good for chiropractic.

From a PPO owners perspective, it is easy to sell chiropractic on the economics alone. But it is with the medical directors and quality assurance managers that some of the tougher questions emerge. Most often these refer to how chiropractic can be integrated into their administrative systems. These issues also concern health policy analysts. They want to know whether or not chiropractors will be able to withstand or perhaps even thrive under the bureaucratic restrictions imposed by managed care.

Basically, both audiences think that at least the four following integration issues must be considered: 1) the nature of patient access to chiropractic providers (i.e., the gatekeeper problem); 2) credentialing; 3) the quality assurance process; and 4) utilization management.

My experience with these audiences is that chiropractors will have to make a strong case for direct access to patients in managed care plans, unless they are owned and operated by chiropractors. In many cases an articulate argument will prevail, but if subsequent cost-effectiveness or quality suffers, direct access to chiropractic care can be kissed good-bye. Chiropractors will have to learn to live with the credentialing process. It has been a fact of medical life for many years, but chiropractors are not used to that kind of scrutiny. There is no reason though that chiropractors cannot stand up to the rigors of credentialing. It is expected of us.

Quality assurance is another one of those "look over your shoulder" irritations, but again, there is nothing in chiropractic that inherently argues against appropriate quality assurance criteria. Most are simple, basic common sense items. How good are your records? How clean and up-to-date is your clinical equipment? Do you meet ADA and OSHA standards? Are your staff well-trained? Are your patients satisfied, not with just the effectiveness of your care, but also the process of receiving it? If you answer yes to these questions, there is little to fear from quality assurance, except perhaps the paperwork. So what else is new?

Utilization management (UM) is the most intrusive of managed care oversite functions. No provider wants to be second-guessed: that's human nature. We should remember that the reason that UM exists in the first place, is the finding that there is a huge variation in the type and amount of many treatments provided to patients. This is despite the fact that there appears to be no logical reason for the variation. Pragmatically, UM is also a fact of life for all managed care organizations if they want to be accredited by the National Commission on Quality Assurance (NCQA), and they must be accredited to be able to sell their services to payers.

The important thing to note about our new visibility with these two new audiences is our increased risk. The risk to which I refer is the one whereby a few bad examples of chiropractic care can result in the total collapse of any opportunities inherent in the new visibility. Both audiences were aware of negative publicity concerning chiropractic, and many had false perceptions about the teachings of chiropractic. The point is that increased professional visibility must be supported by a growing sense of professional and personal responsibility by individual chiropractors and their organizations. Chiropractic simply cannot afford to be tarnished by embarrassing chiropractors, or by embarrassing chiropractic organizations. We must all be responsible for the new visibility of chiropractic. Responsibility means taking personal and professional pride in delivering cost-effective chiropractic care with integrity. Professional responsibility also connotes a certain willingness to: weigh critically before accepting or rejecting an idea no matter what the source; adhere to appropriate quality guidelines; engage in professional discourse; keep up-to-date by reading the professional literature; be open-minded and compromise if necessary; constructively criticize fellow chiropractors for the good of the profession; be pragmatic as well as idealistic; listen carefully, and to accept constructive criticism in a professional manner.

While many individuals in other health professions certainly do not live up to the highest standards

of professional responsibility, that is no excuse for chiropractors to accept less than optimum quality as a professional goal. If chiropractic is to continue its forward march and become an integral part of common health care for all Americans, our goals cannot be too high.

William Meeker, DC, MPH, FICC
Davenport, Iowa

JANUARY 1996