Dynamic Chiropractic

Herding Cats and Other Quality-Improvement Exercises

A TALE FROM THE TRENCHES

Robert Mootz, DC

> "Find it, fix it, leave it alone."
> *- B.J. Palmer, epigram at Palmer School of Chiropractic, circa 1939.*

The conventional wisdom guiding much of the insurance industry these days seems to be that most doctors - particularly the really bad "problem doctors" - tend to be out for themselves, ignorant of the best and most efficient practices in health care. This vantage point stems in part from the number of hours each day that insurance industry personnel spend reviewing poor, ineffective and costly care - mostly from a small number of actual "problem doctors." No matter how much data you show some of them, their bad experiences seem to color everything they think about doctors, causing them to distrust care recommendations any doctor might make.

Additionally, most doctors have no idea of the volume of decisions claim personnel have to process. They also fail to adequately document care in a way that facilitates the black-and-white, yes-or-no determinations they are required to make. Thus, claims personnel can find it pretty easy to think, "Doctors just don't get it." The conventional coping strategy is then to put as many barriers in place as possible to make it difficult for the problem docs to get away with much of anything. The trouble is, all the shrapnel from things like benefits caps, preauthorization, UR and second-opinion exams, end up tormenting the good folks just as much as the bad, driving up their stress and overhead. Throw in a few really *gnarly* network contract clauses and you can create an environment in which good docs decide it's time to take up that second career in music.

Likewise, the conventional wisdom that doctors and trade associations frequently have about the insurance industry is that it sees doctors as nothing more than obstacles to their higher profits. Doctors see claim managers aspersonally vested in preventinga patient from receiving needed care and doing everything possible to stop the doctor from getting reimbursement for the services provided so they can line the pockets of their friends at Halliburton. As a result, doctors tend to believe that insurers have no grasp of the real world of patient care and what it takes to keep a practice going. They find it pretty easy to think, "Insurance people just don't get it." Frustrated, they take the battle to their legislators (who have just met with an insurance lobbyist venting about wretched docs while making a bigger campaign donation than you could ever afford), or to the courts to try and get someone to do something about all the injustice.

And so it goes. Insurers see outlier doctors as their biggest problem and set up what I like to call "whack-a-doc" protocols, aimed at the few folks who try to reverse-engineer and rip off the system, without an understanding of the collateral damage to the good folks. Meanwhile, provider special interests go after those greedy insurance companies as the culprit and demand that the government (*or someone*) do something. Oftentimes, this ends up coming out something like the chiropractic benefit in Medicaid, but nearly always puts doctors and payers at odds and without

any way to engage in constructive problem-solving. The primary beneficiaries of this whole mess are the attorneys, of course. So at least someone wins.

What's a reasonable person to do? Well, like many other things in society, health care is full of the problems that plague human nature: complex communication, economic matters, haves/have-nots, preconceived notions and personal experience, along with bias that colors future action, greed, need and well-intentioned folks doing the best they can under the constraints they are required to work under.

Of course, health care isn't the only place you can find these problems. Business, politics and personal relationships come to mind as well, don't they? Whenever people come across complex problems filled with noxious occurrences, it is human nature to say "they should pass a law" or "they need to stop that." However, people and systems sometimes really only muddle along under the inertia and cumulative workings of a cascade of business-as-usual practices, superimposed on previous "crisis-management" interventions. As much as I hate to invoke a tired cliché, the way out is to "think outside the box."

Health care's previous crisis-management interventions include a lot of perverse incentives. For example, it is reasonably easy to get diagnostic tests approved to be done under the assumption that you will then know what is wrong, and everyone can make good "yes" or "no" decisions. Yet it is pretty difficult to get an intensive rehabilitation plan (shown to be as effective as most surgical options, frequently cheaper and with much lower risk of adverse outcomes) approved for someone whose only other option might be for more costly imaging and possibly spine surgery.

The reason this happens is not what you think (i.e., insurers are in the back pockets of the medical industrial complex who are out to crush the opposition). It's actually based on previous experience with predictability. The rehab option has been plagued with huge practice variation; some PTs, PMRs and DCs may do intensive, active interventions driven by time-limited, functional-improvement thresholds, but most do whatever they were taught in school and bill for as long as the patients come in and insurance companies pay.

Actuarially speaking, there is no consensus, let alone a definitive care standard or two for differenttypes of rehab interventions, frequency or duration of rehab protocols and the like. Basically, it's open-ended and usually involves a contest at some point between the provider and payer that centers on the patient's relief and the provider's lack of commitment as to when it's done. (This is why most payers have just placed a dollar cap on all rehab, physical medicine and chiropractic services.)

Essentially, there is no predictability for those black-and-white (yes/no) decisions that adjudicators have to make. Imaging and surgery, on the other hand, are quite a bit more predictable: a set intervention, a set, all-inclusive DRG charge, and a set time frame. Although outcomes and cost may be somewhat worse in a larger proportion of cases overall, there is far less frequent uncertainty about what the intervention, duration and reimbursement issues are in any given case. From the outside, it looks like surgeons know what they are doing and will just do it; and overall, the rehab and chiropractor types seem, well, pretty flakey.

Interestingly, evidence-based medicine is shaking things up a bit. There has been a lot of work looking at patient outcomes lately, and recent research is shedding brighter light on the kinds of conservative interventions that offer both good outcomes and some predictability in application. Payers (along with policy) are taking note, but the struggle between the inertia of how things have always been done and how things need to be done is a challenging one. The title of this column is also its punch line. In order to make the system better, a bunch of folks (in both payer and provider

communities) who traditionally wander their own separate and autonomous ways will have to be able to set aside many of their preconceived notions and business-as-usual practices to make changes.

If you think changing provider behavior is tough, wait till you see what it takes to change payer behavior. Can it be repaired before it's too late? This column lays the groundwork for my rantings in 2008, which will center on ideas and experiences aimed at making sustainable, incremental improvements (aka, slaying of those sacred cows) on all sides.

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