Dynamic Chiropractic

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Pressures on Practice or Opportunities?

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The pressures on health care have never been greater. What used to be the byproduct of an individual and personalized relationship between a doctor and a patient has essentially become a commodity, much like your cable or energy service. Primary reasons for this include the following:

- Insurance coverage has removed patients from most of the direct involvement in the financial costs of health care. This was good for patients because they didn't have to worry so much about money when a health crisis occurred. It was good for doctors because they no longer had to worry about getting money from individual patients; it just came from the big-insurance or taxpayer pool. But it could be bad for patients because the money that bought the doctor's time was no longer theirs. Therefore, third parties had more say in what health services looked like. And it was bad for doctors because business realities unrelated to an individual patient chipped away at their autonomy in making care decisions.
- As health technologies improve, many advances end up costing more. While some advances like microsurgical techniques may reduce costs, other advances such as implants, newer drugs, and new diagnostic and imaging end up costing more. Medical inflation in the United States exceeds that of the general economy, meaning a greater proportion of the gross national product each year goes to health care costs. Therefore, health care expenses are a containment target.
- Medical errors and safety concerns are common enough to become an accountability issue for society. Doctors make mistakes, care doesn't always work as expected and deep pockets become a target for the aggrieved in a litigation-oriented culture, between professional liability programs and the actual or perceived wealth of doctors and health care systems. Professional liability costs contribute to the cost of health care. Another result is increasing demand for performance measurement (e.g., data that highlight which hospitals and doctors get the best outcomes).
- As research sophistication evolved, better ways to look at effectiveness and risks of procedures led to better evidence of many health care procedures. Experimental science, along with substantial government and corporate funding to support it, has resulted in more high-quality research on larger populations. Better information is available about what is effective, what safety profiles of procedures are, and how utilization is impacted by various interventions. For example, a new diagnostic test may lead to what is touted as better information, but has a downstream impact that may or may not be in everyone's best interest. MRIs and discography, which better image abnormal disc structure, may provide a rationale for more patients to get spine surgery, yet the outcomes and costs from the additional surgery may not be an improvement over not having the new test.
- Everybody knows more than they used to. The information age means all your competitors and patients have access to all kinds of health care information, including government Web sites like PubMed and the National Cancer Institute, in addition to all the other consumer resources that are accessible.

Essentially, this all means that doctors not only have to pay attention to what might be going on with an individual patient; they also have to cope with things like benefit restrictions, preauthorization, utilization review and more reporting, as well as discounting and wholesaling strategies common to most businesses (i.e., being paid less for doing more). In addition, much of

the paperwork may not seem directly relevant to the care you need to provide patients.

Although the clock will not get turned back to anyone's golden era, many of the factors increasing pressure on the system also provide opportunities, particularly for those with a mind toward harnessing the tools of quality improvement to overcomethem. Each of these issues provides a unique opportunity for DCs to evolve more toward an essential health care resource and away from the conventional perception (and frequently behavior) as another special interest group.

With insurers and employers (the folks who pay most of the health care premiums in the U.S.) having the lead role in making coverage and reimbursement determinations, doctors need tools to make it easy for the payers to determine when care is appropriate. Payers need reasonable and explainable amounts of practice variation that can be allowed, as well as clear thresholds for what constitutes high-quality care. Best practices and practice guidelines have become the *de facto* approaches for handling this throughout health care, yet they are a contentious thing among providers. When meaningful clinical thresholds can't be agreed upon by all, payers simply place arbitrary caps or set up preauthorization and utilization-review processes to limit their risks.

The conventional wisdom on both sides about guidelines is often misguided, assuming that they will serve either as a red or green light for what either party wanted to do regardless. What is the solution? Guidelines need to be a resource to help clarify meaningful thresholds of effective, quality care. Addressing functional-improvement benchmarks, timelines, referral pathways and standardized ways of measuring them can help. When the available scientific evidence is inadequate to provide a perfect answer (which is usually the case), a reasonable proxy is to develop quality indicators that are straightforward to track.

For example, quality markers in a probable carpal-tunnel patient might include obtaining a nerve-conduction studyto assess the degree of median nerve entrapment, as well as specific improvementtargets (e.g., pain-free nights, hours ofpain-free work) within a certain time frame.

If these aren't achieved under conservative care, obtaining timely specialty or surgical consults might be appropriate. Working with a community of doctors and a payer to facilitate improvements in a particular group of patients can foster a working relationship that not only helps doctors assure care goals are identified and achieved, but also improves confidence and the level of comfort a particular payer might have in working with chiropractors.

Another example is how the Washington State Chiropractic Association has worked with the state's worker's compensation system to develop a process to train chiropractors in occupational health and worker's compensation issues. These doctors then serve as chiropractic consultants who can be called upon statewide by other DCs to help them with second-opinion evaluations to determine progress, if max-imum improvement has been reached, carealternatives or other issues relevant to occupational injuries. As such a resource, they both help their peers to enhance the quality of chiropractic care workers receive and clarify important system issues that help claim managers. This has contributed greatly to the perception of DCs as an integral part of our worker's compensation system. Next time, we'll look at how other health care system pressures can be opportunities for chiropractic.

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