Dynamic Chiropractic

CHIROPRACTIC (GENERAL)

The Paradigm Shift

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For decades, the likes of Vear, Hansen, Iannelli, Krantz and myself, as well as a few other wretched insurance types in our midst, have been harping on the idea of "quality improvement" in chiropractic. The general idea is to begin to build an infrastructure and culture in chiropractic delivery settings that measure relevant patient-oriented outcome and process data and use it as an additional "reality check" beyond, say, monthly accounts collected/receivable and patient retention rates (types of measurement infrastructure most of us seem to already have in place). This information on one's performance then could be used to keep you apprised on how well you are doing with various kinds of patients and provide some important insight into where to focus your energy to do a better job.

For decades, the likes of Haldeman, Triano, Souza and others have been all over the idea of summarizing and codifying what it is chiropractors do for various patient situations and clinical presentations, and considering what the research has shown in order to describe care pathways, practice parameters, and guidelines that help frame key activities and best practices that can serve as resources for doctors and patients in sorting through the clinical decisions they have to make.

But these two strategies for underpinning chiropractic practice (i.e., performance measurement for quality improvement, and evidence-based care pathways) basically have been met with a resounding thud by us chiropractors and our institutions. The reason, of course, is primarily that they are seen as a threat to physician autonomy, pretty much a sacred cow in the health care world. By the way, it's not just DCs who react this way. Some of you may remember how the orthopedic surgeon community reacted to the Agency for Health Care Policy and Research *Clinical Practice Guidelines for Acute Back Pain in Adults*, which had the audacity to point out that other conservative options deserved abundant consideration and trial before surgical intervention was recommended because the data on patient outcomes for those having surgical intervention just was not very good.

Of course, health care is a complex mixture of preferences (e.g., physician and patient), economics (e.g., consumer, purchaser, and payer, who, these days, are almost *never* the same person), technological evolution (e.g., new devices, treatments, and so on that often come with high research, development and marketing price tags) and politics (e.g., access, affordability, competing business interests among different provider types, payers of premiums and taxes, and regulators/policy-makers). There is no magic bullet that will align everyone's respective interests and lead to harmonious, excruciatingly high incomes for every provider, third-party administrator, device manufacturer, drug company or insurance executive, while simultaneously costing next to nothing for every taxpayer and insurance premium payer (usually employers these days). Ah, but that sure would be nice, wouldn't it (just like winning the lottery and having eternal youth)?

But that doesn't stop the system from muddling along with people getting sick, needing and wanting providers to do something for them and providers needing to offer something of value in exchange for being able to, at a minimum, stay afloat financially. Yes, among those competing interests are payers,

plans, and various administrators who view doctors as vendors who simply are contracted to deliver a service and a product at a set price, making their job as easy and profitable as possible. To heck with what it costs the doctor to provide it!

Some other dupe will come along and undercut the market, so just take it or leave it. And then consider how all of these financial incentives are set up to pay more money for relatively useless late-stage tertiary care and high-tech diagnostics, get more for doing more physical medicine and the like. The financial incentives in the system are skewed. Pretty dysfunctional, isn't it? Is there any hope whatsoever?

Well, out of chaos comes order. Or so they say. For the first time in my career, I'm seeing several initiatives wherein enlightened folks within respective interest groups are beginning to form alliances to test new ways to partner with each other to get high-quality, high-value care. There is a lot of out-of-the-box thinking happening to develop "pay for quality" and "pay for performance" approaches. Don't get me wrong. There is still plenty of business-as-usual bureaucratic inertia out there. The conventional wisdom of human nature always seems to focus on the bad apples. Insurance companies typically gravitate to setting up systems to whack outliers and overutilizers (because it's easy to measure and make sense, and they are the fly in the ointment) and providers typically gravitate toward litigate and legislate against egregious payer, with neither side really giving a damn about how these approaches cripple the good apples.

In this column, I've talked about programs like Leap Frog and Bridges to Excellence (Google them and learn), and obviously, in a few typed pages, the best I can do is call your attention to some important trends and opportunities. But the bottom line is this: The good 'ol days are gone forever; the golden goose is dead. The new days are here and we don't know if they will turn out good or bad yet, but one thing is certain: Transition is both a wretched pain and an incredible opportunity. Despite the many amazing advances we have made socially, culturally and scientifically in chiropractic, as a profession in general, we suffer from two potentially fatal afflictions:

1. We gravitate mightily toward isolation over collaboration (with each other as well as outsiders).
2. We are culturally and publicly more about ourselves than about the public we serve.

The paradigm shift in American health care that really began out of the excesses of the '70s and '80s was taking control of health care decision-making away from the domain of the doctor/patient arena and moving it into the policy-maker/community arena. The rules of engagement have changed. The vested interests have changed. And the strategies for engagement and influence have changed.

What do we need? In practices, we need low-overhead, high-efficiency, high-yield patient management strategies. If the patient wallows, if care drags on, if expensive tests or a-la-carte modalities are needed, we need to be darn sure that all parties - patient, purchaser, payer - have abundant evidence (beyond someone's personal preference, opinion or economic need) that it is valuable to society when compared to other uses of that money elsewhere in health care.

In our institutions, we need strategies that prepare us for the culture change of community interest rather than professional interest. We need dual degrees; we need residencies and fellowships in ethical, successful practice settings; we need care tracks that prepare for more than running a "stop-n-pop spine shop"; we need constructive engagement with payers, purchasers, other providers, and we need a profession-wide attitude of problem solving for the greater community good. None of these things happens overnight, or by raising $10,000 to hire a marketing consultant. They require

incremental re-engineering and retooling of the status quo. That means change, transition and discomfort. But it also means not going the way of the buggy-whip manufacturers at the turn of the previous century…

AUGUST 2006