January/February 2016

ACAnews

The Official Publication of the American Chiropractic Association

ACA www.acatoday.org

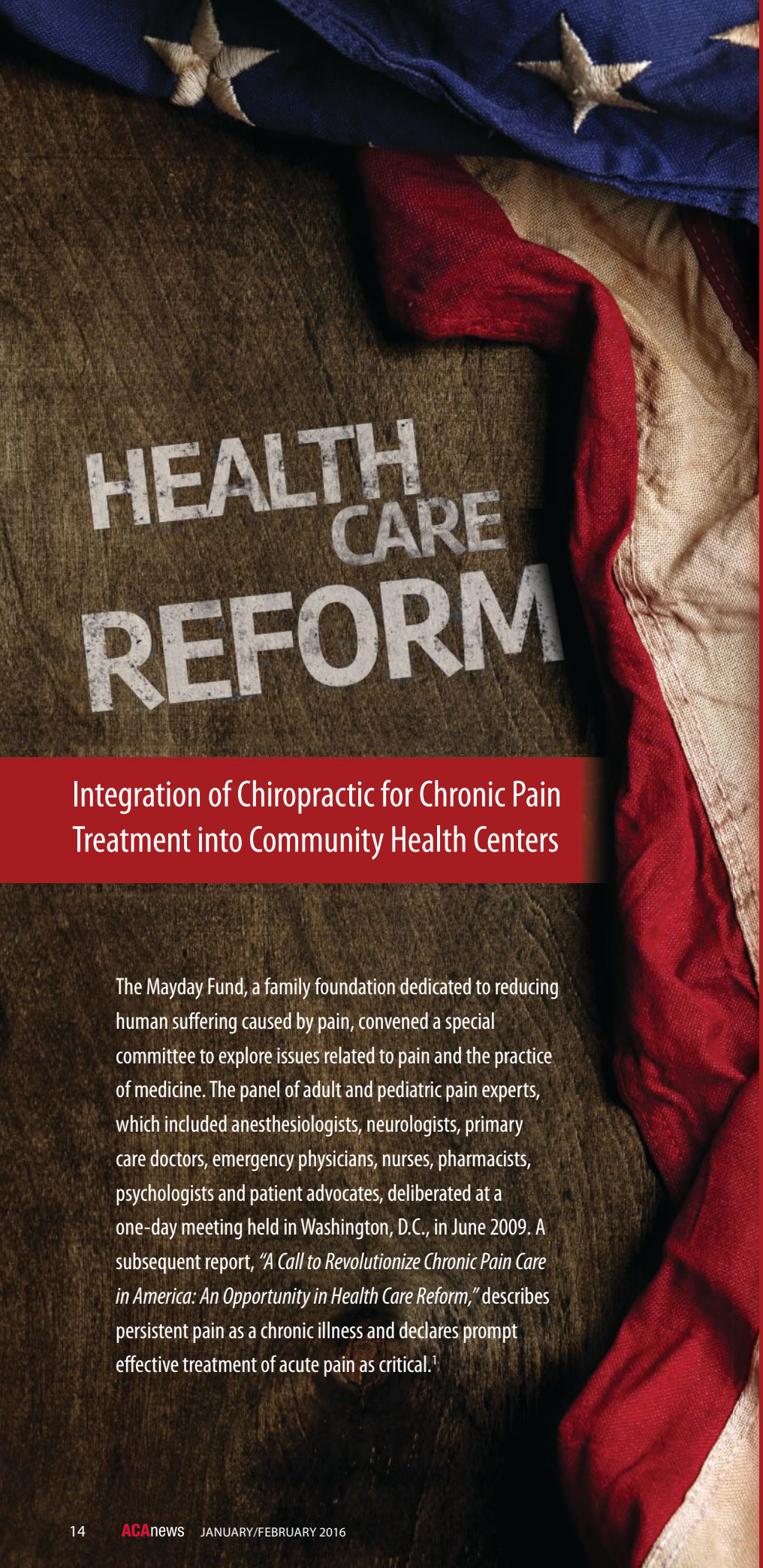
Integration of Chiropractic for Chronic Pain Treatment in Community Health Centers

ACA NCLC 2016
ENGAGE. LEAD. UNITE.
Making Change Matter.

Tendinopathy: Clinical Update

The Birth of the Millenial Think Tank

Is Sitting as Bad as Smoking?



Integration of Chiropractic for Chronic Pain Treatment into Community Health Centers

The Mayday Fund, a family foundation dedicated to reducing human suffering caused by pain, convened a special committee to explore issues related to pain and the practice of medicine. The panel of adult and pediatric pain experts, which included anesthesiologists, neurologists, primary care doctors, emergency physicians, nurses, pharmacists, psychologists and patient advocates, deliberated at a one-day meeting held in Washington, D.C., in June 2009. A subsequent report, *"A Call to Revolutionize Chronic Pain Care in America: An Opportunity in Health Care Reform,"* describes persistent pain as a chronic illness and declares prompt effective treatment of acute pain as critical.[1]

The National Prevention Strategy is America's plan for better health and wellness. The plan intends to increase the number of Americans who are healthy at every stage of life. According to the U.S. Surgeon General, this strategy is a critical component of the Patient Protection and Affordable Care Act (PPACA), and it provides an opportunity to become a more healthy and fit nation. This strategy also calls for coordination and integration of clinical, behavioral and complementary health strategies, including chiropractic services such as spinal manipulation for the treatment of back and neck pain in order to reduce pain and disability.[2]

Ten years before President Obama signed into law the current health care reform act, a Canadian researcher promulgated the integration of chiropractic services into health care systems because of solid and impressive economic and related justification.

The role and position of chiropractic care in the health care system must be transformed from being alternative and separate to alternative and mainstream. This transformation requires that chiropractic services become integrated in the many health care delivery organizations that collectively constitute the health care system. There is solid and impressive economic and related justification for the desired integration. Chiropractic care is a cost-effective alternative to the management of neuromusculoskeletal conditions by other professions. It is also safer and increasingly accepted by the public, as reflected in the growing use and high patient retention rates. There

By James J. Lehman, DC, Margaret Flinter, PhD, Veena Channamsetty, MD, and Daren R. Anderson, MD

is much and repeated evidence that patients prefer chiropractic care over other forms of care for the more common musculoskeletal conditions.[3]

Prior to the signing of the PPACA on March 23, 2010, chiropractic services were integrated into hospitals and health care systems.[4, 5] The PPACA allowed federally qualified health centers (FQHC) and state Medicaid authorities to decide coverage of chiropractic services.[6]

A core recommendation of the *2011 Institute of Medicine (IOM) Report: Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research* is: "The Secretary of the Department of Health and Human Services should develop a comprehensive, population health-level strategy for pain prevention, treatment, management, education, reimbursement and research that includes specific goals, actions, time frames and resources."[7] Subsequently, the Joint Commission called for the use of non-pharmacologic care for patients suffering with pain including chiropractic services,[8] and the National Pain Strategy released a draft recommending that clinicians take active prevention measures to avoid the progression of acute to chronic pain and its associated disabilities.[9]

In a study, researchers Fritz, Kim and Dorius discuss the important values of a chiropractic clinician seeing a patient presenting with a new episode of low-back pain. The study demonstrates there is a lower utilization of surgical, medical and diagnostic services for the new episode of low-back pain if the patients' episodes of care commence with chiropractic management. They conclude that new low-back pain episodes beginning in chiropractic or physical therapy are less likely to involve imaging, surgeon visits or injections over the subsequent year relative to episodes beginning with a doctor, particularly physiatrists.[10]

As discussed in the November 2014 issue of *ACA News*, there are many opportunities for chiropractic clinicians to focus on the evaluation and management of patients suffering with chronic pain.[11] This article explains the integration of chiropractic services into the Community Health Center, Inc., an FQHC patient-centered medical home (PCMH) headquartered in Middletown, Conn., in order to provide chiropractic services to chronic pain patients.

Federally Qualified Health Center (FQHC)

An FQHC is a public or private non-profit, charitable, tax-exempt organization that receives funding under Section 330 of the Public Health Service Act, or is determined by the Department of Health and Human Services (DHHS) to meet requirements to receive funding without actually receiving a grant (i.e., an FQHC "lookalike").[12]

Originally known as neighborhood health centers and later community health centers, these organizations reflected a new model of care focused on specific, targeted populations in high-need areas, emphasizing a comprehensive approach to care and had

James J. Lehman, DC
Dr. James J. Lehman is an associate professor of clinical sciences and director of health sciences postgraduate education at the University of Bridgeport. He is a board-certified chiropractic orthopedist and neuromusculoskeletal medicine specialist at the Community Health Center, Inc. in Waterbury, Conn., a federally qualified health center and a patient-centered medical home. He teaches nonsurgical orthopedics, neurosciences, neuromusculoskeletal medicine, evidence-based practice and health care reform classes for U of B. He also serves as the team chiropractor for the Bridgeport Bluefish professional baseball team and mentors fourth-year chiropractic clerks and chiropractic residents in orthopedics/neuromusculoskeletal medicine. Contact him at *jlehman@bridgeport.edu*.

Daren Anderson, MD
Dr. Daren Anderson is the vice president/chief quality officer of the Community Health Center, Inc. (CHCI), an associate professor of medicine at Quinnipiac University and director of the Weitzman Quality Institute. He is a general internist at the CHCI, as well. CHCI is a large, multisite community health center providing primary care to more than 130,000 medically underserved patients across Connecticut. In his role as chief quality officer, he is responsible for directing all quality improvement work across the agency. The Weitzman Institute is a center dedicated to health services research in underserved settings and the development and promotion of new approaches to systems redesign and quality improvement. At the Netter School of Medicine at Quinnipiac University, Dr. Anderson teaches and mentors students in quality improvement and applied research in community settings.

Veena Channamsetty, MD
Dr. Veena Channamsetty is the chief medical officer of Community Health Center, Inc., where she is responsible for the clinical leadership of a large staff of medical providers and caregivers for the state's largest federally qualified health center. She is responsible for the delivery of evidence-based medical standards, medical staff recruitment/retention and provider affairs. Dr. Channamsetty oversees the clinical and non-clinical training orientation, training and onboarding for all new CHCI medical providers, including physicians, APRNS and physician assistants. She is responsible for ensuring Joint Commission and patient-centered medical home compliance. She is president of the medical staff and chair of the medical quality improvement committee. She is a clinical preceptor for the APRN residency. She works with the chiefs of behavior health, dentistry and nursing to promote interprofessional care, supporting the successful integration of multiple disciplines for team-based patient care. She implements multiple care delivery initiatives statewide.

Margaret Flinter, PhD
Margaret Flinter, PhD, APRN, PHD, FAAN, FNP-C, is the senior vice president and clinical director of CHCI and a family nurse practitioner.

community control of the board of directors as part of its core strategy for community empowerment. From the earliest health centers in the mid-1960s, the health centers have grown to 1,278 FQHCs and have served 22.3 million individuals per annum.[13] More than 90 percent of the patients served have incomes below 200 percent of the federal poverty level.

The story of the community health center movement is grassroots activism, community and consumer control and innovation. Health centers were early adopters of (1) the electronic health record, with more than 90 percent of health centers having an electronic medical record (EMR) in 2014, (2) integrated clinical services and (3) a range of health care providers utilized as primary care and specialty providers. Health centers follow strict standards of care and service delivery as delineated in federal statutes.[14]

"As far back as 1999, CHCI recognized the challenge of treating and managing chronic pain and the burden and potential risk posed by opioid medications on its patient population."

Community Health Center, Inc.

The Community Health Center, Inc. (CHCI) was established in 1972 as a free clinic by a group of community activists with a commitment to health care as a right, not a privilege. From a second floor walk-up apartment in downtown Middletown, Conn., providing general dentistry services, the organization quickly grew to offering a comprehensive approach to primary care with medical, dental, behavioral health and nursing services at the core, supported by nutrition, podiatry, psychiatry and a host of support services appropriate to the population. CHCI's commitment to vulnerable populations and to working deeply into its communities is reflected in its dedication to the homeless population, patients living with HIV and victims of domestic violence. Today, CHCI is a statewide organization with primary care hubs in 13 cities, more than 200 service delivery locations and 150,000 active patients. In addition, CHCI is a leader in education and training for health professionals, research and innovation and quality improvement through its Weitzman Institute.

CHCI is designated as an FQHC, is Joint Commission-accredited and is recognized as a Level 3 PCMH. All services use a single, integrated electronic health record.

As far back as 1999, CHCI recognized the challenge of treating and managing chronic pain and the burden and potential risk posed by opioid medications on its patient population. The medical and behavioral health staff focused efforts on standardizing the assessment of pain using accepted pain scales, developing consistency in prescribing and monitoring of opioid use and establishing care guidelines for stopping the use of opioid medication when indicated. In addition to improving the capacity to care for these patients within CHCI, the medical staff worked to refer patients to services beyond the scope of CHCI, such as physical therapy, chiropractic medicine, massage therapy and specialized pain clinics. However, issues of cost, insurance coverage, language, transportation and a paucity of specialized services for patients with chronic pain were major deterrents. CHCI continued to work to address the problem of chronic pain and, in particular, sought solutions that more expertly diagnosed and treated the condition and the source of the pain rather than simply treatment of the symptoms of pain.

In 2010, the leaders of the University of Bridgeport College of Chiropractic (Medicine) and the CHCI came together to consider the possibility of collaboration. This collaboration was made possible by the Medicaid plan of the state of Connecticut, which recognizes chiropractic as a covered service for Medicaid patients, though only when delivered in a FQHC. CHCI sought permission from the federal agency charged with oversight of FQHCs, the Health Resources Services Administration (HRSA), for a "change in scope" to allow it to add complementary/alternative services, including chiropractic medicine. The approval was granted. This paved the way for the University of Bridgeport and CHCI to develop appropriate credentialing, privileging and protocols for the delivery of chiropractic services at CHCI, as is described further.

CHCI and UB Pilot Study

A detailed analysis of patient data revealed that in 2012 there were more than 12,000 patients cared for at CHCI with a chronic painful condition. These patients accounted for nearly 40 percent of all adult patient visits during that year. Opioids were commonly used in primary care to treat chronic pain. More than 1,200 patients were managed with opioids for more than 90 days. Very few patients with chronic pain were referred to providers of complementary and alternative medicine and none to chiropractic providers.

To test the potential of providing a pathway for integrated chiropractic care for patients with pain, CHCI and University of Bridgeport conducted a single-site pilot study in which a chiropractic attending provider and three chiropractic students from the University of Bridgeport offered chiropractic services for patients suffering with painful musculoskeletal conditions. The chiropractic providers practiced within one of the CHCI primary care facilities using the health center's electronic health records (EHRs). The internal referrals for chiropractic services were received via the primary care providers (e.g., MD, DO, APRN). Chiropractic and primary care providers collaborated closely and used the principles of stepped care treatment. Chiropractic physicians utilized custom templates created in CHCI's integrated EHR, eClinicalWorks (eCW), to document all care.

Working in an examination room in the primary care clinic with appropriate equipment, the DCs provided chiropractic treatment to health center patients for two days a week from January 2012 to August 2012. Seventy-six unique patients, referred by 10 PCPs, underwent treatment during this period and completed a satisfaction-with-chiropractic-services survey. Results demonstrated very high degrees of satisfaction (i.e., 98.7 percent of patients were completely satisfied). Ninety percent of all patients who completed chiropractic treatment stated that their conditions improved.

Based on these results, CHCI expanded this project and added on-site chiropractic treatment to nine sites across Connecticut. Today, doctors of chiropractic (DCs) who are fully integrated serve at all CHCI sites in the patient-centered model of care, along with UB faculty, residents and students participating in our intercollaborative professional practice and education model of care.

Credentialing of Medical Providers

This medical home model presents an opportunity to provide comprehensive team-based care to patients experiencing pain, which includes the important role of the DC. In this model, both the primary care providers (PCPs) and the DCs collaborate to deliver comprehensive care to patients with diagnosed pain conditions. At CHCI, this model embeds the DCs into the primary care medical home, situating the chiropractor within the pod with the other members of the healthcare team. In addition to being physically co-located with the patients' medical team, the DC uses the integrated EHR, allowing not only for the PCP to review the care delivered by the DCs but also for the DCs to review the treatment history and full medical record of patients at the time of the chiropractic visit. The goal of such integration is not only to deliver evidence-based care that is collaborative but also to avoid fragmented and duplicative care.

CHCI has a robust credentialing and privileging process for all licensed independent practitioners. Chiropractic physicians are appointed to the medical service at CHCI and thus are deemed credentialed and privileged to the medical staff by the credentialing committee, chaired by the chief medical officer. As medical providers, all chiropractors are appointed to CHCI for a two-year appointment period. This involves multiple steps, including but not limited to: verification of education and training; documentation of board certifications and continuing education; review of past disciplinary actions and of the National Practitioner Data Bank; and references by three persons, including one from the most recent clinical supervisor.

Once the complete initial appointment material has been submitted, the credentialing committee meets to review the full application. Based on the review of the material, the chief medical officer makes a recommendation for appointment to the medical staff. Once approved by the credentialing committee, the application will be reviewed and approved by the clinical issues committee of CHCI's board of directors and then by the full board. Following this initial appointment to the medical staff, all providers practice within the scope of approved privileges in their discipline. Medical providers are reappointed every two years.

As members of the medical staff at CHCI, DCs take part in the ongoing peer review process. Peer review/chart reviews are completed twice a year by all providers, during which ten random charts are thoroughly reviewed by a peer. Data from the peer review are aggregated, analyzed and reviewed by the providers and performance improvement committee to make follow-up adjustments and provide learning opportunities. In addition, annual performance appraisals are conducted by reviewing the clinical charts of all DCs, including detailed appraisals of multiple measures and appropriate documentation, as well as patient experience data.

Chiropractic Services

Currently, three board-certified chiropractic faculty members and three chiropractic orthopedic residents provide medical services in nine CHCI primary care facilities within Connecticut. Chiropractic clerks (i.e., fourth-year chiropractic students) apply for nine-week rotations, which avails them to mentoring with three different faculty members. The clerks

participate in clinical sessions at three different primary sites per week.

The patient population presents with chronic pain complicated by numerous co-morbidities including mental health diseases, obesity, diabetes and many other diseases. These complicated cases present challenging experiences for both the providers and the students. Consequently, the residents and the clerks experience advanced clinical training within a community-based primary care environment.

The chiropractic providers evaluate and manage patients suffering with both acute and chronic pain. Most often, the patients referred from the primary care providers have been experiencing chronic pain for many months or years. Trauma is the most common cause of the chronic pain syndromes and the following neuromusculoskeletal conditions:

- Myofascial pain syndrome
- Lumbar facet syndrome
- Whiplash associated disorders
- Axial neck pain
- Piriformis syndrome
- Cervical or lumbar radiculopathy
- Cervicogenic headaches
- Spinal degenerative joint and disc disease
- Upper and lower extremity nerve compression syndromes
- Upper and lower extremity tendinosis

Conclusions

The PPACA and the state Medicaid programs enable chiropractic clinicians to integrate into community health centers and FQHCs as chiropractic specialists.

Community health centers are willing to credential chiropractic clinicians that have advanced clinical training in the areas of neuromusculoskeletal medicine and non-pharmacologic pain management.

Chiropractic clinicians should embrace this new opportunity to relieve pain in America and provide non-pharmacologic pain care, which may alleviate the suffering of millions of Americans afflicted with chronic pain.

Chiropractic clinicians should become more aware of the need to integrate into community health centers.

A simple Internet search will provide valuable insights regarding chronic pain in America and the need for chiropractic services without cost. Please read the following:

- *A Call to Revolutionize Chronic Pain Care in America: An Opportunity in Health Care Reform.*
- *National Prevention Strategy.*
- *National Pain Strategy.*
- *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research.*

Chiropractic clinicians must comprehend the potential adverse reactions of the pain medications consumed by their patients. Hence, chiropractic postgraduate education departments should offer additional training in pharmacology and pain management.

Board-certified chiropractic clinicians willing to focus on the evaluation and management of neuromusculoskeletal conditions and chronic pain should attempt to integrate into community health centers as credentialed members of the primary care team.

Chiropractic colleges should enhance clinical training for students and graduates by offering clinical training within community health centers.

Resident training within community health centers for chiropractic graduates leading to board certification in chiropractic orthopedics will increase the number of chiropractic specialists. ■

Endnotes

1 A Call to Revolutionize Chronic Pain Care in America: An Opportunity in Health Care Reform. The Mayday Fund. Nov. 4, 2009. Amended March 4, 2010.

2 National Prevention Council, National Prevention Strategy, Washington, D.C.: U.S. Department of Health and Human Services, Office of the Surgeon General, 2011.

3 Manga P. Economic case for the integration of chiropractic services into the health care system. *JMPT*, Feb 2000; 23(2): 118-122.

4 Paskowski I, Schneider M, Stevans J, Ventura JM, and Justice BD. A Hospital-Based Standardized Spine Care Pathway: Report of a Multidisciplinary, Evidence-Based Process. *JMPT* Vol. 34, Issue 2, Feb. 2011, Pages 98–106.

5 Pasternak DP, Lehman JJ, Smith HL, and Piland NF. Can Medicine and Chiropractic 01Practice Side-by-Side? Implications for Healthcare Delivery. *Hospital Topics* Vol. 77, Issue 2, 1999.

6 Lehman JJ and Anderson DR. Health Care Reform: Primary Care Teams in ACOs. *ACA News* April 2013.

7 National Pain Strategy: A comprehensive population health level strategy for pain. Available from: *http://iprcc.nih.gov/National_Pain_Strategy/NPS_Main.*htm.

8 Burkhart LA. Chiropractic Added to Joint Commission Standard on Pain Management. *ACA News* Jan/Feb 2015. Available from: *www.acatoday.org/content_css.cfm?CID=5616.*

9 National Pain Strategy. Available from: *http://iprcc.nih.gov/docs/DraftHHSNationalPainStrategy.pdf.*

10 Fritz JM, Kim J, and Dorius J. Importance of the type of provider seen to begin health care for a new episode low back pain: associations with future utilization and costs. *Journal of Evaluation in Clinical Practice* (2015).

11 Lehman JJ, Anderson DR, and Taylor M. Opportunities in Health Care Reform: Chronic Pain Focus for DCs. *ACA News* Nov. 2014.

12 Section 1861(aa)(4) of the Social Security Act.

13 2014 Health Center Profile. Health Center Program Grantee Profiles. U.S. Department of Health and Human Services; HRSA Health Center Program. Available from: *http://bphc.hrsa.gov/uds/datacenter.aspx?q=d.*

14 HRSA Program Requirements. Examining Requirement 1: Needs Assessment By Amy Garwood, Director of Communications & Training, IPHCA. Available from: *http://bphc.hrsa.gov/programrequirements/index.html.*