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Interviewer: Good morning, everyone. This is Robin Masheb and I will be hosting our monthly pain call entitled, “Spotlight on Pain Management.” Today’s session is “Innovation in non-pharmacologic treatment options for musculoskeletal pain: Studying the implementation of VA’s chiropractic program.” I would like to introduce our presenter for today, Dr. Anthony Lisi. Dr. Lisi is the Director of Chiropractic Services for the Veteran’s Health Administration. He is Associate Professor of Clinical Sciences at the University of Bridgeport College of Chiropractic and is published on topics including low back pain management, spinal manipulation, interprofessional education and chiropractic services. We will be holding questions for the end of the talk. If anyone is interested in downloading the slides from today, please go to the reminder emails you received this morning and you will be able to find a link to the PowerPoint presentation. Immediately following today’s session, you will receive a brief feedback form. Please complete this as it is critically important to help us provide you with great programming.

Dr. Freidhelm Sandbrink, VA Deputy National Director for Pain Management will be on our call today, and he will take questions related to policy at the end of our session. Now I am going to turn this over to our presenter, Dr. Lisi.

Dr. Anthony Lisi: Thank you, Robin. Are the slides visible?

Molly: Yes, they are. Thank you.

Dr. Anthony Lisi: Okay, great. Thank you very much for inviting me to give this presentation to this audience. For full disclosure, I am a clinician and administrator who has been fortunate to partner with some senior researchers in getting some work done. I think the value of that partnership research has been very helpful in this regard because chiropractic services have been one area or one type of innovation in non-pharmacologic treatment options that VA has unrolled over time. By following an approach to assess and maximize the outcomes of the chiropractic program potentially provides a model for assessing and maximizing other non-pharm options the VA may be considering moving forward.

In terms of background, your VA introduced chiropractic services in two phases. Each was in response to a congressional mandate to a law that was passed. In summary, in 2000, VA began non-VA care approaches. There were some rare examples of that beforehand, but it began in earnest in 2000. Then in 2004, chiropractic care was added to the VA standard medical benefits available to all Veterans, with the minimum of one facility per VISN that had to deliver this in-house. The rest could either be in-house or by fee.

Back in 2004, this posed some potential value but also some potential obstacles. We know that chiropractic care is commonly used in the use. About 12% of the general population, about 40% of the chronic pain population sees chiropractors. We also know that it was in demand by Veterans. About 75% from one study of the Veterans who did not receive chiro at VA would like to receive that. The treatment options that chiropractors provide are supported by reasonable evidence, at least in terms of low back pain and neck pain for at least mild to moderate effect size. There is some data showing a negative correlation with opiate use in terms of chiropractic care as a black box, that when patients have access to chiropractic services early on for low back or neck conditions, they tend to use less opiates downstream. However, chiropractic care was very rare in hospitals at the time and still is somewhat rare. Very widely varying perceptions among physicians. We know that the chiropractic profession has had a long history of being external to mainstream medicine, so this was potentially a barrier. It was also a congressional mandate for VA. So, all of these things presented some challenges for VA implementation. When VA ultimately started up a program office nationally to begin some administrative oversight of the program, the aim for program assessment was to follow both administrative processes as well as to engage in research partnerships to begin a series of projects that would attempt to do a qualitative and a quantitative assessment. Those are two studies that I will present some data from today. It was those partnerships between the research and operations that I mentioned that were valuable in this effort.

At this point, I will just take a quick pause and turn it back over to Molly to conduct this poll question.

Molly: Thank you. So for attendees, as you can see on your screen, we would like to get an idea of who is joining us today. So, we would like to know what your primary role in VA is. Are you a Clinician, researcher, administrator, manager or policy maker, student trainee or clinical or other, or non-VA? Please keep in mind if you are selecting Other, we will have a more extensive list of job titles in the feedback survey at the end of this session, and you might find your exact title there to select. It looks like we have a nice responsive audience; over 80% have replied. So I am going to go ahead and close out the poll and share those results.

As you can see, almost half of our respondents selected Clinician, 13% Researchers, 20% Administrator, Manager or Policy Maker, 2% Student Trainee or Clinician, and 21% selected Other or Non-VA. Thanks again to those respondents, and I will turn it back to you now, Tony.

Dr. Anthony Lisi: Thanks, and that is helpful to see that breakdown of attendees. The first project was the qualitative study. This was published in Medical Care in 2014. It was through working with Brian Mittman who was then at the time the project was undertaken was the Director of Cypress Center at VA Greater Los Angeles. This study aimed to assess and describe the implementation of the chiropractic program at a group of VA facilities and to look at various organizational structures and processes and outcomes.

We followed an observational comparative case study as a health services model at seven of the eight facilities that were selected for their known diversity at the time, some from the early implementation in 2004, some later on. Then we attempted to get some geographic variation as well as breakdown of service lines. We conducted semi-structured interviews with stakeholders as well as did analysis of policy and procedural documents. We used a directed content analysis approach where our thematic codes partially emerged from transcript review, but partially we had some A-priori hypotheses based on our knowledge of the literature and of the VA program to date. We coded these with NVivo for the interviews and with Word for the policy documents.

We conducted site visits at all seven sites and also did supplemental phone interviews and had 118 stakeholder interviews and 75 policy documents, and we did show good agreement between investigators in terms of our coding.

The interview subjects are just shown for breakdown. The majority were in the non-DC clinician category, with the majority being physicians and some nurses, PA’s and physical therapists also, a small number of patients and you will see the rest of the breakdown. But you will see it was an attempt to obtain a wide scope of input from various people who are involved in the clinical services at each facility. The policy documents, as you can imagine, were facility and VISN policies as well as any local service agreements or other guiding documents, and the clinicians’ individual privileges.

This is our conceptual model which I will not review in detail. Essentially, we developed a model in which we saw that the context in which an individual facility began its chiropractic clinic was noteworthy as well as differences in the way these clinics were planned or implemented. Then you will see the more familiar structures, processes, outcomes. We were able to organize our A-priori themes as well as emerging themes to fit in this model. What I would like to do now is go through some representative examples of what we learned following this conceptual model and then move into the quantitative study next.

First, in terms of the context. At the national level, when VA first was essentially identified by Congress that this had to be done, we uncovered some significant barriers. Here is an example or a quote that was by a Central Office administrator who was tasked with overseeing the chiropractic program at the time. You will see that there was some significant resistance, that this person’s boss was totally opposed according to the interview to the subject and just thought that it was a terrible idea and really there was a major obstacle in obtaining support or willingness to proceed with this by some senior leaders at Central Office at the time. We also found some barriers that were not so much related to chiropractic per se, but just about the fact that this was a Congressional mandate. Here we have a stakeholder who says that a lot of what VA gets is unfunded mandates, of which this chiropractic program was just another. Between the expected resistance to the chiropractic profession as well as the unique aspect of VA facing Congressional mandate, there were two rather stark obstacles that this program had to face in terms of unrolling.

At the facility level, there was variation. This shows you two examples of that variation. Here we have a physician who thinks that there is no scientific basis and it is quack medicine, and another physician who had a positive perception because of their view on the literature and thinking it would be a good move for Veterans. This was a commonly repeated theme that there were some local stakeholders who felt strong opposition, but they were in the minority of stakeholders, and others who felt some support. One common determinant of support was not so much the individual familiarity with the literature, but really their prior individual personal experience. So, stakeholders who had some type of a previous existing person-to-person interaction with chiropractors that was favorable were more inclined to view this as a positive thing for VA. Those who did not have any interactions or only had what they perceived as negative interactions were more negative.

The planning and implementation also was quite variable. Some sites tasked the planning and implementation of the clinic to one person who had very little or any real knowledge of chiropractic services. Whereas others engaged with external stakeholders and others with subject matter expertise and more robust planning process.

We also found some variation in the way the sites felt they were guided by Central Office. We actually saw a report of at least a change in perception with some of the very early sites that said they had zero information except for the directive from Central Office, and a later site who felt that the support from Central Office was quite helpful. So this is potentially a positive thing seeing that at this stage in the evolution of the program, the facilities feel there is at least reasonable guidance in how these things should be delivered or implemented. We found some variation in the alignment in what service line the chiropractic clinics were administratively oriented, but I would like to defer that and I will show that when I have the quantitative data later on. But about the chiropractor, that was a key feature. The stakeholders again and again found that, or reported to us that, the individual characteristics of the chiropractor were key to their program’s success or lack of success. In one case, an individual chiropractor was identified as having some trouble getting along with the others and had some personality issues that really was a major barrier, because this was the only chiropractor at a given facility. So it really sort of was hinging on that individual’s ability to successfully integrate or not.

In terms of care processes, there was much similarity in the patient population and the services delivered, which I will again show with the quantitative data. We did find some differences in the initial privileging of providers that normalized over time, and some differences in the degree to which care is actually co-managed with team collaboration. Those again and again were reported to be consistent with VA practices in general. There did not seem to be anything unique about the chiropractic clinics that were hard to do that as much as just the challenges of manpower and time to actually meet at VA.

In terms of the impacts or outcomes, at the time all of the clinics were functioning but actually after we completed our study, at one of the clinics actually the provider retired and the facility decided to not backfill the position and just move to using purchased care. At the time of our study, the use trends were increasing at all facilities and the stakeholder perception was predominately favorable. There were only some rare instances of opposition that were strong opposition but in a small minority. We also found that factors such as clinical outcome and value are not routinely tracked and harvested in any reasonable way.

The Veterans themselves were highly satisfied with chiropractic services. The reported satisfaction that they were able to receive these in-house, but many were very critical of the access or the wait time to get in and then of the actual dosage of only being able to perhaps get one or two visits over a very extended period of time, which was not typical for the waits delivered in the community.

A specific sidebar on physician themes because we know that that is critical to the uptake and use of novel therapies. Physician perceptions in a large system like VA is perhaps more critical than any policy document or anything else. We found that across the board, physicians, whether they referred or not to the chiropractic clinic, had limited knowledge of chiropractic services, what it entailed at all, and also limited knowledge of the data on guidelines on management for low back and neck conditions. Yet those that referred, many fell into that category yet still referred, and the ones who were referring were highly satisfied with the chiro clinic and reported their perception that they were actually viewing this as an option to writing for analgesics, which was something they were very satisfied with. Some of the referring physicians themselves were also critical of the access and the capacity. A common theme was that a physician would refer a patient who might report some benefit but then would be discontinued from chiropractic and they would argue that they would like that patient to be able to receive some type of repeat treatment downstream. Most of these facilities just didn’t have the capacity to do that. We also found some evolving perception, reports of initial resistance or initial ambivalence that were then changed to favorable. This is an example of a pain medicine physician who was running a chronic pain program and started looking at Veteran preference and Veterans were stating that they had been to a chiropractor and thought it seemed to help. Then this facility realized they just did not have one available, so they decided to go ahead and implement the service. For them it was a positive outcome. This is an example of a site that came on after the initial implementation in 2004, and we see the sort of slow organic uptake of the service as I will get more into coming up next.

Limitations with this work are that our results are not generalizable probably across VA but certainly outside of VA. We did use a systematic sampling process to try to obtain variation in facilities we studied, but we did not collect data from the nonparticipants, so we do not know how that would change results; although we did look at some models of predictors or indicators of positive outcome in terms of our conceptual model. That being we found a tendency for facilities that were not mandated from Central Office to actually begin a clinic, where they made the decision on their own and did it with some subject matter expertise in the planning stage and then were able to recruit and hire a high quality chiropractor. Those seem to be predictors of positive outcomes and well-integrated clinics, but in this small study we would need more work before we could actually correlate any of those themes with end results.

This provided a basis for us in terms of a broad qualitative understanding of what the facilities faced in implementing the clinics, which was an underpinning that led to a second partnership, this time with my colleague, Dr. Cindy Brandt from the PRIME Center here at VA Connecticut, where we published a study of VA’s administrative data on trends in the use of chiropractic services in VA. This was a serial cross-sectional analysis of data from VA’s corporate data warehouse. We sampled from the first record of chiropractic services identified in VA as well as the first indications of chiropractic workforce provider types, sampled from the first record through the end of fiscal year 2015, and we used a previously evaluated methodology with the appropriate codes: stop codes, employee codes as well as ICD and CPT codes to identify these services. Our report results now in terms of the on-station chiropractic services and, with that, a subset of patient characteristics that are being seen in VA, the workforce in VA and then VA’s use of purchased care or of non-VA care.

For the on-station data, we identified 11 visits in fiscal year 2004 or prior to October 1st of 2004. Those were the first few clinics that were implemented, but for analysis purposes we then looked at fiscal year 2005 through 2015, or the 11-year period of October 1, 2004 through September 30, 2015. That is the data that are presented for on-station use. Here you will see a slow but steady trend. The absolute numbers are small but there is a steady increase. It averages out to about 18% increase per year in terms of the number of unique patients that is seen in VA. So about 4,000 Veterans in fiscal year 2005 to just under 40,000 Veterans in fiscal year 2015. The number of on-station visits was about 20,000 in 2005 and just around 160,000 at the end of 2015. It is worth pointing out again that at the end of fiscal year 2005, VA had met the Congressional mandate, so any of the growth seen from 2006 forward is organic growth of the program as both new clinics came on board as well as existing clinics grew in terms of their patient use.

I mentioned we analyzed some characteristics of the chiropractic patients or patients being seen in VA chiropractic clinics. We analyzed this for each year and report some interesting information on demographics on the ICD codes, so the diagnostic codes for which their visits were coded as well as the procedural codes that were attached to these visits. This slide presents fiscal year 2014 as representative. You will see that the age of the patients seen in VA chiropractic clinics spans across all five age groups depicted but tends to be skewed a little bit towards the younger side. So, chiropractic clinics tend to see Veterans that are a little bit younger than the average VA patient. This is fiscal year 2014 data, but that was very stable across all 11 years of our analysis. There is no substantial change. We also tend to see patients in chiropractic clinics that have a slightly greater tendency of female users. About 18% of VA chiropractic patients are female; whereas about 10% of overall VA are female. Again, this is fiscal year 2014 as a representative example, but that, too, was stable across all 11 years of our analysis.

Using ICD codes to identify the reasons patients were seen in the VA chiropractic clinics, not surprisingly you will see the majority for low back pain as well as neck, some other musculoskeletal conditions and thoracic. This, again, was fiscal year 2014 being presented here as representative, but these percentages were very stable across all 11 years and really have not changed much at all.

Lastly, the types of services being delivered in the chiropractic clinics. The most common service is chiropractic manipulative therapies, spinal manipulation, manual manipulation. The next common is evaluation and management services. Then you will see physical modalities, other manual treatment, acupuncture and exercise. Here, this is fiscal year 2014, but here we actually did see a change over the 11-year period. There was about a 9% decrease in the using of physical modalities codes and a corresponding increase in the use of exercise and other active care codes. That was a trend that was the only change we saw overall in terms of national trends in patient characteristics for what they are receiving.

In terms of the workforce, in 2005 there were 22 chiropractors staffing 24 VA chiropractic clinics. I actually updated this data just to where we are right now in 2016. There are 108 chiropractors in 67 chiropractic clinics or points of care. The clinics themselves, about half are administratively aligned under physical medicine and rehabilitation. About a quarter are in primary care, and about a quarter are in pain. There is a tiny percentage that fall into some other categories.

In addition to the in-house chiropractic care, as I mentioned upfront, VA began its purchased chiropractic care prior to the in-house care. So that began in 2000, and as you can see from this chart, there is very little use of purchased care from 2000 through 2005. Then, congruent with the implementation of on-station care as well as the directive Vet and aid chiropractic part of VA’s standard benefits from 2005 onward, we see an increased uptake in the use of purchased care. These are facilities that, for the most part, do not have care in-house or have some capacity that is being exceeded or demand that is being exceeded by their internal capacity. This has been a little more of an erratic change, but it has been a slow, steady growth as well.

Just for comparison, this slide plots the difference in utilization rates, the average number of visits per year per Veteran, with the red bars being off-station chiropractic clinics and the green bars being purchased care or fee basis. There is a clear difference in the greater number of visits per Veteran with the off-site care versus in-house. For the past few years it has averaged around four visits per Veteran per year in-house and just over eight visits per Veteran per year with offsite care.

Putting some of these points in context, I think I mentioned this when I was presenting the results, the growth from 2005 onward appears to be organic growth. There has been no other statutory requirement. This could potentially be explained by just the natural diffusion of change in the large system of VA. There could be some unique aspects of VA in terms of patient demand or access that drove this, or it could be due to the slow way that the program was rolled out, with the initial sites providing some basis for acceptance or willingness of more recent sites to come on board. We did find some differences in terms of the patients. The tended to be somewhat younger and a greater female proportion, which is consistent with the current Veteran cohort from the recent conflicts which are known to have a high prevalence of musculoskeletal pain disorders. We also found the difference in average annual utilization rates with purchased care being greater than on-station. This is consistent with some other studies that have looked at self-insured private sector plans that provide services in-house or purchase those services. There is a common greater utilization when there is a fee-for-service model in most healthcare settings. Interestingly, we found that the rates for both are lower than what are commonly seen in private payer systems and actually lower than published data on thresholds of effectiveness for things like spinal manipulation. We know there was some early concern that there would be a potential for overutilization of chiropractic services and that could cause a problem for VA. In terms of the actual number of visits being seen in-house, we actually know that we are below the threshold of assessing effectiveness that has been demonstrated in some studies looking at manipulation for chronic low back pain, and the purchased care as well. So, at the moment the concerns about gross overutilization of chiropractic services are not borne out by the data.

Limitations to this study, as with any administrative database, our analysis is dependent on the fidelity of the data that are transmitted to the Corporate Data Warehouse. We feel confident in our ability to access that data, but the expectation is that this gives us not a perfect picture but a very, very accurate picture. We know that they are relying on ICD or CPT coding to determine the reason for visits and what patients receive is limited as well, because that varies at the provider level. In many cases we expect that there is some underreporting of procedures being delivered because codes are not always attached by the provider. A classic example is exercise. We did some separate work in a project outside of this trying to analyze the amount of exercise prescription going on in chiropractic clinics and it was much higher than what was being coded. So we know that there is variability and that does not give a complete picture but at least gives us a frame of reference.

The trends in use are not presented as optimal practice, but just the actual occurrence of what we see in the VA right now. We know that VA is still enrolling chiropractic services. There are many facilities that are providing very little access that are ramping that up. We expect to see some continued use of non-VA care and some continued growth of in-house care until VA reaches some sustainable size going forward. Also, we did not include contractors in our workforce data and we did not attempt to correlate labor mapping or look at provider productivity for clinical work versus other areas.

Overall, if I could summarize the results of both of those projects, VA has slowly and steadily expanded access to chiropractic care over the past 11+ years. Chiropractors in VA have been providing services that are consistent with evidence-based recommends as non-pharmacologic options for musculoskeletal pain and the patients they are seeing are, for the most part, the vast majority are musculoskeletal pain patients. We have seen expected barriers and facilitators to implementation we knew along would be there. Overall, that seems to have resulted in some limited degree of uptake and service delivery. There are many facilities where the penetration of the chiropractic clinic in terms of percent of patients receiving access is robust and does not compare well to nation averages in the U.S., but it is growing and there are others where the percentage is much smaller. So, a large facility that provides access to only maybe five or ten patients a year might still check the box at providing access to chiropractic care but not really doing that in a reasonable way to serve the patients or the referring providers. So we know we have to do some continued work to best understand the optimal way of delivering care in VA in order to get the best outcomes for Veterans as well as the best outcomes for the system across the board in terms of potentially minimizing or offsetting the use of other services in VA. These experiences could be relevant to VA as it considers other services or initiatives aimed at additional efforts of non-pharm options for back pain or for musculoskeletal pain. Again, I would stress the value of partnered research. As I mentioned upfront, all of this work was possible because of collaborations with centers of excellent in the health services research and development world. That has been a valuable aspect in terms of analyzing the program and presenting the data in both research forums as well as our managerial analysis.

With that, I will show this last slide that has my contact information at the bottom for any subsequent questions or offline questions as well as two webpage resources, the internet which has general public facing information as well as the intranet site that contains resources that could be helpful for VA facilities as they are considering implementing chiropractic clinics or overseeing their existing clinics. With that, I would like to ask Molly how to handle the questions at this point.

Molly: Thank you, Tony. Actually, Robin Masheb from PRIME is going to go ahead and moderate the questions. For any of our attendees looking how to submit one, go ahead and use the question section of the GoToWebinar control panel and just click the plus sign next to the world “questions,” and that will expand the dialog box and you can submit them there. Robin, I will turn it over to you.

Robin Masheb: Great, thank you. Thank you, Dr. Lisi, for a wonderful overview of chiropractic care in the VA. This is so helpful to give us the background of the work that you have been doing. We do have some questions, but please feel free to keep sending the questions in.

The first question is could you comment on how the VA has selected the chiropractors that they have and, to your knowledge, how they might differ from non-VA chiropractors? What are the standards that are used?

Dr. Anthony Lisi: Sure. Prior to the hiring of the first chiropractor, VA drafted qualification standards. I did not get into this in this talk but after the initial law that required VA to do this was 2001, there was three-year period where VA had a Federal Level Advisory Committee that included expertise from within VA and also external subject matter experts who drafted the initial policies and the initial directive about chiropractic services in VA. At that time adding chiropractors to the system was a new effort. It was the first time a new provider type had been entered to VA in about 30 years. The last previous provider was optometrists about 30 years prior. So, the qualification standards and other employment characteristics were done as a result of this process. Now, hiring is still done at the facility level, and at the early groups some facilities engaged with expertise outside of VA. Let us say that some folks had some knowledge of either chiropractic educators or others in the community that assisted them. Over time now, with the existence of a pool of chiropractors in VA, when a new facility is looking to hire, they might ask for input from other chiropractors in the VISN or they might sometimes ask Central. We can then provide that type of guidance in assessing qualifications of a provider. As to whether they differ from chiropractors in private practice, we really cannot say that. We aim to recruit and retain the highest quality DCs that we can, and I think that at this point in time I can speculate only that VA seems to have a reputation for that among the chiropractic community. So we tend to attract a good number of high level candidates to the position. Then we also aim to have a strong mentorship process with them across the board so that we really aim to grow our folks so that they really are at the highest level around. That is a little bit of partisan pride in that part, but I really cannot answer the other question.

Robin Masheb: That is very helpful. That is very helpful background. Here is somewhat of a related question. As the VA team is getting prepared to have a new DC on their team, what could be done—this is really your opinion—to bring that person into the team to provide better care for Veterans and maybe get some of those folks who have negative impressions or feelings about chiropractic care on board or at least open to these types of services?

Dr. Anthony Lisi: Sure. So, I think that the strongest agent of change is successful interactions with a high quality chiropractor. We have seen time and again where facilities have started clinics and there might be some stakeholders in another facility who did not think it was a good idea upfront but then over the course of a few years they have changed their minds and come around and are actually pleased. There really is no clear way to ensure that all stakeholders of facilities have a favorable impression at any given point in time. Part of the obstacle is that there has been very little interprofessional education between chiropractors in their training as well as physicians in their training. In a very small way we have tried to bridge that in VA by standing up a pilot chiropractic residency program in partnership with Office of Academic Affiliations, where we now have chiropractic residents that are training and cross-training with internal medicine residents and pain medicine physiatry and so on. Over time, this really is what is the best barometer of integration going forward. But at any given facility right now, we have seen this dozens of times, if we can hire a high quality DC and just position that person to be in a position to integrate with other facilities, the rest works itself out.

Robin Masheb: Do you have any sense of what the ideal number of FTE DCs would be? Because the directors at every VISN should have one, but is there any data from the general population, let us say for every 50,000-100,000 people?

Dr. Anthony Lisi: We have some population data that shows in the U.S., depending on the study, anywhere from 9-12% of the U.S. population uses a chiropractor in any given year. I can tell you that in VA we can see great variation in that use based on the individual facility unique. So, we have some facilities where the access to the population is around 4, maybe 4.5% of that facility uniques. That is at the top end. We are averaging around 1.2% across all, but then we have other facilities where they may only be using purchased care. In those facilities, only on the order of 0.1% of their patients receive access. So we see a wide variation. We have developed a couple of models of staffing based on lower levels of access that we think might be reasonable in VA. In other words, they are trying to emulate the U.S. national population use. This has not been well tested. Actually, across all of VA, understanding staffing models is still an area that has a lot of more work ahead of it. I can say on average, if you had a facility that had a catchment of 50,000 core facility uniques would be approximately 4 FTE DCs. That is a rough model.

Robin Masheb: Can you talk a little bit about those couple studies that gave the percentage of how many people in a year use chiropractic services? There was the Weeks study that was 12% of the general population and the Williams Study that was 13% of the DoD population. That just seems kind of high in one year that that many people would seek out chiropractic services. Is there something special about those populations?

Dr. Anthony Lisi: So, the Weeks study was actually done by the Gallop Polling Agency. It seemed to be a very reasonable methodology. The DoD study was actually a report of DoD data. So that actually shows the use by their administrative data. So these are patients that were coded with those visits. The other data that had come out previously by Nahin has put it about 9% roughly. So in the 9-12% range, I think that is the best estimate we have right now.

Robin Masheb: Great. Could you talk a little bit about copays and if they differ depending on where the DC is located? Is there a primary care versus someplace else?

Dr. Anthony Lisi: No. So, even if the DC is administratively aligned with primary care, their copay is still assessed as if it was a specialty clinic.

Robin Masheb: Great. Do we have any more questions out there? Perhaps Dr. Rohan has some thoughts that he would like to share about this presentation.

Dr. Freidhelm Sandbrink: This is Dr. Sandbrink here. Tony, thank you very much for that overview. I find it really interesting the background, of course, but I think in particular as you have been answering the questions it becomes very much evident that, compared to outside care, at the VA we are really still in the infancy. Maybe that is reflected in the rather tremendous growth that you are documenting with an 18% increase every year. Now, I do find it interesting that even the patients that we take care of in our system, there is a lower utilization rate, as you documented, with about four visits per unique Veteran versus 8% in the fee-basis care and then probably even higher in the communities. So not only that we have less patients participating, we seem to have lower number per patient. I am wondering whether your data somehow would be able to tell us what the spread of the range of the utilization per unique patient is of the Veteran. Whether we have some Veterans who more or less behave as if they would be in private practice with the 8-10 visits and whether we have others who maybe give up after the first time. Maybe it is because they have distance to overcome to make it to our VA medical centers in-house.

Dr. Anthony Lisi: That is an excellent point. We do not have a very good analysis of that. There is also one other permutation. We have some patients where we could—As we understand, the patient will have a consultation with an in-house VA chiropractor but then they may be sent offsite to receive purchased care because the in-house capacity is extending beyond the next visit or beyond the 30 days of the clinically indicated date. So that could also potentially explain why the utilization rate in-house is lower than offsite, because some of the Veterans are actually receiving care in both systems but we did not analyze the data to that degree of precision. But those are excellent questions and some of our next work that we are trying to look at.

Dr. Freidhelm Sandbrink: Somewhat related to that, Tony, and I hope that you will be looking to down the road is what are the satisfaction rates and possibly the outcomes data in regard to that. We are spending, as you pointed out, more than 10 million dollars in fiscal year 2015 for outside care. As that seems to all show a rather tremendous growth, we should really see—Especially if the choice program changes in the setup to a different kind of system—what is going to be the process going forward and how much can we make an argument, at least for the ones who want to support chiropractic care that we get this in-house and make it available? Certainly, we are looking for alternatives to pure pharmacologic options for patients with chronic pain. So, we are trying to expand different kinds of modalities and that certainly includes rehabilitation modalities, behavioral or psychological approaches to pain management, but increasingly also integrated modalities. Acupuncture and chiropractic care are, I think, the two modalities where we really feel there is quite good at least anecdotal evidence that they help as part of this bridging therapy as we are trying to move patients towards more multimodal self-management approach.

Dr. Anthony Lisi: Absolutely. The point about assessing quality and value of purchased care, I absolutely agree. Rehabilitation nationally has been, as all other program offices have been engaged in the process of giving recommendations for any changes to the Choice Program that may be coming up, that has been a consistent recommendation in this idea of accountability. I hope that there is a process built in for that. As far as in-house, that is absolutely correct also. We are aiming to look at ways that we can assess the impact of delivering or providing access to chiropractic services. If that indeed has some change in the patients’ use of other services, that could be a favorable change, maybe decreasing the use of other services that might have a higher cost or a higher safety concern factor. At this point, it is hard to do that. Let me rephrase that. Up until now, for maybe the past five years or so that we are starting to get more of a critical mass of chiropractic services delivered in VA, we are now approaching the point where we could actually look at national data and try to measure this. Whereas early on it was trying to put a tiny drop in a large ocean to try to look at any change.

Dr. Freidhelm Sandbrink: Thank you. There might be other questions from participants here, but one last point that I would like to make is—and you pointed it out twice—how important it is to have a very successful interaction, you said, with a high quality chiropractor is the best way of increasing acceptance and basically form a trust in the service as it is being offered to Veterans among these other colleagues and professional staff. In addition, I would like to emphasize that what we found, at least in patients with chronic pain management, that their interaction within the staff in regard to coordination of the patient care is just so important. As we try to make sure that the messages between the different staff members and providers of a particular patient, that they are consistent, that we provide a care that is consistent system wide. It is just so important if these chiropractor providers are somewhat integrated into our teams. That does not mean that they have to be at team meetings, but at least that they have an understanding where we are in the VA system as we move patients away from opioids but we emphasize that management, and that they have a chance to provide feedback to the providers in primary care and pain specialty and rehabilitation medicine in regard to the experience with this patient and possibly guide other providers to a more successful outcome.

Dr. Anthony Lisi: Absolutely. We see that time and again with the clinics that get established and are functional where that does happen. It happens as well as it does with many other specialties. We know that is an important issue. Because pain touches so many specialties and so many areas of the facility, it is a challenge to get all providers having the same message. When we have a reasonably functioning chiropractor clinic, they are a part of that discussion. They are part of that planning, and it does work well.

Robin Masheb: This is a terrific presentation and listening to the conversation between the two of you is so helpful in terms of getting a high level understanding of what has been going on and where things can go. I just want to thank Dr. Lisi for sharing his work with us today and thanks to the audience for writing in with some great questions. It made for a really interesting discussion. Just one more reminder to hold on for another minute to receive the feedback form. If anyone is interested in downloading the PowerPoint slides from today, please go to the reminder email you received this morning and you will be able to find the tinyurl link to the presentation. If you are interested in downloading slides from any of our past sessions, simply do an internet search on VA Cyberseminars archive and you will be able to use the filters to find previous seminars. If you would like confirmation for your attendance today, please send an email to the Cyberseminar mailbox immediately following the session. Our next cyberseminar will be by Dr. Lori Bastian, and the title is “Smoking as a risk factor for chronic opioid use.” This will take place on Tuesday, November 1st at 11 a.m. We will be sending registration information out around the 15th of the month.

I want to just thank everyone for joining us at this HSR&D Cyberseminar, and we hope to see you at a future session.

Molly: Great. Thank you, Robin, and thank you to our presenter and our discussant. We really appreciate you coming on and lending your expertise to the field. I am going to close out the presentation now and our attendees will be redirected to a feedback survey. Please take just a moment to fill out those questions. We do look closely at your responses. It helps us improve presentations we have already given as well as ideas for new sessions to facilitate. This does conclude today’s HSR&D Cyberseminar. Have a great day, everyone.

[End of audio]