Chiropractic in FQHCs

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Barriers to access are not necessarily financial.

Surveys of Community Health Centers have revealed a growing interest to add Chiropractic to their scope of services. In California the survey found over 30% interest; and when the same survey was conducted in the East Coast and the Mid-west clinics that percentage of interested clinics was more in the 60% range. However, there are still so very few fully integrated chiropractic programs in America. Why has it been so difficult to see similar levels of growth of chiropractic that has occurred with the addition of Dental services in FQHCs? The answer has two components: Perception and Logistics.

At present (2016) there are just over four dozen Doctors of Chiropractic (DCs) treating patients in California FQHCs and most are managed through the Chiropractic Community Health Alliance, a sister company to the Chiropractic Service Corps. If access to chiropractic in FQHCs was the same as is currently available to the general public, there would be about 250 DCs in California FQHCs. Quite a disparity!

In recent years clinics have been expanding physical capacity to meet the increase in needed space for dental, mental health and a greater diversity of medical specialties offered. So why is chiropractic not being fit into the future planning for space allocations? The answer again comes back to false perceptions and the unfamiliarity with the logistics necessary for the successful and sustainable implementation of non-primary care services.

False perceptions: patient need, money and delivery

The first false perception is that there is too small a **need** for chiropractic in FQHCs - after all MDs don't often make request for chiropractic referrals. Naturally, the historical lack of familiarity between medical and chiropractic professionals has contributed; but when we place a DC in a Community Clinic we begin to see the same levels of utilization seen in the local private chiropractic practices. Access is the key! Equal access produces normal utilization levels. In reality 90% of chiropractic encounters in FQHCs are patient and self-referred.

It is also incorrect to believe that local chiropractors are meeting the need in delivering care. Not unlike the private medical and dental practices, DCs cannot afford to see many Medicaid patients under the fee-for-service rates. It is easy to see that DCs do not accept Medicaid patients except for the few who make occasional exceptions for humanitarian purposes. And when we also consider the uninsured population - it all tends to fall back on the Community Health Centers.

What populations do FQHCs mostly serve? - The poorest and less educated people. An interesting statistic shows how the need for chiropractic care increases inversely with a person's education and their hourly income. Yes, the very make-up of FQHC patient demographics place them with the highest percentage of need for chiropractic care; yet the clinics that are dedicated to serving this population have either denied access through limited understanding of how to assess the true needs, through the unavailability of space for DC providers, or by actually having discriminatory policies toward DC providers. Plainly speaking - the group of people who need chiropractic care the most in our communities, those who suffer the burden of America’s back-breaking jobs, are being denied access to this service - that is, until it is made available within their Community Health Centers.

Money. Chiropractic is a covered service in some thirty state Medicaid plans, but since private chiropractic practices cannot get by with fee-for-service rates, who is standing in to provide this unmet need? Less than 20% of clinic CEOs stated that they knew chiropractic was covered as a regular clinic encounter when provided in their organization. So, it is possible that a false perception that FQHCs could not afford DCs may have also been a contributing factor. Included was the clarification that chiropractic services were included in the definition of a regular clinic encounter. Chiropractic services that are properly scheduled and managed can only increase a clinic's financial stability. Small startup costs are probably the biggest surprise when contemplating the addition of chiropractic services.

Delivery. Unlike Dental and Behavioral Health startup programs that cost hundreds of thousands of dollars to set up before services even begin, this is far from the case for chiropractic departments. In fact the Chiropractic Community Health Alliance has programs for FQHC startups that restore all starting budget expenses in as little as 90 days. A DC can effectively serve 25-35 patients per day in one 10x12 exam/treating room. Staff support is limited to a receptionist who keeps on top of the patient appointments while the billing for chiropractic is reported to be the easiest provider to enter services by the billing staff. X-rays are basic and usually referred out while all other diagnostics are routed through the existing medical providers. It is important to realize that 90% of chiropractic visits are self-referred by the patients with on average only 10% coming from medical provider referrals. The delivery of chiropractic services, when implemented and supervised by experienced personnel, can be one of the simplest and most rewarding programs yet put into practice by any Community Health Center.

Logistics

In future planning, such as the case of adding Dental or Behavioral Health programs, proper consideration of the chiropractic department space needs can easily be factored into the design stages. In an FQHC the chiropractic provider is best situated within the primary care facilities as with Behavioral Health, except that there is no need for a separate waiting area. In fact integrating services of both Chiropractic and Behavioral Health brings an important and effective new case management tool to the primary care physician. So again, why does the addition of chiropractic services seem so distant or difficult to be an integral part of these planning conversations?

It is only natural for people to be confidently challenged by things they are familiar with and conversely would shy away from things they are unfamiliar. Starting up and managing a non-medical discipline by a staff that has extensive training in medical delivery systems makes it quite a daunting enterprise. One that may partially explain why there are so few DCs in Community Health Centers. There are always so many other priorities that take FQHC administrative leaders energy and attention.

In America, chiropractic is viewed as a mainstream healthcare system but the challenge comes when we integrate chiropractic into a medical structure; which by default, views chiropractic as just yet another modality for the treatment of pain. The fundamental difference in managing a non-medical healthcare service lays in their unique philosophical training and basic practice objectives. Medicine is an object-based discipline that uses different modalities to treat a specifically diagnosed condition. Chiropractic is a holistic-based discipline that performs a variety of procedures designed to enhance an individual's ability to heal vs treating any specific condition; one from the outside - in and the latter from the inside - out. In other words, the sum if a person's health is greater than the total of its healthy individual parts.

Both doctors help the patient but one can imagine how it takes separate knowledge to manage these two disciplines. This may explain why several attempts to establish chiropractic services in FQHCs have failed or are only marginally effective when industry consultants are not involved. There is the need to bring experts into the implementation of a chiropractic program but this does not necessarily mean extra costs.

Implementation. The State requires notification of any change in scope of services and this applies to chiropractic, but in most cases there are little to no startup costs and services fall under the usual protocols for payment under already approved benefits. It's merely a formality. To start chiropractic services there are little to no changes required in physical facilities and all standard patient flow, patient charting and billing protocols remain the same. Logistically speaking, the addition of chiropractic services tends to be the simplest, most uncomplicated program to implement, when one knows how to train and where to get the providers who can integrated well within a medically organized structure.

The Chiropractic Service Corps recognizes the challenges faced by Community Health Centers. Issues of small communities, provider availability, limited resources of funds, space, staff and opportunities continue to challenge FQHCs in meeting the needs of their patients. Often we find that the CHC is the only healthcare provider in town and there is only a medical physician on site for a limited number of hours per week or month. Since Chiropractors are trained as primary healthcare screeners, they can in part fill the vacancies of medical provider shortages. It is important to recognize the eight years of university level training it takes to become a chiropractor.

In small communities, the DC can supplement the available primary care access since DCs are educated to be primary care screeners in evaluating patients with non-emergency medical conditions. Although DCs do not make a medical diagnosis, they are trained to do whole body health assessments for the purposes of determining if the patient has the need for concurrent medical management and to make appropriate referrals. FQHCs can strengthen their team with the presence of a chiropractor. Unlike medicine where patients treat themselves at home daily by taking their prescription, a chiropractic patient has to be seen and personally treated by the DC, requiring that the DC be onsite at least 1-2 days per week. This elevates the quality of care since DCs often schedule multiple repeat appointments and patients are watched more closely.

In Conclusion, it is not too surprising when considering that once the focus of a clinic's mission to maintain basic medical services expanded to provide a broader scope of services, the time for chiropractic is now just appearing on the FQHC radar screens. Fortunately, there are now a small number of industry specialists available to advise and supervise the implementation of chiropractic services - something that could not be declared 10 - 20 years ago. There are no Community Health Centers without the need to integrate a chiropractic program and so few barriers to overcome. The question is when as the opportunity becomes ripe for each clinic to act in due time. The goal is to see Chiropractic services available for the under privileged populations through America’s network of existing safety net clinics; now becoming the providers of choice in so many communities.

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