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"Integration" - The New Buzzword

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"Discuss whether chiropractic practice should be delivered as 'stand-alone' care or should be integrated with more conventional therapies."

This was one of the topics I was asked to address by the White House Commission on Complementary and Alternative Medicine Policy in December 2000. I was forced to think very hard about the pros and cons of the new buzzword "integration." This concept seems to be on the lips of everyone thinking about so-called complementary and alternative medicine. Whether we like it or not, chiropractic is often placed in this category by powerful policymakers, and we must deal with it.

Usually the word "integration" means the incorporation of various "CAM" procedures and products into conventional medical practice. When it refers to herbs, supplements, botanicals and the like, the concept easily makes sense. Instead of using Prozac, why not try St. John's Wort? It's safer, cheaper and just as effective. At least in behavior, it's just the same old drug model anyway.

But when it comes to talking about non-MD health professions, the discussion gets a lot more complicated. There is no doubt that some MD turf is being protected. That is why MDs are being certified in acupuncture, homeopathy and other forms of care. Spinal manipulation is being taught as well (although the success of that venture is not that clear, as witnessed by Carey's recent paper in *Spine*). In its worst sense, integration might mean the absorption of chiropractic and acupuncture into medicine. On the other hand, we should not totally dismiss the idea of integration. Full chiropractic integration of the positive kind is a worthy goal that has not yet been attained. As a profession, we have no choice if we are going to reach all of the people that need our help. Integration is a buzzword, but it can be used to our advantage if we're smart enough to understand it.

Since chiropractic is a profession and not simply a procedure or a product, the issue of chiropractic integration is a complex systems problem that must be examined from the perspectives of the:

- patient
- health practitioner (clinical)
- reimbursement and delivery system
- regulatory and policy
- cultural, social and political

The most potent integrator in health care is the patient. At this level, chiropractic is already very well integrated; many patients employ chiropractic with their overall use of health care. Chiropractic use has tripled in the last two decades from about 3.6% in a 1980 survey, to an estimated 11% in a 1997 national random telephone survey. This translates to an estimated 190 million patient visits to chiropractors in a year, or about 30% of visits to all CAM practitioners. Chiropractors are utilized more often than any other so-called CAM provider. Studies demonstrate that chiropractic patients generally represent a cross-section of U.S. population demographics. Patients less than 18 years old account for approximately 12%, and patients 65 years and older make up approximately 15% of the chiropractic patient population. Consumer-oriented surveys, observational studies and randomized trials leave little doubt that chiropractic patients are very satisfied with the treatment they receive, often at rates much greater than with other health professionals. Chiropractors must continue to nurture this level of integration, for it is our most powerful ally.

At the second level, however, chiropractors are not very integrated in the sense of coordinating their clinical behaviors with those of conventional medical doctors. Integration in clinical practice can also be described on a model I'll call the "continuum of integrative practice." It can be characterized in three types of practice:

- parallel
- collaborative
- consultative (multidisciplinary/interdisciplinary)

Today, the majority of chiropractic and medical practices are *parallel* to each other. Most of the time, the practices move along simultaneously in the community. Patients choose and integrate their own health care, and direct communication between doctors is minimal. Some chiropractic patients and some medical

patients may cause *collaborative practicing* in specific circumstances with exchanges of information and referrals. There is evidence that chiropractic is increasingly moving into this stage with increasing referral rates both ways, but there is still little data. *Consultative practice* consists of the regular and systematic exchange of expert advice on a health care team, often called multidisciplinary or interdisciplinary practice. Integration decisions occur at the practitioner-to-practitioner level instead of at the patient level. There are some chiropractors working on multidisciplinary health care teams in certain settings, but the number is still quite low and undocumented.

Getting back to levels of integration we come to the reimbursement and delivery system level. Historically, chiropractic has seen a steady increase in third-party coverage from all sectors of the health care industry; for example, in insurance, HMOs, employee-health plans, the military, Medicare, and workers' compensation plans. Although not without controversy and much fighting over the form and amount of integration, chiropractic is being included in a larger proportion of these institutional processes.

Space limitation precludes a discussion about chiropractic integration at the regulatory/policy and cultural/social/political levels, but suffice it to say that chiropractic has made valuable inroads, but has a way to go. When chiropractic is at least on a par with all of the other health care professions, then integration may be considered complete.

Examining the various *levels* of integration in conjunction with the *continuum of practice* model yields complexities that deserve additional study and consideration. For example, chiropractic is well integrated at the patient level, and increasingly so at the reimbursement/payor level. However, due to the nature of the way in which reimbursement systems are organized (by licensed professional with unique payment codes), chiropractic may continue to operate only in the parallel and collaborative practice modes at the practitioner level of integration. In other words, true consultative multidisciplinary/interdisciplinary practice may be very difficult to obtain. This may limit the number and kinds of jobs available to chiropractors.

On the other hand, whether this is bad for chiropractic is debatable. Perhaps integration should be kept at the patient level; perhaps the dilution of professional autonomy necessary for effective consultative interdisciplinary practice will eliminate the attributes of chiropractic that make it attractive and effective. There is no data on this issue, and it should be on our research agenda.

This discussion is only an introduction to the health services and clinical issues that need to be grappled with, under the umbrella of integration. My answer to the discussion topic at the beginning of my colunmn is **both**. Chiropractic care should be delivered as a stand-alone clinical practice, **and** it should be integrated in health delivery systems that provide direct access and choice of providers for patients and appropriate autonomy to chiropractors. Integration can be a good thing if it is on our own terms.

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