CHAPTER 6

Collaborative Care

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I. OVERVIEW

All patients of all health care providers have the right to expect health care services at the highest level of quality. The preservation of patient trust and confidence depends on this. When the needs of the patient demand the inclusion of other providers or institutions in the program of care, extra caution and extra effort are required to ensure that no gaps in service or conflicts will be allowed to jeopardize the quality of care. The chiropractic practitioner should be aware of programs of cooperation and/or collaboration which can assist the patient.

Relationships between health care professionals can only become more complex, and possibly more contentious as we presently enter an era of great change and instability in health care. Concepts such as "managed care," "preferred provider" and "gatekeeper physician" are becoming the new currency of health care policy. As efforts to control health care costs center more and more on the managed care theory of cost and utilization containment, a credible protocol for interaction becomes an urgent necessity.

To ensure that all requirements for patient care can truly be addressed, this new model must consider cooperative relationships in all settings, including institutional settings such as the hospital, nursing home, and hospice, and among all health care professionals. The model to be devised must be comprehensive, clear to all parties involved, and flexible and dynamic enough to adapt to the daily realities of practice.

In an era in which greater scrutiny is being given to all health care procedures and pathways, it is particularly important that the chiropractic profession take steps to ensure that relationships with other providers are based on the best interests of the patient at all times. Likewise, we must carefully safeguard the rights of chiropractic patients and ensure that other providers are conscious of the need to conduct patient care in a totally objective and professional manner. When professions interact in the delivery of health care services, economic and social factors as well as professional competition or misunderstanding should never be allowed to override the fundamental obligation to the patient. There is no place for such distractions in the delivery of quality health care, nor should the chiropractic profession or the public tolerate prejudice or discrimination in the conduct of health care policy at any level.

II. LIST OF SUBTOPICS

Reasonable Patient Expectations in the Cooperative and Collaborative Care Setting

A. The Patient and the Primary Care Provider
B. Freedom of Choice and Informed Consent
C. Professional Knowledge and Understanding
D. Referrals
E. Exchange of Information and Records between Providers
F. Professional Interaction in the Hospital or Other Institutional Setting.
G. Economic Considerations

III. LITERATURE REVIEW

Collaboration can be defined as the reciprocal inter-professional interaction of two or more health care providers. Collaborative care involves this interaction in the management of the patient's

current health status. Collaborative care, therefore, includes care in a private practitioner's office, where interaction exists on a daily basis between the practitioner and his/her assistants, as well as care within a complex institutional setting such as a medical specialty ward in a hospital and care within a managed care setting. Various specialty fields exist within chiropractic and are available as a resource.

Hospitals and other institutional inpatient settings represent to some degree a new frontier for chiropractic. Chiropractic has an enormous impact to make in this context. As well, hospitals are of great social, political and economic importance in North America. It is here that the largest publicly-supported concentration of leading-edge diagnostic equipment is to be found. Hospitals are also the scene of the vast majority of clinical information gathering and research.

Collaborative care is neither new nor unique to this generation of providers, though cooperative relationships between the medical and chiropractic professions have been less frequent in the past. The federal court judgment in 1987 in Wilk et al. vs. AMA et al., which effectively eliminated formal barriers previously established to the collaboration of the chiropractic and medical professions, has been a key factor in increasing cooperation. However, as greater emphasis is now being placed on the concept of nominating one primary care doctor as a "gatekeeper" whose function is to ensure appropriate care yet contain specialist and other costs, new effort is required to understand the appropriate role of different health disciplines. This is a difficult task for a number of reasons.

Firstly, from an organizational viewpoint, much of modern medicine is based on a "problem-oriented model" rather than one based either on the management of chronic illness or disease prevention. The problem-oriented model is less conducive to an interdisciplinary team approach than a "goal-oriented model" where the patient's achievement of highest possible level of health is the goal of all concerned.

When incorporating chiropractic care into patient care guidelines, it is always understood that the role of the doctor of chiropractic is separate from other health disciplines and should be presented as such. Whatever the unique needs of the individual patient, the objective of chiropractic remains the same. The correction of vertebral subluxations is the goal of chiropractic regardless of whether any other disease or condition is presented.

As the doctor of chiropractic participates more and more in other patient care settings, the importance of keeping the body free from subluxation is paramount to promoting a return to the patient's full health potential. Through greater understanding of the chiropractic objective by both the patient and collaborating professional, the pursuit of cooperation and quality patient care can be enhanced.

Clarity of roles is vital. This clarity is dependent to some extent on the probability of a successful care outcome and to some extent upon the provider chosen. This should be understood when clinical policies and guidelines are made on decision-making in patient management. Dixon has noted that while policies can be helpful in simplifying complex clinical dilemmas, they have at times been adopted without evidence of benefit and that research studies using appropriate clinical methodology should be encouraged in order to prevent useless or even dangerous algorithms of care.

The development of wise patient care guidelines, incorporating the many approaches available in health care today, should provide for the most effective balance of resources for the patient's needs. Determining the role of each profession in the various algorithms for patient management should reflect the varying and unique needs of each individual patient. Developing such algorithms, which are currently not in place nationwide, may reasonably be expected to have a significant impact on health outcomes in general, as well as on the difficult inter-professional issue of cost-containment. To that end, for example, Wenneberg has stated that patients' understanding of their care options is

anticipated to be a major contributing factor in their care selection. He noted that health care allocation by patient preference is likely to be cost-effective because patients prefer and select less invasive, less expensive treatments. It is in the best interest, therefore, of all concerned that the health care system have all its professional resources, and ready information on them, available to all patients.

Initially, as the chiropractic profession explores the arena of collaborative care more fully, documents generated by practitioners engaging in this work and setting out inter-professional referral protocols can serve as guidelines. As part of the health care system at large, however, the chiropractic profession must now begin to focus more of its resources in researching and developing clinical standards relevant to collaborative care. As noted earlier, such efforts are needed to meet the many and varied needs of all patients.

IV. RECOMMENDATIONS

A. The Patient and the Primary Care Provider

1. Patients are entitled to a clear explanation of why the participation of other health professionals has been determined to be necessary.

6.1.1 **Rating**: Necessary
Evidence: Class II, III

B. Freedom of Choice and Informed Consent

1. All health care professionals should recognize and respect the right of the patient to select his/her own methods of health care and the setting in which that care is delivered, as well as the right of the patient to change providers at will.

6.2.1 **Rating**: Necessary
Evidence: Class III

2. Primary health care providers should supply sufficient information to enable the patient to make an informed decision regarding choices in care and of providers.

6.2.2 **Rating**: Necessary
Evidence: Class III

C. Professional Knowledge and Understanding

1. Chiropractic practitioners should make reasonable effort to be familiar with other health care providers whose care may have implications for the care of their patients, and should strive to communicate such information, as appropriate, to the patient.

6.3.1 **Rating**: Recommended
Evidence: Class III

2. Professional Knowledge and Understanding

Chiropractors shall supply sufficient information to enable the patient make an informed decision regarding their choosing of chiropractic care.

6.3.2 **Rating**: Strong positive recommendation
Evidence: E, L

D. Referrals

1. Primary health care providers should consult or refer if the needs of the patient so indicate.

6.4.1 **Rating**: Necessary
Evidence: Class I, II, III

2. Chiropractic practitioners should accept referrals from other health providers.

6.4.2 **Rating**: Recommended
Evidence: Class III

E. Exchange of Information and Records between Providers

1. Chiropractic practitioners referring a patient to a peer or another professional should take all necessary steps to provide information from the case history and diagnostic findings to the practitioner receiving the referral in an effort to minimize unnecessary testing or repetition of diagnostic procedures.

6.5.1 **Rating**: Recommended
Evidence: Class III

2. Post-referral communication between referring and receiving practitioners should be complete and adequately detailed. Appropriate records of clinical findings or recommendations should be exchanged.

6.5.2 **Rating**: Recommended
Evidence: Class III

3. Questions about care decisions made or recommended by another provider should be addressed directly to that provider in a constructive manner. Relying on the patient to be an effective messenger of critical information is inappropriate.

6.5.3 **Rating**: Recommended
Evidence: Class III

4. Response to requests for records should occur in a timely fashion. Likewise, records requested by the practitioner that are another practitioner's property should be returned in a timely fashion.

6.5.4 **Rating**: Recommended
Evidence: Class III

F. Professional Interaction in the Hospital or Other Institutional Setting

1. In a collaborative or cooperative care setting, every effort should be made to develop and present to the patient a consensus among all participating practitioners on the recommended course of care.

6.6.1 **Rating**: Recommended
Evidence: Class III

2. Practitioners should seek access to other health care facilities and institutions as necessary to meet the needs of their patients. This may include authority to admit or co-admit the patient into the appropriate clinical setting or hospital.

6.6.2 **Rating:** Recommended
Evidence: Class Ill

3. In the process of concurrent care, each professional party should be aware of the care decisions made by other participants, and fully coordinate activities and information for the patient's benefits.

6.6.3 **Rating**: Recommended
Evidence: Class III

4. The resolution of disputes between members of different professions on the course of care for a given patient should be based on: a) the best professional judgment of the practitioners involved; b) the objective evaluation of appropriate clinical options and intervention alternatives; and c) responsible family involvement where appropriate. Informed consent on the part of the patient continues to be necessary.

6.6.4 **Rating**: Recommended
Evidence: Class III

5. To facilitate patient access to the widest possible range of health care resources and options, practitioners should investigate participation in managed health care organizations (e.g., HMOs, PPOs, etc.). Managed care plans should provide for direct access to chiropractic services.

6.6.5 **Rating**: Recommended
Evidence: Class III

G. Economic Considerations

1. No referral should be sought or made on the basis of economic considerations and no financial relationship should exist between parties in a referral process. No fee, rebate or commission should be paid to any referring provider for the referral.

6.7.1 **Rating:** Recommended
Evidence: Class III

2. Determination of the need and appropriateness of chiropractic procedures constitutes the practice of chiropractic. Such determinations should be based upon a review and records and a physical examination of the patient by a licensed chiropractor. Rendering an opinion concerning the need or appropriateness of such care without an examination of the patient constitutes unprofessional conduct.

6.7.2 **Rating**: Necessary
Evidence: Class III

3. Primary providers should cooperate to secure proper insurance payment for all clinically-indicated health care services.

6.7.3 **Rating**: Recommended
Evidence: Class III

V. COMMENTS

Professional behavior should be governed by the principles of the philosophy, art and science of chiropractic, and a strict set of ethical canons which go beyond the legal obligations of licensure. Ethical requirements are as compelling and imperative to the delivery of quality care as any clinical indications.

Interaction between professions in a hospital or other institutional setting will be governed by the laws and regulations of the jurisdiction within which the facility operates and the rules and bylaws of the hospital or facility. Recognition of the degree to which professional roles are specified by such regulations should eliminate much of the confusion and concern surrounding the participation of chiropractic practitioners in the hospital setting.

In situations where patients need or request diagnostic outpatient services or inpatient care, the practitioner should provide a full and accurate explanation of his/her professional access to such facilities. It is important that degrees of institutional access be understood by all parties in a collaborative care situation. Under no circumstances should any chiropractic practitioner overlook or minimize the need to employ outside services because he/she does not have access, referral or staff privileges at a specific facility. It is incumbent upon the practitioner to find a means to meet patient needs on a timely basis, all such considerations notwithstanding.

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