

Spine care: Controlling the midfield



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The superbowl is over, folks!
And, just maybe,
so is American football
Even our healthcare system
Is looking more like the European game
Lets talk back pain



Disclaimers



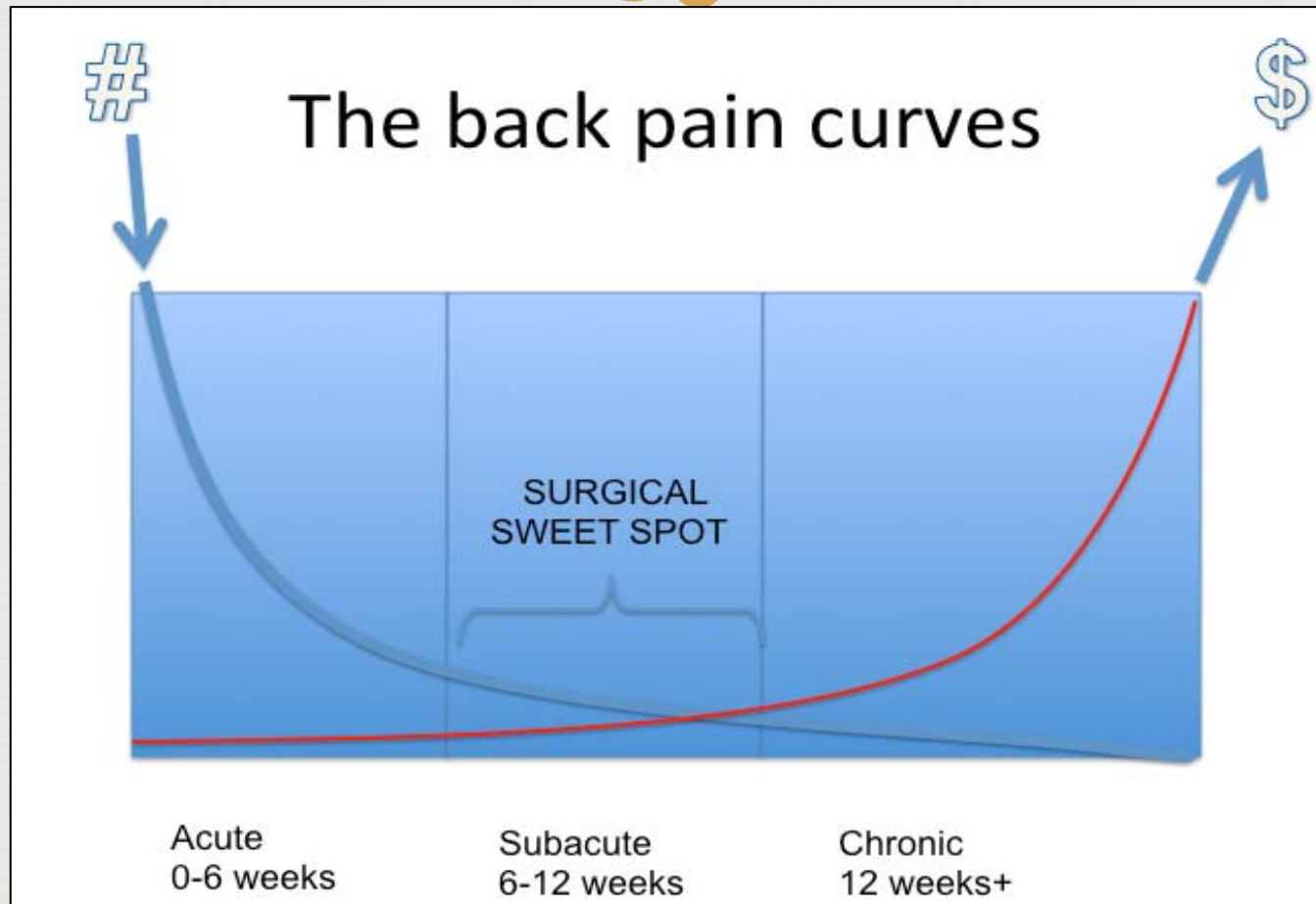
- ❧ New job! Vice President for Accountable Care, Mary Free Bed Rehabilitation Hospital
- ❧ Haig et al., Consulting builds rehabilitation programs in the US and internationally
- ❧ Haig work on this project was not funded.
- ❧ Thanks to John Fox and Priority Health!

Back pain 101



- ❧ Most everyone gets a disabling episode
- ❧ 5% see a doctor each year
- ❧ 5% of these get surgery
- ❧ Costs \$100 billion per year
- ❧ 4/5 of the cost is non-medical

Time and money...



Diagnosis



- ❧ Pain down the leg: Disk herniation or spinal stenosis
- ❧ Pain only in the back: facet, sacroiliac joint, disk tear
- ❧ *Except when that's wrong...*
- ❧ Cancer, infection, fracture, paralysis
- ❧ Stuff that looks like its radiating
 - ❧ Whip the hip
 - ❧ Upset the facet
 - ❧ Poke the trochanter
 - ❧ Smack the sacroiliac
 - ❧ ...and nerve problems down in the leg...

Diagnostic tests



- ❧ The doctor's history and physical examination
- ❧ MRI
 - ❧ Finds cancer, infection, fracture, but...
 - ❧ Herniation in 1/3 of younger people who don't hurt.
 - ❧ Stenosis in 2/3 of older people. (Haig et al., JBJS 2007)
 - ❧ arthritis, degenerative joint 'disease' are normal aging
- ❧ Electromyography
 - ❧ Nearly 100% specific when positive
 - ❧ finds alternative diagnoses like neuropathy
 - ❧ Diagnoses nerve problems, not joints
- ❧ Spinal injections
 - ❧ Numb it up. If pain goes away that's the spot.

Treatments



- ❧ Surgery
- ❧ Injections
- ❧ Medications
- ❧ Therapies
- ❧ Advise and wait

The secrets of acute and chronic pain

❧ Acute pain:

- ❧ The only effective long term intervention is teaching patients to ignore it. (Indahl)

❧ Chronic pain:

- ❧ 70% can be predicted at the first visit (Hazzard)
- ❧ Predictors are almost all psychosocial
- ❧ Reversible sequelae: (Haig 2007)
 - ❧ Psychiatric disease (anxiety, depression, PTSD...)
 - ❧ Profound physical deconditioning (1 flight of stairs...)
- ❧ Multidisciplinary rehabilitation highly effective, rarely paid for (e.g. Mayer)

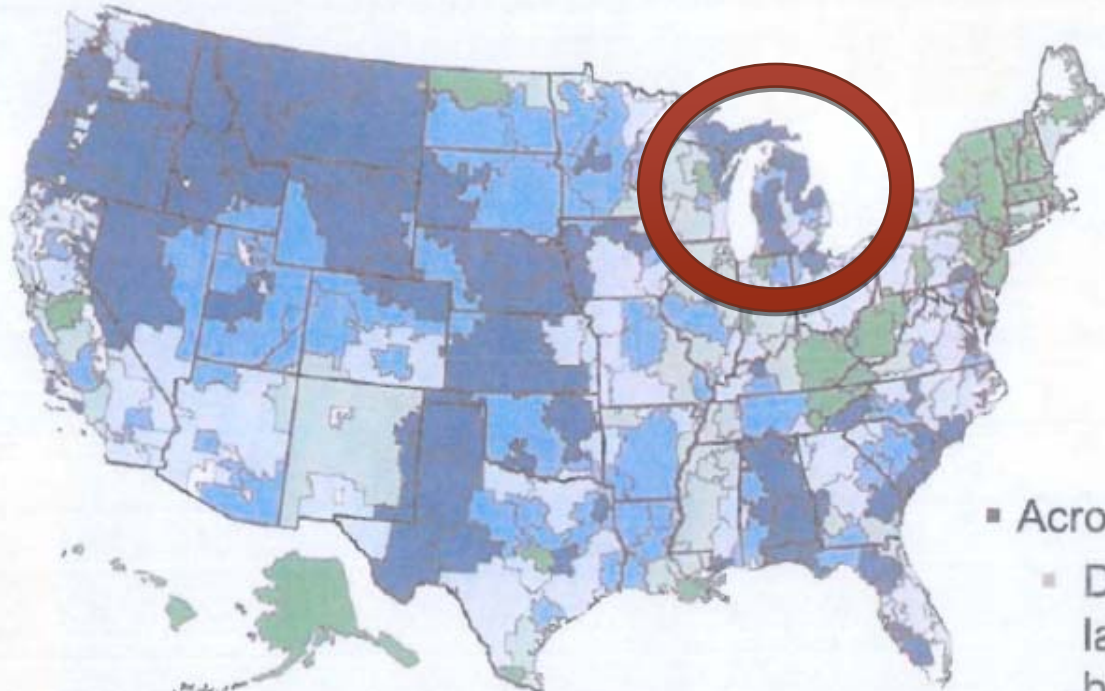
Mismatches



- ❧ Some patients get paid to not get better
- ❧ Primary care physicians have little training: risk of disability, interpretation of tests, surgical indications.
- ❧ Abnormal imaging in normal people sets the stage for surgery
- ❧ Surgeons make more money operating than talking
- ❧ Primary insurers save money by delaying treatment (thus delaying return to work)
- ❧ Opioids please patients and get them out of the office
- ❧ Effective multidisciplinary rehab opens the 'psych' can of worms

Predictably...we're stuck

Ratio of Total Spine Surgery Rates to US Average, 2002–2003



■ Across regions:

- Discectomy and laminectomy rates vary by a factor of 8
- Spinal fusion rates vary by a factor of 20

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Potential solutions?

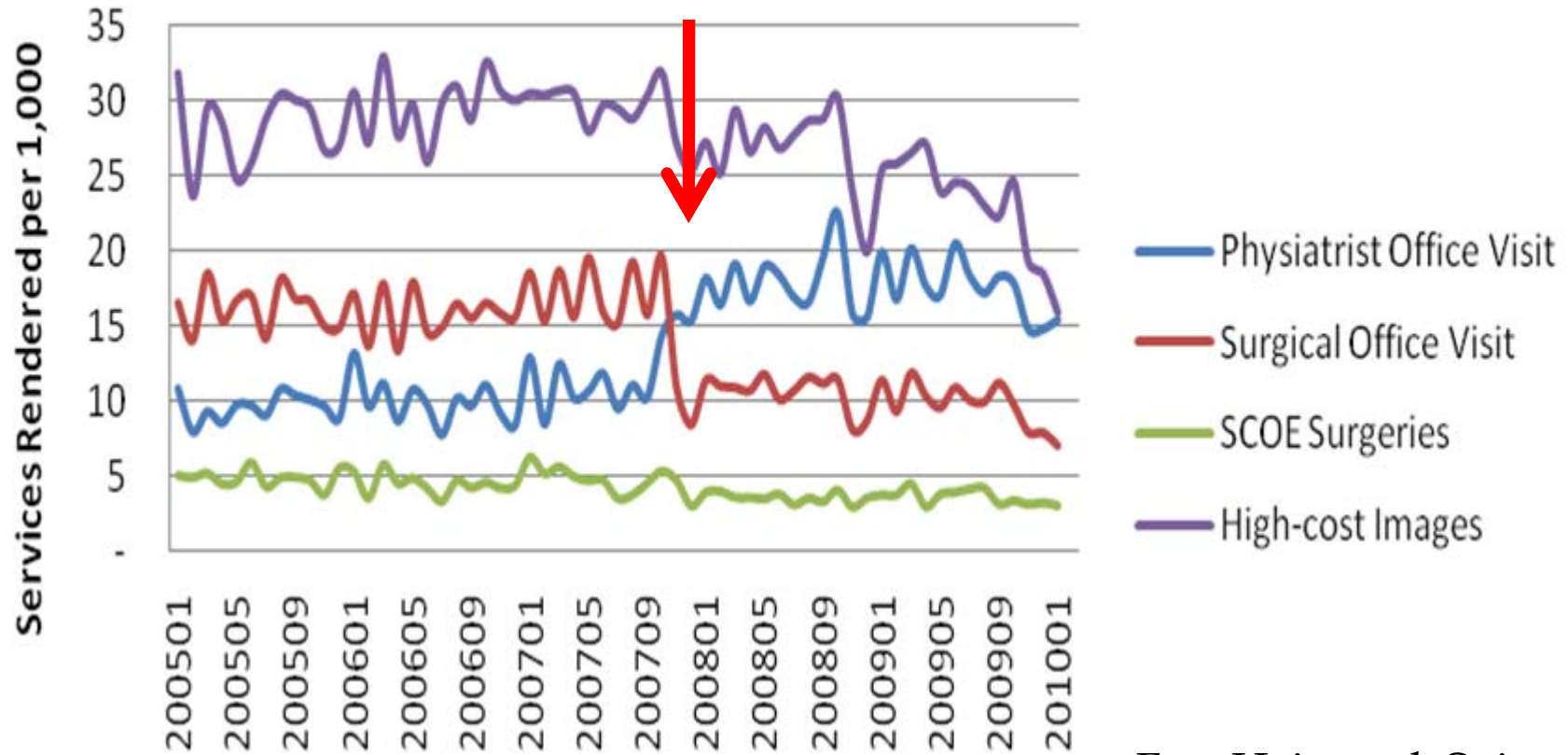


- ❧ Get 12th grade educated insurance clerks to outthink doctors who graduated from 26th grade. Done.
- ❧ Make primary care docs smarter. Right.
- ❧ Make surgeons less greedy. Check.
- ❧ Ask the physiatrists to help?
 - ❧ PM&R: “We’re already busy.”
 - ❧ BCBSM: “There aren’t enough of them.”
 - ❧ John Fox of Priority Health: “Heck, lets do it anyway.”

Solution:

Priority Health's experiment

Combined Data



What happened?

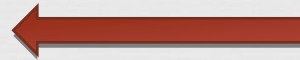


- ❧ Surgery -29%
- ❧ Advanced imaging -18%
- ❧ EMG +14%
- ❧ Injections +4%
- ❧ Total PMPM cost -12%
- ❧ Continued patient satisfaction

Who won this game?



Health System	Change in Surgery Rates
A	+17.1%
B	-21.6%
C	-30.3%
D	-36.1%
E	-16.5%
F	-42.3%



Already
had PM&R
screening
cases

OUCH!!!

Priority Health Project Implications:

- ❧ Its not just surgeons! Primary care doctors make bad referral decisions
- ❧ Lay off 1/3 of the smartest, richest content experts? What will they do for a living?
- ❧ Will this just happen all over the country? Or is a catalyst needed?
- ❧ Will the local PM&R community be ready?

Hospitals on Heroin!

Tough to quit...

- ❧ The operating room and MRI make money
- ❧ The surgeons are the respected content experts. Do you get them off the planning committee?
- ❧ Many surgical groups are private: they can just quit
- ❧ Spine surgeons are truly valuable: brain bleeds, spinal fractures, etc.
- ❧ The primary care physicians think they can handle it
- ❧ Only one insurer requires this? Bag it and go for Medicare, workers comp, other insurers.

Health care system solution: Control the Midfield!

❧ Acute care:

- ❧ PM&R build a collaboration with the Emergency Department and PT
- ❧ PM&R and PT develop a limited rapid therapy program with handoff to PM&R not primary care

❧ Subacute care:

- ❧ Cast a wider net AND make surgeons more efficient in clinic by having a PM&R triage program

❧ Chronic care:

- ❧ Structure therapy finances to incentivize PM&R to lead multidisciplinary rehabilitation pain assessments

Payor reform: Change the referee's rules

❧ Acute:

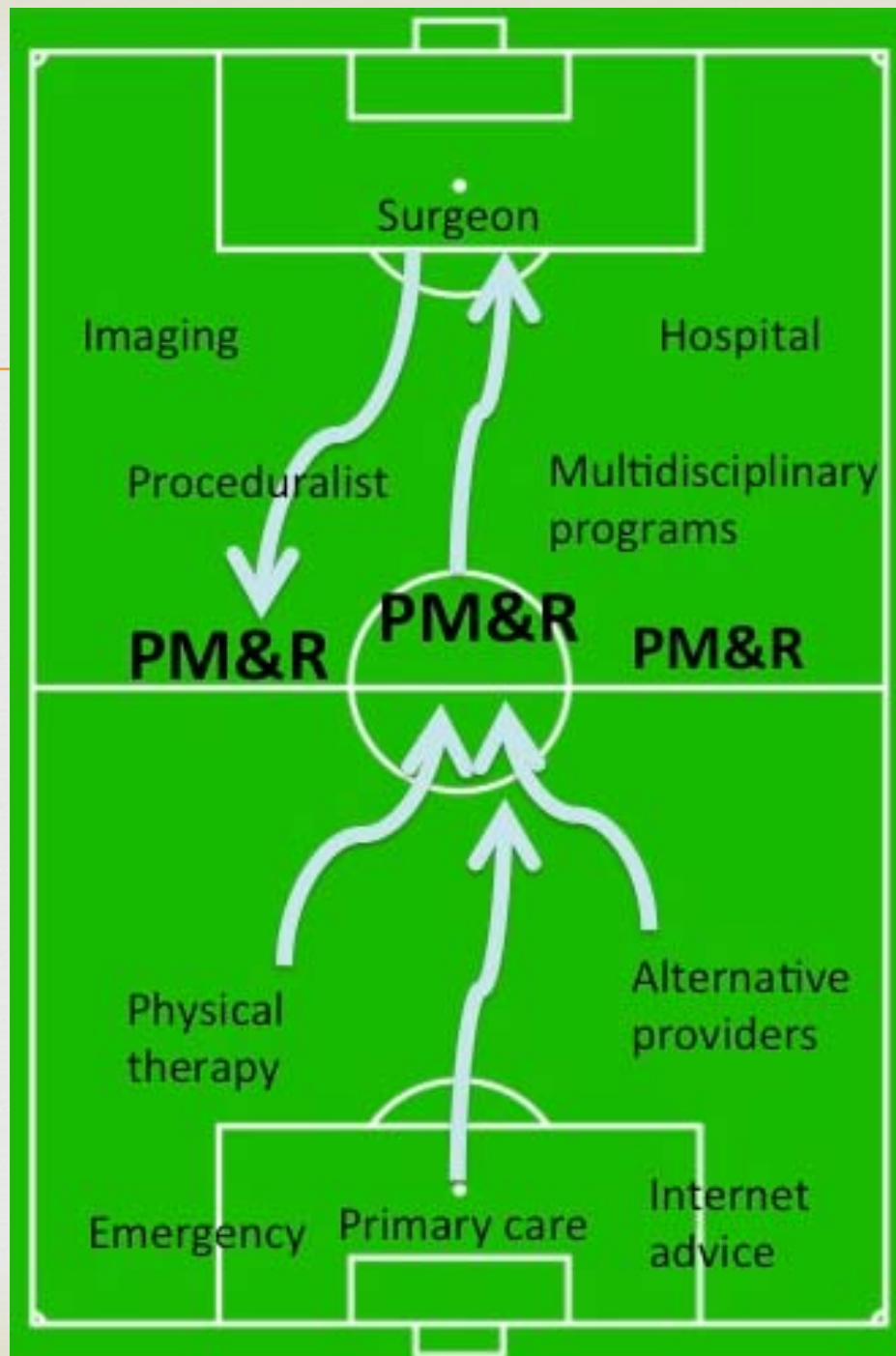
- ❧ Permit first access to 4 visits with PT, if they educate and the outlet is PM&R

❧ Subacute:

- ❧ No surgery without PM&R screening
- ❧ Support surgical pre-hab

❧ Chronic:

- ❧ Multidisciplinary rehab assessments (yeah, a psychologist and a team meeting) for all high-cost/high risk patients before surgery, implants, or long term narcotics.



Health systems: Prepare!



Payors; Give warning and
look at the big picture!