Frank Lasee

WISCONSIN STATE SENATOR

FIRST SENATE DISTRICT

Senator Lasee's Testimony

Senate Bill 762: Primary Spinal Care Practitioner Bill

Healthcare is all about patient outcomes. When healthcare has the ability to heal patients quickly it is better for the patient, as well as the community at large.

The concept of a primary spinal care practitioner is an interesting one: having licensed chiropractors partner with the medical community to create an additional option puts patients in the driver's seat for a method of healing that works for them. The government, chiropractors, and medical community need to strive to provide pathways of care that the patients want, as that leads to the fastest healing and best outcomes.

The framework that we created in Senate Bill 762 creates a new option for patients while ensuring safe and professional care. The training that chiropractors receive in their licensure is comprehensive and when we couple the chiropractic training with the training that will be required for the Primary Spinal Care Practitioner license, we create a new option that ensures safety and competency of practice that all medical licenses require, but with a scope and focus on spinal care that is broader than any option that patients currently have in Wisconsin.

I hope that you can join me in support of this new concept in spinal care.

Chair: Committee on Insurance and Housing

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MEDICAL COLLEGE OF WISCONSIN

TO: The Honorable Members of the Senate Committee on Health and Human Services

FROM: Shekar N. Kurpad, MD, PhD
Interim Chairman, Department of Neurosurgery
Professor of Neurosurgery
Director, Spinal Cord Injury Center
Director, Spine Surgery Fellowship

DATE: May 24th, 2016

RE: Senate Bill 762, licensure of primary spinal care practitioners

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Good morning Chairperson Vukmir and members of the Senate Committee on Health and Human Services. Thank you for holding an informational hearing today on Senate Bill 762 (SB 762), legislation creating licensure for primary spinal care practitioners in Wisconsin. The Medical College of Wisconsin (MCW) appreciates the invitation and opportunity to testify today on SB 762. My testimony is for information only.

One of MCW's core missions is to be a distinguished leader and innovator in the education and development of the next generation of physicians, scientists, pharmacists and health professionals. MCW currently educates 845 students in the School of Medicine, 400 students in the Graduate School, and 160 postdoctoral fellows in the Graduate School of Biomedical Sciences. Additionally, more than 670 physicians are in residency training through the Medical College of Wisconsin Affiliated Hospitals (MCWAH), along with 180 MCWAH physicians in fellowship training.

MCW is also launching a School of Pharmacy in Milwaukee to prepare the next generation of pharmacists to meet the growing healthcare needs of society. MCW's PharmD graduates will have the knowledge and expertise to practice at the "top of their license" and contribute to patient-centered care within a team-based model. In addition to the School of Pharmacy, MCW is creating a new Anesthesiologist Assistant program (MS), which will matriculate students in August 2016 in Milwaukee.

MCW has a strong and storied history of providing high quality education and training, and is continually looking toward educational innovation for the next generation of health care practitioners. Should the state enact this legislation, MCW has interest in creating the educational and training program outlined within the bill. Following enactment of the legislation, MCW would intend to pursue an internal evaluation and feasibility study of creating such a degree program. The outcome of this review would guide our decision-making process on whether ultimately pursuing the official development of this program would be appropriate.

Developing a new academic program requires a significant investment of institutional resources, staff, and finances to plan and implement. This is especially true within the context of a scope and licensure expansion. For reference, MCW undertook a similar process when developing the new Anesthesiology Assistant (AA) program. This took place following the passage of legislation officially licensing AA's in

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Wisconsin. In this instance, these internal deliberations necessarily occurred after the passage of the bill, as a result of the significant resources required to complete a thorough institutional review.

In the full interest of disclosure to policy makers, MCW is interested in providing this educational program, but cannot ultimately guarantee that our institution would be the academic entity moving this forward on the educational front. As a result, MCW is not taking a formal position on SB 762.

In regard to MCW's clinical enterprise, chiropractors have been on faculty at MCW for 20 years, working side by side with our spine surgeons and physicians in a team-based setting. Chiropractors are an integral part of taking care of a diverse group of patients, and their value extends beyond treatment and carries into how we examine patients and determine the best course of care.

From a clinical standpoint, chiropractors who become primary spinal care practitioners would take on an expanded responsibility of providing front line care for patients with spine related complaints. For example, these practitioners would be acting in a capacity of triaging and managing most patients across the entire treatment expanse and managing referrals to other providers when necessary. If done responsibly in partnership with organized medicine, a modest scope expansion for chiropractors obtaining additional training could help address health care shortages in our state by providing a high level of care at a lower cost. This type of expansion has the potential to be a positive for our state's patients.

Thank you again Chairperson Vukmir and members of the Committee. We appreciate your time and attention. If you have any questions following this public hearing, please feel free to contact Kathryn Kuhn, Vice President of Government and Community Relations, or Nathan Berken, Director of Government Relations, at 414.955.8217, or kkuhn@mcw.edu, or nberken@mcw.edu.

Wisconsin Physical Therapy Association
A CHAPTER OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION
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May 24, 2016

To: Senate Committee on Health and Human Services
- Senator Vukmir (Chair)
- Senator Moulton (Vice-Chair)
- Senator LeMahieu
- Senator Carpenter
- Senator Erpenbach

Re: Testimony on SB 762

Senator Vukmir and members of the committee, my name is Connie Kittleson and I am President of the Wisconsin Physical Therapy Association. I want to thank you for the opportunity to speak to Senate Bill 762. Today I am testifying for information only.

The Wisconsin Physical Therapy Association's primary questions concern the creation of a new title, licensure category and credentialing board for this type of practitioner. This bill establishes a new category of licensure requiring a specific type of education that does not currently exist. Therefore, it also establishes a new licensing scheme (including a new credentialing board) before there exist any programs or practitioners who would qualify.

Additionally, our concern is that this bill has the potential to create significant public confusion about who these providers are, and what differentiates them from other providers. This bill would allow chiropractors with 60 additional hours of training and 12.5 weeks of clinical rotations to identify themselves as Primary Spinal Care Practitioners. They are chiropractors, but this bill does not require them to identify themselves as such. Will the public understand that they are still chiropractors and not physicians? Even the white paper published by the Wisconsin Chiropractic Association identifies these practitioners as Primary Spine Care Physicians. Under Wisconsin Chapter 448, a physician is defined as an individual possessing the degree of doctor of medicine or doctor of osteopathy or an equivalent degree as determined by the medical examining board, and holding a license granted by the medical examining board. Would this bill allow for the medical examining board to designate primary spinal care practitioners as physicians when the vast majority of their education and training has been in chiropractic care?

The Wisconsin Physical Therapy Association also has questions regarding the term Primary Spinal Care Practitioner. Currently, physicians, chiropractors and physical therapists are health care practitioners working in primary care settings delivering spinal care. Would this bill limit these practitioners from identifying themselves to the public as primary care providers of spinal care which they currently are?

This bill also defines a new type of medical practice called "spinal medicine" as the integration and application of the practice of chiropractic and the practice of medicine and surgery, but it goes on to say that it does not include surgery. Attempting to partially blend the definitions of what are now distinct healthcare entities has the potential to cause confusion and it unclear how this serves the public.

Currently patients already have direct access to chiropractors. This bill's primary public impact is not increased access to these practitioners, but rather easier access to prescription drugs and advanced medical imaging studies which would be provided by chiropractors with specific training. As this committee is aware, Wisconsin Act 375 passed earlier this year allowing physical therapists with specific training to order x-rays. This expansion of scope of practice for certain physical therapists did not require a separate title, licensure category or credentialing board. It is unclear why a similar expansion of scope of practice for certain chiropractors would require these steps.

Finally, for these patients who are being treated via direct access by chiropractors and who need prescription medication to manage their spinal conditions, it is likely that these prescriptions would be for such medications as muscle relaxers and pain medication including opioids. It is unclear that easier access to these medications is warranted at this time. The national conversation surrounding prescription medication right now is around appropriately controlling access due to the opioid abuse epidemic. Prescribing practices are under significant scrutiny at the state and federal levels. Given this context, is granting prescribing privileges to another profession appropriate at this time?

I thank you for your time and for allowing me to present these questions.

Connie Kittleson, PT, DPT
President
Wisconsin Physical Therapy Association

Wisconsin Medical Society

Your Doctor. Your Health.

TO: Senate Committee on Health and Human Services
Senator Leah Vukmir, Chair

FROM: Donn Dexter, MD
Chief Medical Officer

DATE: May 24, 2016

RE: Testimony on Senate Bill 762 – Primary Spine Care Practitioners

On behalf of more than 12,500 members statewide, the Wisconsin Medical Society appreciates this opportunity to share our thoughts on Senate Bill 762, which aims to create a new kind of heath care professional called a Primary Spine Care Practitioner (PSCP). I am Donn Dexter, the Society's Chief Medical Officer. I am a practicing physician – a neurologist – at a major health system in Eau Claire.

When issues arise related to which health care professionals can give a certain level of care, physicians are very willing to add their expertise to the discussion. "Scope of practice" is a phrase that sometimes makes legislators recoil, for understandable reasons: many lawmakers do not have extensive experience in the health care world and therefore are often asked to make decisions based on often-divergent opinions. Because of this the Society's membership understands that physician expertise can be quite valuable.

Reflecting the importance of analyzing these types of proposals, the Society has policy setting the groundwork from which our physician members evaluate specific proposals:

SCO-001
Scope of Practice: The Wisconsin Medical Society believes that health care professionals should work as partners in health care within the limitations of each profession's legal scope of practice. The Society also recognizes that the practice of medicine and other health care professions are dynamic disciplines. Enhancements in technology, advances in science, improvements in education and training and changes in health care delivery may necessitate changes in the scopes of practice for non-physician health care professions. In evaluating whether a change or expansion in a non-physician health care profession's scope of practice is necessary and appropriate, the Society will, at a minimum, evaluate answers to the following questions:

1. Are members of the profession appropriately educated, trained and experienced in the actions, treatments, responsibilities or procedures for which authority is sought to ensure that if the profession's scope is changed as proposed the care patients receive:
    a. Is competent and of high quality?
    b. Adheres to accepted or reasonable standards of patient safety?

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2. Has a genuine patient-care need been identified sufficiently to justify the degree of changes requested to the profession's scope of practice?

3. Are corresponding changes to the profession's liability insurance requirements necessary to ensure that patients may be adequately compensated in situations of professional malpractice?

4. Will the changes proposed have a negative impact on the cost of or access to health care?

5. Are the proposed changes unambiguous so that
   a. Patients may easily understand the limits of the profession's legal authority and practice?
   b. Members of the profession may not expand the scope of professional practice without appropriate legislative action?

When these criteria are met, the Society will work to ensure that proposed changes to non-physician health care professional practice acts and regulations accomplish their stated intentions in consultation with medical subspecialties affected by these changes. (HOD, 0415)

The Society's Council on Legislation reviewed Senate Bill 762 with the above questions in mind and recommended to our Board of Directors that the Society not support the proposal. The Board agreed with the Council, and earlier this spring that recommendation was ratified at the Society's House of Delegates.

Reasons for this opposition are numerous; some highlights include:

- The bill expands certain chiropractors' scope dramatically – the PSCP appears to be a kind of chiropractor/physician hybrid that is not found anywhere else in the country.
- The bill's definition of "spinal medicine" (p. 38) is very broad. While the definition includes the verb "limited," the section goes on to include a large area of medical care.
- Under this bill the PSCP would – among many other things – be allowed unfettered ability to prescribe all drugs – including potent Schedule II drugs that can lead to opioid addiction and misuse. Increasing the number of people allowed to prescribe these powerful drugs runs directly counter to other public health debates currently sweeping the nation.
- The education and experience requirements (p. 42 of the bill) appear to be well short of that required in medical school and residencies (and certainly short of experience gained during fellowships), and there are no specifics regarding curriculum requirements.

Senate Bill 762 does not satisfy many of the fundamental questions the Society's policy asks, and therefore we do not support the bill.

Thank you again for this opportunity to share the Society's thoughts on Senate Bill 762. If you have questions about this bill or other health care issues, please feel free to contact the Society at any time.

THE WISCONSIN SOCIETY OF ANESTHESIOLOGISTS, INCORPORATED

TO: **Chair, Senator Leah Vukmir**
Members, Senate Committee on Health & Human Services
FROM: **Joshua Sebranek, MD, President**
DATE: **May 24, 2016**
RE: **Opposition to 2015 SB 762 – Informational Hearing**

On behalf of the hundreds of Anesthesiologists practicing in Wisconsin we appreciate the opportunity to express our strong opposition to 2015 SB 762.

SB 762 is vast – both in paper and in scope – and contains many very troubling proposals. Others representing physicians and patients are speaking today, so we focus here on but one area in this 66-page proposal, specific to the advanced medical specialty of Anesthesiology. SB 762 would authorize chiropractors to "prescribe and administer drugs," and to "administer a general anesthetic" under the direction of a physician. By our understanding, Wisconsin would be "first in the nation" to adopt such authorities for chiropractors. *Both represent a radical departure from Wisconsin healthcare policy, and carry with them substantial risks for patients.*

"General Anesthesia" is a term for drugs administered to patients (via injection or inhaled) that render a patient unconscious, paralyzed, and unable to feel pain or remember surgery. Administered and monitored properly, general anesthetics are very safe. But they are also among the most powerful medications created. The possible medical complications of General Anesthesia are many, can be unpredictable even with the healthiest patients, and can result in severe and permanent mental or functional disability and death.

Though authorized to do so by their License to Practice Medicine & Surgery, most physicians who are not Anesthesiologists would never consider administering a general anesthetic to a patient – specifically because of the risks to the patient. Anesthesiologist Assistants (AAs) and Nurse Anesthetists (CRNAs) are licensed professionals who have received advanced, Masters-level training specifically in Anesthesia. Yet, despite this advanced training, either by law or hospital regulation, in the vast majority of cases neither AAs nor CRNAs administer anesthesia without the *supervision* of a Physician-Anesthesiologist. SB 762 proposes allowing a chiropractor to administer these same powerful drugs under the simple "direction" of any physician. Simply put, this is wholly unnecessary and exceedingly dangerous for patients' safety.

Finally, some Anesthesiologists pursue even more specialized Fellowship training in Pain Management – a sub-specialty of Anesthesiology. Pain Management specialists treat and manage both acute and chronic pain with a variety of modalities – among them, medications injected directly into the spinal column, nerves or other areas, or powerful prescription narcotic and opioid medications. Beyond "general anesthesia," SB 762 would authorize chiropractors to administer, inject or prescribe all of these without any involvement of a physician or anesthesia specialist whatsoever. Again, this is wholly unnecessary and would put patients at substantial risk.

Wisconsin's nationally recognized HOPE Agenda is only just beginning to tackle the scourge of prescription medicine abuse, but among its core principals are improving patient care by better understanding prescribing patterns, drug-seeking behaviors and identifying unintended pressures/incentives within our health care and

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health insurance systems to give patients medications that may be stronger than necessary, or in greater quantities than necessary. SB 762 would authorize chiropractors to prescribe the most abused medications – including narcotic and opioid pain medications (Vicodin, Percocet, OxyContin), stimulant medications used to treat ADHD (Adderall, Ritalin), and sedatives used to treat anxiety disorders (Valium, Xanax). All can be addictive when abused, all have tremendous black-market value, and all are finding their way to our streets, our schools and our communities in alarming volumes. Setting aside patient safety issues associated with chiropractors prescribing any medications, with just this epidemic in mind, authorizing yet more providers to prescribe these frequently abused medications makes little public policy sense.

Through years of research, perfection of medical equipment, creation of newer, safer and more powerful medications, and the advanced training received by Anesthesiologists and Pain Management specialists, Anesthesiologist Assistants and Nurse Anesthetists, anesthesia and pain management have become "routine" in the eyes of many. But they are far from routine. SB 762 is a very troubling proposal in its treatment of Anesthesia, Pain Management and narcotic/opioid prescribing. We ask for your strong opposition.

CHIROPRACTIC SOCIETY of Wisconsin

The Chiropractic Society of Wisconsin extends our appreciation to Chairperson Senator Vukmir and the other members of the Senate Health and Human Services committee to allow our organization the ability to provide testimony regarding SB 762.

The comments provided today will outline our 100% opposition to the proposed Primary Spinal Care Physician (PSCP) legislation. We oppose the legislation based on 3 primary points:

1. The overwhelming majority of chiropractors not only in Wisconsin, but the entire United States oppose the concept of chiropractors prescribing drugs.
2. The proposed educational component of the PSCP legislation is grossly inadequate and creates a public safety concern. There should never be a shortcut when public safety is involved.
3. The proposed legislation prohibits non-PSCP licensees from indicating that they are primary spinal care practitioners. This restrictive language not only confuses the public, but is a direct insult to the entire chiropractic profession as we currently are primary spinal care practitioners.

The overwhelming majority of chiropractors oppose the PSCP concept of chiropractors prescribing drugs.

Wisconsin has a strong and vibrant chiropractic history. The Gonstead clinic located in Mt. Horeb Wisconsin is internationally known. The Toftness technique was developed in Cumberland Wisconsin.

For over 125 years, the chiropractic profession has proudly provided natural drug-free healthcare to millions of citizens. Chiropractors are integrated into the VA and Department of Defense. You will find chiropractors on the sidelines of not only professional athletic teams, but college and high school teams as well. Chiropractors are in demand for the natural drug-free treatments that they uniquely provide to patients.

The proposed language contained in SB 762 to expand the scope of practice of chiropractic to include the ability to prescribe drugs is not wanted by the majority of the chiropractic profession.

The chiropractic summit, which is a national organization comprised of over 40 influential chiropractic organizations including the American Chiropractic Association, International Chiropractors Association, Congress of Chiropractic State Associations, and the Association of Chiropractic Colleges has released an official statement on this controversial subject:

> "the drug issue is a non-issue because no chiropractic organization in the Summit promotes the inclusion of prescription drug rights and all chiropractic organizations in the Summit support the drug-free approach to health care."

Thus, the CSW's opposition to the PSCP is in alignment with all recognized and established national and state chiropractic institutions and organizations.

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The proposed educational component of the PSCP legislation is grossly inadequate and creates a public safety concern. There should never be an educational shortcut when public safety is involved.

It is important to note that the members of the CSW are not opposed to any healthcare provider obtaining education that will advance their ability to treat patients. We are not here today to testify against the ability for any chiropractor to further their education and receive a separate established healthcare degree. In fact, there are many chiropractors who have obtained other established healthcare degrees including MD, DO, PA and the various levels of nursing degrees. In each case, the chiropractor has taken the necessary time and energy to obtain a valid separate and established medical degree to complement their chiropractic degree. They did not take any shortcuts to earn the second degree.

What we are discussing today, and why the CSW is opposed to this specific legislation, is that the proposed PSCP degree is not an established healthcare degree. There are no states that license such a degree. There are no medical or chiropractic colleges in the United States that provide a masters in spinal medicine. Wisconsin, if approved by the legislature, would be the first and only state to create such a degree and associated regulatory affiliated board.

Section 90 of SB 762 modifies the Medical statutes creating subchapter 448.973, which contains the new "master of science degree program in spinal medicine." It is our position that the proposed masters level educational components listed in SB 762 to achieve the PSCP degree fail to meet even the barest of minimal medical education, especially when related to the increased risk to the public associated with the action of prescribing narcotic opioid drugs.

The following are the 3 components of the new educational process to become a PSCP that the WCA contends will properly train a chiropractor to be able to safely prescribe drugs:

1. At least 60 hours of instruction, including classroom instruction (which means that some can be online instruction).
2. At least 500 clinical rotation hours under the supervision of a physician.
3. An examination in spinal medicine approved by the affiliated credentialing board.

That is it. 60 hours of instruction and basically one day a week for a year participating in vague clinical rotation hours under the supervision of a physician. Once a chiropractor completes these two tasks, they can simply take an exam approved not by the Medical Board, but by the newly created affiliated credentialing board comprised of a majority of PSCP providers.

Upon further review, SB 762 defines the 60 hours of instruction to include the following 7 subjects:

a. Causes of spinal pain and differential diagnosis (Taught at all chiropractic colleges.)
b. Case management and coordination of care in spinal pain patients (Taught at all chiropractic colleges.)
c. Spinal injuries, correlated with diagnostic imaging (Taught at all chiropractic colleges.)

d. Public health issues and epidemiology of spinal pain conditions (Taught at all chiropractic colleges.)

e. Pharmacology (Although not as extensive as medical schools by any means, doctors of chiropractic are taught the various effects and interactions of drugs on the human body.)

f. Nutrition for musculoskeletal health (Taught at all chiropractic colleges.)

g. Interpreting research and applying evidence in spinal care practices (Taught at all chiropractic colleges.)

It is difficult to comprehend that only 60 hours of instruction would equate to the several years of instruction and clinical residency that medical students receive to have the necessary knowledge to correctly prescribe drugs to patients. However, what is of even greater concern, is that only one of the seven line items listed in SB 762 directly relates to the actual education of pharmacology. The remaining 6 line items will merely be a review of their previous chiropractic education.

The only other educational component requirement found in SB 762 before a chiropractor would be able to prescribe drugs to the public is contained in the 500 clinical rotation hours. The WCA indicated in their press release that this requirement could be achieved by completing a rotation one day a week for a year. There is no definition of what the clinical hours entail and what supervision is required to achieve the necessary clinical knowledge to assume the risks and responsibilities of prescribing drugs to patients.

It is obvious, at least to us, that the educational requirements established in SB 762 are not adequate to protect the public. At the very minimum the educational requirements would need to be at the same level as comparable medical degree education.

The proposed legislation prohibits non-PSCP licensees from indicating that they are primary spinal care practitioners. This restrictive language not only confuses the public, but is a direct insult to the entire chiropractic profession as we currently are primary spinal care practitioners.

It is important to note that Doctors of Chiropractors, who are designated as Physician level providers by Medicare and specifically trained through their extensive educational process, are already considered to be primary spinal care providers. In fact, chiropractors have been considered to be primary spinal care providers for over 125 years.

The current legislation will specifically limit to a very select few and prohibit from the vast majority of chiropractors in Wisconsin the ability to state that they are primary spinal care providers. This is not only an insult to the entire profession, but it creates serious confusion to the public, especially when the public may only receive narcotic treatments and not actual chiropractic adjustments to the spine from the proposed PSCP provider.

In closing, the members of the chiropractic society are very proud of their natural drug-free approach to healthcare and are opposed to the expanded scope legislation that would result in chiropractors prescribing drugs.

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FOR IMMEDIATE RELEASE: Nov. 14, 2013

Chiropractic Summit Promotes Drug-Free Approach to Health Care

Arlington, Va.—The Chiropractic Summit, an umbrella leadership group of prominent chiropractic organizations, met on Nov. 7 in Seattle, Wash. and approved, by unanimous motion, the following historic statements of agreement:

- **Summit Promotes Drug-Free Approach:**
  The drug issue is a non-issue because no chiropractic organization in the Summit promotes the inclusion of prescription drug rights and all chiropractic organizations in the Summit support the drug-free approach to health care.

- **Summit Supports the Council on Chiropractic Education (CCE):**
  The Summit fully supports the continued recognition of CCE. Even though there are some issues of concern remaining, such as CCE's governance model, many good things have occurred the last couple of years. In addition, CCE has agreed to carefully review governance models for possible improvements beginning in 2014 in connection with the Summit Roundtable.

  In addition, the Summit voted unanimously to reaffirm its support of CCE before the Department of Education's (DOE) National Advisory Committee on Institutional Quality and Integrity (NACIQI) this December.

- **Marketing Language:**
  After multiple focus groups, the following marketing language was passed: The Summit acknowledges the concepts of spinal health and well-being as credible marketing messages and we encourage further efforts to refine and test such efforts.

"I am proud to say today that after much time, effort and energy, the Summit partner organizations—representing the leadership of our profession—have come to an agreement on the long divisive issue on drugs," said Summit chair Lewis J. Bazakos, MS, DC. "This truly was an historic meeting."

First convened in September 2007, the Chiropractic Summit represents leadership from some 40 organizations within the profession. The Summit meets regularly to collaborate, seek solutions and support collective action to address challenges with the common goal of advancing chiropractic. For more information about the Summit and its leadership, visit www.chirosummit.org.

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CHIROPRACTIC SUMMIT

One Voice

Chiropractic Summit Member Organizations

American Black Chiropractic Association
American Chiropractic Association
Association of Chiropractic Colleges
Breakthrough Coaching
Canadian Chiropractic Association
Chiropractic Economics
ChiroSecure
ChiroTouch
Cleveland Chiropractic College, Kansas City
Congress of Chiropractic State Associations
Council on Chiropractic Education *(non-voting)*
Council on Chiropractic Guidelines & Practice Parameters
David Singer Enterprises
Dynamic Chiropractic
Foot Levelers
Foundation for Chiropractic Progress
Foundation for the Advancement of Chiropractic Tenets & Science
International Chiropractors Association
Life Chiropractic College - West
Life University
Logan Chiropractic College
National Association of Chiropractic Attorneys *(non-voting)*
National Board of Chiropractic Examiners
NCMIC
New York Chiropractic College
Northwestern Health Sciences University
Palmer College of Chiropractic
Parker College of Chiropractic
Southern California University of Health Sciences
Standard Process
Student American Black Chiropractic Association *(non-voting)*
Student American Chiropractic Association *(non-voting)*
Student International Chiropractors Association *(non-voting)*
Texas Chiropractic College
The American Chiropractor
The Masters Circle
World Federation of Chiropractic

For information on becoming a Chiropractic Summit Partner, please email **admin@chirosummit.org**.

CHIROPRACTIC SUMMIT

Welcome

The Chiropractic Summit was created in September 2007 in recognition of the profession's desire for unity. The first Summit meeting, held in Washington, D.C., was comprised of 13 organizations; the Summit has some 40 **members**, representing leadership from education, research, regulatory bodies, political action, practice management, chiropractic media and national associations.

It is the goal of the Chiropractic Summit to work on the following critical issues:

1. National Health Care Reform/Medicare Reform & DoD/VA/PHSC
2. Doctor Practice Satisfaction & Self Esteem
3. Profession wide collaboration, grassroots mobilization and self regulation.
4. Reimbursement/Anti-discrimination
5. Public Relations - telling the chiropractic story and promoting the brand (competition and cultural authority)
6. Another major focus of the Summit has been to improve practitioner documentation quality and compliance particularly within the Medicare system. The Summit Documentation Committee serves as a resource for the profession in providing accurate and timely information by publishing periodic topic-specific articles on proper documentation.

One voice. One message. Securing a better future.

News!

Documentation Committee Article: Do You Know About the Physican Compare Website?

New

Currently, Physician Compare is a website that allows consumers to search for, and obtain information about, physicians and other healthcare professionals who provide Medicare services. It is important to know about this web site and the information it contains. **More...**

Chiropractic Summit Promotes Drug-Free Approach to Health Care
November 14, 2013

Chiropractic Summit Partners

Chiropractic or Chiropractic plus Prescription Drugs?

Dr. James L. Chestnut B.Ed., M.Sc., D.C., C.C.W.P.

I was recently sent a link to a white paper released by the Wisconsin Chiropractic Association entitled 'The Primary Spinal Care Physician Initiative'.

I rarely publicly respond to positions from political associations. However, due to the position taken in this paper, and since the paper was made public, I feel a visceral need to publicly speak out on behalf of the current expertise and competence of chiropractors and the level of evidence regarding the effectiveness and cost-effectiveness of the current scope of chiropractic practice. I felt there was an acute need to provide an opposing argument to their position.

I am not taking a political stance on this issue; I am taking a scientific evidence and patient advocate stance on this issue. In my opinion politics should have no place in determining scope of practice in chiropractic or in healthcare. Evidence not politics must guide this debate.

The main position points of the Wisconsin Chiropractic Association 'Primary Spinal Care Initiative' paper appear to be:

1. There is a huge burden of non-surgical spine related disorders on the healthcare system
2. Primary care medical physicians have inadequate time, inadequate interest, inadequate specialty training, and have interventions that provide inadequate patient outcomes with respect to spine related disorders
3. Chiropractors as Primary Spinal Care Physicians would have adequate interest, adequate training, and provide adequate outcomes IF THEY INCREASED THEIR SCOPE TO INCLUDE PRESCRIBING DRUGS.

Yes you read that correctly. The Wisconsin Chiropractic Association is actually publicly stating that chiropractors, as they are currently trained and currently practice, are incapable of acting as Primary Spinal Care Physicians. This is actually the main premise of their paper. As a chiropractor familiar with the literature I cannot think of anything less accurate, more insulting, or more harmful to the reputation of chiropractic.

Other than stating that chiropractors are inadequate to act as Primary Spinal Care Physicians unless they prescribe drugs nothing else contained in this paper is new or controversial. As chiropractors surely we all know that non-surgical spine related disorders represent a huge burden and we all know that primary care physician management of these disorders is inadequate in terms of patient outcomes, cost effectiveness, and safety. What I thought we all knew as chiropractors was that the reason WHY primary care physician care is inadequate is because of WHAT interventions primary care physicians use – mainly prescription drugs.

The question being begged, perhaps pleaded on hands and knees, is this: Why could chiropractors not act as Primary Spinal Care Physicians within our current scope of practice with

our current level of education, training, and expertise? What is most puzzling is that the authors provide an extensive bullet point list of the skills and training that would constitute a valid, capable Primary Spinal Care Physician and the ONLY THING on the list that does not read like a standard chiropractic college curricula summary is "management of pharmaceutical therapies".

What this paper completely ignores are the most important and defining questions regarding this topic which are:

1. How would adding prescribing drugs to patients make chiropractic care more effective, more cost effective, or safer?
2. What are the most evidence-based interventions for spine related disorders in terms of patient outcomes, cost effectiveness, and safety?
3. Which practitioners are most highly trained and most competent at delivering these evidence-based interventions?

The authors provide no evidence or even a lucid argument that adding drugs to chiropractic management of spine related disorders will improve patient outcomes, improve cost effectiveness, or improve patient safety. Worse, they completely ignore the evidence to the contrary. A few examples:

Chapman-Smith, David. The Chiropractic Report (September 2008 Vol 22 No. 5)

"Medical leaders such as Waddell, who was a principal consultant for the literature review for both the UK and the US national back pain guidelines in the 1990s and is author of the highly respected text *The Back Pain Revolution,* acknowledge that management of low-back pain was "a 20th century health care disaster" and that "it is now time for a fundamental change in clinical management and reorganization of health care to meet the needs of these patients." For patients with common or mechanical back pain and neck pain/headache there is now a change from extensive diagnostic testing, rest, medication for pain control and surgical intervention based on *structural pathology* as in traditional medical practice, to exercise, manual treatments, early mobilization of patients and education about the spine and lifestyle, based on *functional pathology* as in traditional chiropractic practice.

"This management approach is not only effective but highly cost-effective."

Schofferman & Mazanec. (2008) Evidence-informed management of chronic low back pain with opioid analgesics. The Spine Journal 8 185-194

A recent review found 59% of patients treated with opioids for less than 3 months experienced an adverse effect. Adverse effects were even more common with treatment longer than 3 months, occurring in **73% to 90%** of patients, and up to one-third of patients discontinued treatment because of side effects."

"Constipation occurs as a result of decreased peristaltic propulsive contractions, increased small and large bowel tone, and decreased biliary, pancreatic, and intestinal secretions."

"Clinically, the most common problem in **men** is androgen deficiency because of suppression of pulsatile gonadotropoin-releasing hormone by the hypothalamus which presents as low libido, erectile difficulties, low energy, easy fatigue, and depressed mood."

"In women, there may also be decreased libido and changes in menstrual cycle." "There may also be instances of osteoporosis, and broader hypothalamic-pituitary suppression."

Malanga & Wolff. (2008) Evidence-informed management of chronic low back pain with nonsteroidal anti-inflammatory drugs, muscle relaxants, and simple analgesics. The Spine Journal 8 173-184

"Studies did not provide evidence for long-term use of muscle relaxants in CLBP."

"Muscle relaxants demonstrated more CNS side effects compared with placebo in nearly all trials."

"Sudden discontinued chronic use of benzodiazepines is associated with delirium tremens, whereas abruptly discontinuing baclofen may result in seizures."

"The blockade of COX enzymes, neutrophil function, and phospholipase activity by NSAIDs account for related renal, GI, and potential cardiovascular side effects. The risk of GI, renal, and hepatic complications in patients taking nonselective NSAIDs is well known."

"The costs of side effects associated with these drugs should also be considered. A Canadian study using the Quebec provincial public health-care database found that for each dollar spent on nonselective NSAIDs an extra $0.66 was used on their side effects."

The fact is that the most evidence-based interventions for spine related disorders in terms of effectiveness, cost effectiveness, and safety are chiropractic adjustments or manipulations, spinal fitness exercises, and lifestyle – the very things that are most representative of a typical chiropractic intervention protocol.

These authors are taking a valid point regarding the facts that there is an acute need for Primary Spinal Care practitioners and that chiropractors should be Primary Spinal Care practitioners - a point best articulated in the Manga Report (the most comprehensive review of the topic in history) decades ago and anchoring it to their unfounded, unsubstantiated, illogical, and insulting premise that prescribing drugs is necessary to make chiropractors worthy of such a role. Nothing could be more absurd – based on the EVIDENCE.

The evidence is clear. The less drugs patients take for non-surgical spinal related disorders the better. This is true not just for patient health outcomes but for overall health and for cost effectiveness. Virtually every study that has compared chiropractic care to medical care has shown the superiority of chiropractic care in terms of effectiveness and cost effectiveness and safety. Just so there is no confusion, medical care in these studies, as in the vast majority of clinical practice, is prescribing drugs. Again, a few examples:

Manga et al. The Manga Report. 1993 An Independent Report Commissioned by the Ontario Provincial Government

"On the evidence, particularly the most scientifically valid clinical studies, spinal manipulation applied by chiropractors is shown to be more effective than alternative treatments for low back pain."

Many medical therapies are of questionable validity or are clearly inadequate." "Our reading of the literature suggests that chiropractic manipulation is safer than medical management of low back pain."

"What the literature revealed to us is the much greater need for clinical evidence of the validity of medical management of low back pain."

"There is an overwhelming body of evidence indicating that chiropractic management of low-back pain is more cost-effective than medical management."

"The lack of any convincing argument or evidence to the contrary must be noted and is significant to us in forming our conclusions and recommendations. The evidence includes studies showing lower chiropractic costs for the same diagnosis and episodic need for care."

Legorreta et al. 2004 Comparative Analysis of Individuals With and Without Chiropractic Coverage. Arch Int Med 164 (18)

"In our study population of 0.7 million members who had chiropractic coverage in the medical plan, we estimated an annual reduction of approximately $16 million as a result of lower utilization of high-cost items."

"This study provides additional information regarding the economic benefits and utilization patterns associated with systematic access to chiropractic care."

Sarnat & Winterstein. (2003) Clinical and Cost Outcomes of an Integrative Medicine IPA. JMPT 27 (5) 336-347

In the limited population studied, PCPs utilizing CHIROPRACTORS emphasizing a variety of CAM therapies had substantially improved clinical outcomes and cost offsets compared with PCPs utilizing conventional medicine alone.

Sarnat, et al. (2007) Clinical Utilization and Cost Outcomes From an Integrative Medicine Independent Physician Association.: An Additional 3-Year Update JMPT 30 (5) 263-269

Chiropractors using a nonsurgical/nonpharmaceutical approach demonstrated reductions in both clinical and cost utilization when compared with PCPs using conventional medicine alone.

Von Heymann et al. (2013) Spinal high-velocity low amplitude manipulation in acute nonspecific low back pain: a double-blinded randomized controlled trial comparion with diclofenac and placebo JMPT 38 (7) 540-548

"Low back pain is an important economical factor in all industrialized countries. Few studies have evaluated the effectiveness of spinal manipulation in comparison to nonsteroidal anti-inflammatory drugs or placebo regarding patient satisfaction and function of the patient, off-work time, and rescue medication."

"Spinal manipulation was significantly better than nonsteroidal anti-inflammatory drug diclofenac and clinically superior to placebo."

Schifrin, L.G. Mandated Health Insurance Coverage for Chiropractic Treatment: An Economic Arrangement with Implications for the Commonwealth of Virginia, 1992. Richmond, Virginia.

"A fair interpretation of the evidence accumulated to date indicates that the impact of chiropractic mandates comes close to the "best case" scenario of low costs and high benefits."

"Accordingly, the continuation of mandated chiropractic provider services in health care appears both reasonable and sound. It is a cost-effective provision in health insurance, and one that also serves the important goal of health care cost containment."

Cifuentes et al. (2011) Health Maintenance Care in Work-Related Low Back Pain and its Association With Disability Recurrence. Journal of Occupational and Environmental Medicine pp 190-198

"Provider type during disability episode was associated with the hazard of disability recurrence after returning to work. Compared with only or mostly chiropractor, the groups of only or mostly physical therapy and only or mostly physician had significantly higher hazard ratios (greater hazard or recurrence)."

"Care from chiropractors during the disability episode, during the health maintenance care period, and the combination of both was associated with lower disability recurrence hazard ratios."

"Those cases treated by chiropractors had less use of opioids and fewer surgeries."

"In addition, people who were mostly treated by chiropractors had, on average, less expensive medical services and shorter initial periods of disability than cases treated by physiotherapists and medical physicians."

"This clear trend deserves some attention considering that chiropractors are the only group of providers who explicitly state that they have an effective treatment approach to maintain health."

How could these authors posit that the only way that chiropractors could qualify as primary spinal care doctors is by adding the prescribing of drugs? These authors are completely misleading their membership and the public by making it appear that what chiropractors currently have to offer is somehow not adequate to qualify as valid, effective, cost effective, and safe Primary Spinal Care doctors.

Further, their stance is in direct opposition to the opinion of every independent government enquiry ever produced (Manga Report – Canada; New Zealand Government Commission; Australian Medicare Benefits Review Committee; Swedish Government Commission; Kings Fund Report and House of Lords' Select Committee on Science and Technology (Complementary and Alternative Medicine) and the Appellate Court of the United States (Wilk's Case).

If anything you would think that a chiropractic association would be making the case that their members should be primary spinal care doctors based on the evidence of the superiority of their chiropractic care not based on the inferiority of their care which can only be alleviated by adding expensive, dangerous, ineffective drug prescription interventions to their scope of practice.

The fact is that there is nothing outside the current scope of chiropractic practice that is more evidence-based, more effective, more cost effective, or safer than what is currently within the chiropractic scope of practice.

The very foundation of this paper, written and made public by a chiropractic association, is a belief that chiropractic as it is currently taught and practiced is inferior and inadequate and that the only way to make chiropractors worthy of being primary spinal care doctors is to add prescribing drugs to the chiropractic scope of practice.

Though there may be many valid philosophical arguments against this position I don't believe that this is at the heart of the matter a philosophical issue. This is a scientific and clinical evidence issue. The evidence shows that chiropractic, based on the criteria of effectiveness, cost effectiveness, and safety, is, as it stands, evidence-based and the best suited profession to be primary spinal care doctors.

According to experts like Manga, the Appellate Court of the United States, and many others, the reason chiropractors are not already primary spinal care doctors has nothing to do with an inferiority of evidence for chiropractic or the superiority of evidence for drug or medical intervention. The reasons are political and financial and always have been.

I can't help but wonder what the impetus was for the position of the Wisconsin Chiropractic Association. I find it incredulous that a chiropractic association would take such a public stance. Not because I expect chiropractic associations to have blind faith in chiropractic or to blindly espouse the superiority of chiropractic but because I expect chiropractic associations to be evidence-based and to be literate with regard to the evidence regarding the most effective, cost effective, and safest interventions for the care of patients with spine related disorders.

James L. Chestnut B.Ed., M.Sc., D.C., C.C.W.P.

WISCONSIN ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR WISCONSIN

Testimony on *primary spinal care practitioner legislation* before the
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES
May 24, 2016
Dr. Byron J. Crouse, MD – *WAFP member*

Good morning Chairperson Vukmir and members of the Committee. Thank you for the opportunity to testify today and express my concerns regarding the primary spinal care practitioner proposal before the committee.

My name is Dr. Byron Crouse. I am a practicing family physician and serve as the Associate Dean for Rural and Community Health at the University of Wisconsin School of Medicine and Public Health. I am speaking today in both a personal capacity and as a representative of the Wisconsin Academy of Family Physicians.

The Wisconsin Academy of Family Physicians represents over 2,500 members statewide and is the single largest physician specialty group in Wisconsin. We are committed to promoting high professional and ethical standards in the practice of Family Medicine and improving the quality of medical care across the state.

Simply put, this proposed legislation is a bad idea. The bill would jeopardize patient safety, water down the quality of care in Wisconsin and potentially exacerbate the opioid addition crisis in our state.

The legislation would license and create a scope of practice for primary spinal care practitioners in Wisconsin. In layman's terms, this bill would authorize unqualified practitioners to practice medicine in Wisconsin – including the ability to prescribe and administer narcotics.

This may sound overly simplistic, but if an individual wants to practice medicine, they should go to medical school, not seek enabling legislation. The path to becoming a physician has already been established and certainly has been proven over the years. There are reasons why

education and training standards are in place for certain professions, and when it comes to the health and welfare of patients in Wisconsin, those standards cannot be compromised.

I am not here to disparage the chiropractic profession. In fact, I have great respect for chiropractors and feel they fill an important role. However, chiropractic care focuses on spinal manipulation and is generally considered complimentary health care. Chiropractors are not trained to practice medicine, and the proposed legislation we are discussing today would not change that fact.

In every community that I have practiced, I have found effective collaboration with chiropractors has resulted in good patient care and high patient satisfaction. Referring patients to chiropractors for manipulation and chiropractor referrals to me for management of medications was efficient and provided patients with quality care and excellent patient satisfaction.

Currently, to practice chiropractic care, a chiropractor must attend an accredited chiropractic college and pass a national exam to be licensed. Under the proposed legislation, which would enable chiropractors to practice medicine under certain circumstances, a spinal care practitioner would only require an additional 60 hours of master's level course work, 500 hours of medical rotations, and 50 hours of continuing medical education every 2 years.

By comparison, to be licensed as a physician, at minimum, an individual must complete an under graduate degree; a four-year medical degree; 36 months of medical residency training; pass three nationally accredited exams throughout their training; and complete 30 hours of continuing medical education training every 2 years. To maintain our board certification, 150 hours of CME every 3 years is required. To practice certain specialties, some medical residencies may last an upwards of 7 to 10 years.

My point of comparing these two professions boils down to patient safety. Physicians have the training and education necessary to practice medicine, and chiropractors do not – even if this bill were to pass into law.

Now, I would be the first to admit that: 1.) We have a physician shortage in this state and across the county; and 2.) Mid-level practitioners often help fill the gap in providing patient care.

However, the answer to addressing the physician shortage is not elevating unqualified practitioners to fill the void, but rather to concentrate on policies and programs that strengthen the physician workforce. Gov. Scott Walker and the Legislature have done a terrific job over the last several years to achieve that very goal. From increased graduate medical education funding and primary physician workforce grants to expanded medical school slots and other physician workforce initiatives, we are moving in the right direction. My suggestion would be to continue to focus on these types of policies, rather than short term ideas like the spinal care practitioner bill that are unlikely to address the underlying problem.

Before I close, I'd be remiss if I didn't mention one of today's most pressing public health issues – the opioid addition crisis facing our state and our nation. According to the DEA, America's opioid epidemic currently takes more lives than car accidents. In fact, the epidemic claims 78 American lives per day, of which 2 to 3 are Wisconsin residents. The legislation we are discussing today is in stark contrast to the efforts by policymakers and the entire health care community to restrict the availability of these medications. This bill would increase their availability. My concern is not specific to chiropractors, but rather the increased ability by any practitioner to prescribe narcotics.

In closing, I would like to reiterate the WAFP's opposition to primary spinal care practitioner legislation and its imprudent approach to health care delivery and physician workforce shortage in Wisconsin. I appreciate the opportunity to testify and would be more than happy to answer any questions.

Clyde B. Jensen, PhD

When Clyde B. Jensen, who holds a PhD in physiology and pharmacology, became America's youngest medical school president at the age of 32, the Chairman of the state's higher education system counseled him to use his extended executive career to experience as much of the healthcare and higher education continua as possible. During the next three decades Dr. Jensen led educational institutions ranging from community colleges to research universities and became the only person to lead colleges of allopathic, osteopathic, naturopathic, chiropractic and oriental medicine. While continuing to teach pharmacology and publish on interprofessional education Dr. Jensen coined the phrase "continuum clefts" to describe the costly and precarious gaps that fragment the healthcare continuum.

As the owner of Continuum Biomedical Consultants, Inc., he now devotes his career to "mending the clefts." He has served as an advisory board and adjunct faculty member at the Medical College of Wisconsin, an adjunct faculty member at the University of Wisconsin–Milwaukee and Director of Scientific and Integrative Affairs at Standard Process, Inc. in Palmyra, Wisconsin. Among his current clients is the University of Western States where he serves as Executive Consultant and Adjunct Professor of Pharmacology in the Chiropractic and the Human Nutrition and Functional Medicine Programs. He is also the Senior Executive of the Oregon Collaborative for Integrative Medicine, America's most comprehensive interprofessional health sciences education and research consortium.

Rodney Lefler, DC, CSCS

Dr. Lefler is the current president of the Wisconsin Chiropractic Association. He provides chiropractic services at the Neuroscience Group, an integrated health care center in Neenah. He manages patients with acute and chronic pain of the spine and extremities, work injuries, sports injuries and vertigo. He provides chiropractic care using a variety of techniques and rehabilitation strategies. Dr. Lefler has a special interest in sports injuries and volunteers as a team doctor and strength conditioning coach. He evaluates training injuries, develops rehabilitation and injury prevention strategies for local high school sports programs.

Doctor of Chiropractic – Palmer College of Chiropractic, Davenport, IA
American Chiropractic Association
Wisconsin Chiropractic Association

Frankie Amarillas, DC, CCSP

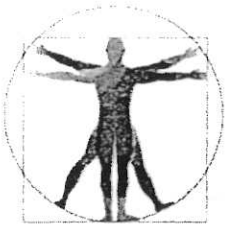
Dr. Amarillas practices at LSM Chiropractic in Fitchburg. His professional interests include evidence-based chiropractic care to treat acute/sub-acute injuries to any joint in the body while stressing the importance of patient participation. His care includes treatment for low back, sports injuries, neck and back pain, occupational back pain and injuries, and pregnancy related back pain syndromes. His many broad personal interests include cooking, weight lifting/physical fitness, traveling, and continuing learning. Dr Amarillas is fluent in Spanish and enjoys being able to educate Spanish-speaking patients regarding their care. He is passionate about helping others; as a member of Clinic Abroad, he provided care to patients in Honduras in 2012.

Doctor of Chiropractic – Palmer College of Chiropractic (Davenport, IA)
American Chiropractic Association
Wisconsin Chiropractic Association

Jason Mackey, DC

Dr. Mackey practices at multiple LSM Chiropractic clinics in Madison. He is passionate about athletics and serves as a team chiropractor for UW Badger athletics and the Madison Mallards baseball organization. He is an active member of the Wisconsin Gridiron Club, the St. Johns Lodge #57 Freemasons and the Zor Shriners.

Doctor of Chiropractic – Palmer College of Chiropractic (Davenport, IA)
American Chiropractic Association
Wisconsin Chiropractic Association



BY THE NUMBERS

Musculoskeletal Conditions

Diseases, disorders, and injuries relating to bones, joints, and muscles

Leading Cause of Disability/Health Care Cost

- 1 in 2 (126.6 million) adults are affected, twice the rate of chronic heart and lung conditions
- **$874 billion (5.7% GDP):** Annual U.S. cost for treatment and lost wages**

Most Prevalent Musculoskeletal Conditions

- Arthritis and Related Conditions
- Back and Neck Pain
- Injuries: Falls, Military, Sports, Workplace
- Osteoporosis

- **51.8 million** adults report they have arthritis
- **75.7 million** adults suffer from neck or low back pain
- **4.5 million** sports musculoskeletal injuries require medical attention each year, 64% of all sports injuries
- **1 in 2 women and 1 in 4 men** over age 50 will have an osteoporosis-related fracture, with 20% mortality rate within 12 months of a hip fracture
- **Millions** suffer from spinal deformities, congenital conditions, cancers of bone and connective tissue

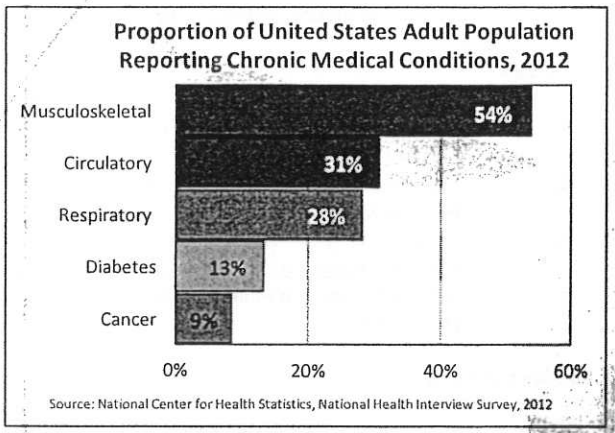
Health Care Impact

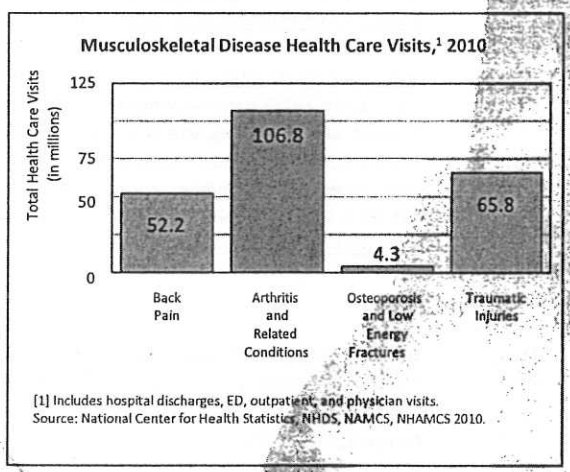
- **18%** of all health care visits*
- **52 million** health care visits for low back pain*
- **6.7 million** hospitalizations for arthritis and other rheumatic conditions*
- **65.8 million** health care visits for injuries; **14.4 million** health care visits for childhood injuries*
- **1.14 million** hospital discharges for fractures, 53% for persons age 65 and over*

Economic Impact: Lost Work Time and Wages

- **83.1 billion:** hospital cost to treat injuries**
- **291 million:** lost work days due to back and neck pain***
- **3 days longer** off work than for other types of workplace injuries
- **461.5 billion:** annual earnings loss for persons with arthritis condition**

* 2010, ** 2011, *** 2012





THE BY NUMBERS: Musculoskeletal Conditions is sourced from *The Burden of Musculoskeletal Diseases in the United States (BMUS), www.boneandjointburden.org.*

The United States Bone and Joint Initiative (USBJI) is part of the worldwide campaign to advance understanding, prevention, and treatment of musculoskeletal disorders through education and research. To learn more, visit www.usbji.org.

Bone and Joint Initiative USA

www.boneandjointburden.org

References: For additional information, refer to the tables listed below at www.boneandjointburden.org.

Leading Cause of Disability and Health Care Cost

[1] T1.2.1: Source: National Health Interview Survey (NHIS), Adult sample. www.cdc.gov/nchs/nhis/nhis_2012_data_release.htm Accessed July 2, 2013.

[2] T10.4: Source: Medical Expenditures Panel Survey (MEPS), Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, 2008-2011. http://meps.ahrq.gov/mepsweb/

[3] T10.14: Source: Medical Expenditures Panel Survey (MEPS), Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, 2008-2011. http://meps.ahrq.gov/mepsweb/

Prevalent

[1] T1.3.1: Source: National Health Interview Survey (NHIS), Adult sample. www.cdc.gov/nchs/nhis/nhis_2012_data_release.htm Accessed July 2, 2013.

[2] T1.3.1: Source: National Health Interview Survey (NHIS), Adult sample. www.cdc.gov/nchs/nhis/nhis_2012_data_release.htm Accessed July 2, 2013.

[3] T6C.1: Source: United States Consumer Product Safety Commission. National Electron Injury Surveillance System, 2011, 2012, 2013. https://www.cpsc.gov/cgibin/NEISSQuery/home.aspx Accessed October 27, 2014.

[4] National Osteoporosis Foundation (NOF). Available at: http://nof.org/news/185. Accessed February 16, 2015.

[5] Multiple tables

Health Care Burden

[1] T1.10.2:Source: Healthcare Cost and Utilization Project (HCUP). NIS 2011 & NEDS 2010. Agency for Healthcare Research and Quality, Rockville, MD. www.hcup-us.ahrq.gov/nisoverview.jsp, and National Center for Health Studies, NHAMCS_OP &NAMCS, 2010. www.cdc.gov/nchs/nhds/nhds_questionnaires.htm Accessed April 23, 2013.

[2] T2.4.2: Source: National Center for Health Studies, NHDS, NHAMCS_OP, NHAMCS_ED, NAMCS, 2010. www.cdc.gov/nchs/nhds/nhds_questionnaires.htm Accessed April 23, 2013.

[3] T4.2: Source: HCUP Nationwide Inpatient Sample (NIS). Healthcare Cost and Utilization Project (HCUP). 2011. Agency for Healthcare Research and Quality, Rockville, MD. www.hcup-us.ahrq.gov/nisoverview.jsp.

[4] T6A.2.2.1: Source: National Center for Health Studies, NHDS, NHAMCS_OP, NHAMCS_ED, NAMCS, 2010. www.cdc.gov/nchs/nhds/nhds_questionnaires.htm Accessed April 23, 2013.

[5] T6A.2.2.2: Source: National Center for Health Studies, NHDS, NHAMCS_OP, NHAMCS_ED, NAMCS, 2010. www.cdc.gov/nchs/nhds/nhds_questionnaires.htm Accessed April 23, 2013.

Economic Burden

[1] T6A.4.1.1: Source: HCUP Nationwide Inpatient Sample (NIS). Healthcare Cost and Utilization Project (HCUP). 2011. Agency for Healthcare Research and Quality, Rockville, MD. www.hcup-us.ahrq.gov/nisoverview.jsp

[2] T2.11.1: Source: National Health Interview Survey (NHIS)_Adult sample, 2012. www.cdc.gov/nchs/nhis/nhis_2012_data_release.htm Accessed July 2, 2013.

[3] T6B.2.1: Source (2008-2010): "Supplemental Table 6: Number, percent distribution, and median days away from work for nonfatal occupational injuries and illnesses involving days away from work by selected worker and case characteristics and musculoskeletal disorders, (2008 - 2010"). U.S. Department of labor, Bureau of Labor Statistics. http://www.bls.gov/iif/oshcdnew.htm Accessed October 25, 2013.

[4] T10.13: Source: Medical Expenditures Panel Survey (MEPS), Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, 2008-2011. http://meps.ahrq.gov/mepsweb/

Filling the Shortage of Primary Care Health Care Providers in Wisconsin:

The Primary Spine Care Physician, a new class of health care provider.

A Wisconsin Chiropractic Association Policy White Paper.

See p. 35 for authors/contributors. See p. 36 for research references.

According to a 2011 report by the Wisconsin Hospital Association, Wisconsin must add 2,196 extra physicians in addition to those already expected to enter the workforce to meet the demand by 2030. This equates to just over 100 extra physicians each year. The impending shortage will hit hardest in the primary care sector, where 80 percent of the shortage is expected to fall. This problem is exacerbated in rural areas where communities struggle to attract and keep well-trained health care providers (Mareck, 2011), and by the thousands of new Wisconsin patients who now have health insurance coverage through the Affordable Care Act.

The Wisconsin Medical Society's paper, "Who Will care for Wisconsin?" reported an expected increase in total office visits from 18,783,000 in 2006 to 21,288,000 in 2020 and 22,906,000 by 2030. This represents an increase of 22 percent. This shortage leaves primary care physicians with large patient panels that only continue to grow and results in decreased patient access and continuity of care.

Primary Care Physicians (PCPs) spend significant time dealing with spine-related disorders (SRDs) including low back and neck pain. In fact, low back pain is the second most common reason for a patient to see their primary care physician (Cypress, 1991, Wolsko, 2003). Additionally, low back pain (LBP) is the leading cause of disability worldwide, with neck pain ranking fourth (Lim et al., 2012). Moreover, a recent systematic review showed that LBP rates sixth in terms of overall disease burden, (Hoy D et al., 2014). Wisconsin's obesity epidemic likely exacerbates SRDs as obesity is a precursor to joint disease, among other chronic conditions, as well as a risk factor in spinal impairment (University of Wisconsin School of Medicine and Public Health Wisconsin Partnership Program Five-Year Plan, 2014; Liuke M, 2005; Vismara, 2010). A recent survey of Wisconsin adults shows that 73 percent were either overweight or obese (UW School of Medicine and Public Health, Wisconsin Partnership Program Five-Year Plan, 2014).

The Problem: The significant burden of spine-related conditions on the health care system and the shortage of physicians in the state of Wisconsin.

The burden of SRDs weighs heavily on our health care system, society and industry. Between 1999 and 2008 the mean inflationary adjusted costs for ambulatory neck and/or back pain increased by 95 percent in the United States (Davis et al, 2012) with LBP accounting for 27 million patient visits per year and neck pain 10 million visits (Haldeman, 2013). Most of the increased spending was associated with increased specialty visits and not primary care evaluation (Davis et al, 2012). With the significant increase in spending one would expect outcomes to improve. In fact, disability from SRDs is rising (Kosloff et al 2014; Murphy, 2011). The annual direct costs for spine care in the US have been estimated to be about $102 billion, with about $14 billion in lost wages (United States Bone and Joint Decade, 2008).

Low back and neck pain were previously thought to be self-limiting conditions, yet current research shows that the conditions significantly increase the risk of limited physical and social functioning many years after onset (Thelin et al, 2008). Gureje, Simon, and von Korff reported that about 50 percent of LBP patients experience persistent pain for at least 12 months following its onset and between 50 percent and 75 percent of those who report neck pain continue to experience the pain one to five years later.

Several evidence-based guidelines have been published on appropriate management of LBP. However, recent studies have shown that providers are not implementing these guidelines appropriately, especially with regard to overutilizing advanced imaging, specialist referrals and invasive procedures (Finestone et al 2009, Williams et al, 2010; Buchbinder et al 2009). Treatment that is incongruent with guideline recommendations is associated with higher overall costs related to SRDs (Allen et al).

It is not difficult to think that the inappropriate treatment of acute LBP can lead to patients developing chronic low back pain. Studies show that patients with chronic low back pain have double the overall health care costs compared to those without (Jhawar, 2006). Part of the struggle in managing SRDs is that the potential causes of spinal pain are multifactorial and may be related to structural, neurophysiological or psychosocial issues.

Patients often consult their PCP for diagnosis and management of their SRDs. Several peer reviewed studies and published articles show that SRDs may be challenging for the PCP to manage appropriately. A University of Rochester School of Medicine and Dentistry study showed that between the second and fourth year of medical school, students scored better when being tested on musculoskeletal conditions, but reported that their clinical confidence over this same period remained low. Despite the low levels of clinical confidence, a high percentage of SRDs are managed in primary care. Given the increasing burden of musculoskeletal disorders combined with low clinical confidence, an escalation of health care cost is possible (DiGiovanni et al).

In one interview study, PCPs perceived back pain as a low clinical priority and uninteresting in comparison to the major chronic illnesses such as heart disease, or diabetes that they must manage for their patients (Sanders et al). In the same study, shifting this population of patients to a non-physician provider was perceived by PCPs as a positive step towards alleviating their burden of work. A study published in the European Journal of Pain in 2007 reported that some PCPs lacked confidence in their ability to assess and supply evidence-based care for back pain and that some expressed anxiety about not being able to help or give adequate explanations (Breen et al, 2007)

The Solution:

The previously discussed papers by the Wisconsin Hospital Association and Wisconsin Medical Society both support the idea of team-based care, in which health care providers work together to efficiently manage patient care and disseminate best practices while maintaining improved access and continuity of care.

Because of the acute need for a class of healthcare providers who can effectively take the lead in managing patients with spinal pain, it is proposed that Wisconsin establish a Primary Spine Care Physician (PSCP) certification that allows providers who obtain it to act as a primary point of contact for patients with SRDs. Primary Spine Care Physicians (PSCPs) will work with a team of other providers and will help alleviate the primary care physician shortage in two ways;

1. By managing a large percentage of patients with spine-related conditions in a manner that produces better outcomes and is more cost effective (Paskowski et al).

2. By allowing PSCPs to manage patients with SRDs, PCPs will have more time to effectively manage major chronic illnesses and other health concerns.

To achieve this goal such a provider would need:

• Astute diagnostic capability, including the ability to differentiate systemic/inflammatory disease from degenerative processes as well as other causes of spinal pain including occasional red flags;

• Effective and efficient management of the majority of spine conditions;

• Delivery of evidence-based care, with infrequent referral to other providers;

• Specialized training in SRDs and numerous forms of non-operative alternatives including manual therapies, management of pharmaceutical therapies, percutaneous invasive therapies, rehabilitation and other treatments;

• Familiarity with surgical interventions and their evidence-based indications and implications to make appropriate and timely referrals based on this evidence;

• Intimate awareness of the abilities and limitations of other spine care providers and specialists who can provide necessary complementary interventions (both surgical and non-surgical);

• Evidence-based, scientifically defensible, cost-effective, clinically-relevant, collaborative, patient-centered care practices for SRDs;

• Appreciation for minimalism and quality of care to combat excess spending and the development of treatment dependency;

• Understanding of the unique aspects of work-related and motor vehicle collisions-related SRDs;

• Broad perspective on the public health correlations with SRDs including smoking, obesity, lack of exercise, mental health disorders;

• Ability to screen for psychosocial morbidity and professionally communicate with appropriate providers of care for these conditions and other aspects of bio-psychosocial rehabilitation;

• An understanding of pain and chronicity from a biological and clinical research perspective, with a working knowledge of effective case management, the clinical implications for proper patient communication, and establishing realistic patient expectations.

• A commitment to addressing modifiable risk factors, activities and other behaviors during daily life, work and recreation;

• Ability to coordinate care among numerous practitioners and follow patients for a prolonged period of time if necessary.

Chiropractors are ideally suited to fill this role and help meet the growing need for an appropriate patient-centered treatment paradigm working within a team-based delivery system.

Chiropractors receive extensive training (4820 hours) in differential diagnosis and procedures with a heavy focus on management of spinal conditions. Chiropractors are trained in and have the ability to order appropriate imaging and laboratory testing as needed under their current scope of practice in Wisconsin. Additionally chiropractors have additional training in addressing exercise, diet and rehabilitation associated with SRD health concerns.

Chiropractic care has been shown to be effective for a wide variety of SRDs. Evidence supports the efficacy of chiropractic treatment for back pain, neck pain, and headaches. (Murphy et al; Tuchin et al; Bronfort et al, 2004; McMorland et al; von Heymann et al; Bronfort et al, 2012). This efficacious and cost effective care is also consistently associated with high patient satisfaction (Butler et al; Hertzman-Miller et al). Furthermore there is evidence that properly accessed and provided chiropractic treatment has the potential to reduce health care costs in the treatment of SRDs (Allen et al; Legorreta et al; Manga et al; Michaleff et al; Sarnat et al).

In a study tracking a major self-insured workforce, patients that sought chiropractic care were least likely to receive treatment that went against guideline recommendations in the areas of imaging, surgeries and medications (Allen et al). In that same study, chiropractic care was also linked to lowest total costs of all treatment options. The Allen study also reported that surgery was tied to highest overall costs of all treatment options.

Researchers who studied workers compensation claims in the state of Washington found that patients who sought care from a chiropractor first were much less likely to end up having surgery–1.5 percent–than those that sought care from a surgeon first–42.7 percent (Keeney et al). Studies following the same group of workers compensation claims linked chiropractic care with lower odds of chronic work disability and early use of MRI, which is against guideline recommendations in most cases (Graves et al; Turner et al).

In a hospital setting in Plymouth, Massachusetts this type of team-based care with chiropractors acting as the primary point of contact has been shown to be effective both in patient outcomes and satisfaction (Paskowski et al). In this setting the mean cost of care was $302, pain levels on averaged dropped from 6.2/10 to 1.9/10 and 95 percent of patients rated care as "excellent".

In a survey study of PCPs, nurses and patients in the United Kingdom aimed at determining what

steps could be taken to improve access to care and outcomes for patients with low back pain, access to chiropractic care was repeatedly raised as a needed intervention (Breen et al, 2004).

In the UK and Sweden where non-medical providers have been put in place as front-line diagnosticians for patients with musculoskeletal problems, patient wait times to see rheumatologists and surgeons have been reduced and good patient outcomes have increased (Foster et al).

To be more effective at managing care, reduce the burden on primary care and decrease referrals to specialists, Wisconsin should expand the scope of practice for chiropractors trained as PSCPs to include limited prescription rights and the ability to perform some minor procedures. To obtain the appropriate training necessary for an expanded scope of practice, we propose a program similar to that required of nurse practitioners and physician assistants, who also have prescription authority in Wisconsin. This program would build upon the doctoral level training chiropractors already possess.

The components of this innovative health care reform initiative include:

- A two-year accredited Master's Level academic program delivered online and in class room.
- A ground-breaking clinical rotation program for Primary Spine Care Physicians similar to the chiropractic residency programs being piloted at six VA hospitals across the country.
- State funding for chiropractic graduate medical education (GME) similar to the funding Wisconsin currently provides for family medicine and primary care residencies.
- Eligibility for the rural health care loan repayment program to incentivize Primary Spine Care Physicians to practice in underserved areas.
- Modifications to the chiropractic scope of practice law and malpractice insurance coverage.

This program will give the 2,300 licensed doctors of chiropractic in Wisconsin the opportunity to obtain the additional training necessary to better treat and manage SRDs, thereby contributing toward alleviating the shortage of physicians and increasing access to quality, affordable health care for Wisconsin residents.

When considering how this would affect rural communities, a study in the American Journal of Public Health found that chiropractors provide a considerable amount of care in these areas (Smith et al). By expanding their scope of practice, chiropractors can expand the breadth of SRDs that they can manage effectively and improve access to quality care in rural communities. Provider retention has always been a struggle for rural areas and chiropractors who have established practices within these communities would be unlikely to leave once receiving PSCP training. This proposal builds upon steps that Wisconsin has taken to address the severe shortage of primary care available in underserved areas.

In its last state budget, Wisconsin approved grants to increase the number of primary care residencies located in more underserved areas. Wisconsin is also moving forward with creating new medical school programs in Green Bay and other regions of the state. In addition to being aligned with the position papers of the Wisconsin Medical Society and Wisconsin Hospital Association, this proposal also fits within the US Bone and Joint Initiative's (USBJI) recommendations for adding value to musculoskeletal care. The USBJI is a multi- disciplinary initiative that strives towards a goal of promoting patient-centered care to improve the prevention, diagnosis, and treatment of musculoskeletal conditions. At an interdisciplinary summit in 2013, the USBJI published their recommendations to move towards this goal. Their recommendations included training programs to advance the knowledge, skills and attitudes of providers in the management and diagnosis of musculoskeletal conditions, and expand the workforce of musculoskeletal care across all health care disciplines to meet the demands of the population. They further recommended the development of vertically-integrated models of care that encourage a collaborative, interdisciplinary approach to patient care and improved patient outcomes (Gnatz et al).

Furthermore, the Primary Spine Care Physician proposal builds upon the innovative change to Wisconsin Medicaid policy crafted as a result of the Affordable Care Act. Wisconsin took the unique step of rejecting Medicaid funds but still expanding Medicaid eligibility to all Wisconsin residents under 100 percent of the Federal Poverty Level. In general, those above that income threshold are expected to seek insurance coverage through the Federally Facilitated Marketplace, where over a dozen private insurance plans participate. This new Medicaid policy fosters patient choice in health coverage by em-

powering patients to choose the best coverage for them. Similarly, the PSCP proposal fosters patient choice in health care providers for spine-related conditions and offers effective measures to meet the impending physician shortage with a highly trained, evidence-based, cost-effective provider to manage a wide variety of spinal complaints.

Moreover, the proposal works to ensure patient safety and quality in health care by requiring chiropractors interested in becoming Primary Spine Care Physicians to undergo additional training (M.S. + 500 hour clinical) before being able to work under an expanded scope that includes pharmacological and more invasive treatment techniques. This is much more intensive than programs required of non-medical prescribers in Europe where training consists of 27 days in classroom and 12 days in practice under the supervision of an MD or DO (Courtenay et al).

This PSCP proposal would enable chiropractors to better meet the needs of patients in Wisconsin with SRDs by utilizing their training in less invasive (and less expensive) techniques while being able to utilize medication and other treatment options when absolutely necessary. The PSCP proposal also recognizes the importance of collaboration between PSCPs and other health care professionals. Indeed, working collaboratively with other professionals is not new for chiropractors. State law (Wis Stat. s. 446.02(7d)(c)) already requires chiropractors to refer patients to physicians when the practice of chiropractic is no longer able to treat the condition.

Such collaboration is not only required, but essential to the success of the Patient Centered Medical Home Model (PCMH) and Accountable Care Organizations (ACOs) emerging throughout the State. The success of these models is premised on a critical mass of primary care professionals who can effectively coordinate care across the spectrum of health and wellness providers. The proposal increases the number of primary care providers available for these models of care.

It is important to highlight that there is precedent for expanding the scope of practice of other professions in Wisconsin. Nurses who obtain additional training and certification may have prescribing authority as Advanced Practice Nurse Prescribers (Wis. Stat. s. 441.16.(2)). Permitting chiropractors to have such authority is the next logical step, particularly since chiropractic training is more closely aligned with Medical Doctors (MDs) and Doctors of Osteopathy (DOs).

In the United Kingdom, several professions can operate as non-medical or allied health prescribers. These include nurses, pharmacists, optometrists, physiotherapists, radiographers, chiropodists and podiatrists. (Courtenay et al) In 2009, the UK Department of Health (UK-DH) released a report stating that in an 18-month period none of the 60,000 medication incidents were related to allied health prescribers (UK-DH). As mentioned earlier, typical training for these prescription rights is 27 days of in class training and 12 days working under an MD/DO (Courtenay et al). In its report, the UK-DH states that non-medical prescribers have the potential to:

- Improve patient care without compromising safety.
- Make it simpler and more efficient for patients to get the medications they need.
- Increase patient choice in safely accessing medications including access to care closer to home.
- Make better use of the skills of health professionals and increase value for money.
- Contribute to introduction of a more flexible work team.
- Facilitate early discharge from hospital.
- Prevent hospital admissions altogether.

(Department of Health; Morris et al)

The PSCP program is also a new approach to healthcare education. It is an advanced education program where curriculum is designed around specific conditions and body systems. The complexity of managing SRDs has grown tremendously in the past decade and developing a new type of provider to manage those complexities requires a different approach. The PSCP program combines the clinical doctorate training in spine and musculoskeletal conditions of Doctors of Chiropractic with traditional pharmacological training, resulting in a condition-based program. The M.S. degree provides pharmacological training with evidence-based training focused on the spine and SRDs. The skills learned in the M.S. program will then be further developed in a 500-hour clinical rotation program where providers will have the opportunity to gain hands on experience. The result will be a specialist in SRDs that has the ability to provide evidence-based, patient-centered care required to optimize clinical outcomes in a cost-effective manner.

M.S. Degree in Advanced Clinical Practice: Board-certified Primary Spine Care Physician

The M.S. Degree is a two year, 55 didactic credit hour, 500 hour clinical rotation, board certification program. The board certification will allow providers an expanded scope of practice as a primary spine care physician. Graduates will be certified to provide primary diagnostic and therapeutic intervention for spinal related conditions (SRDs).

YEAR ONE: combination of on-line and on-ground course work.

Core Courses – Advanced Practices

- Primary Care Practice: Topics in Medicine
- Advanced Imaging & Laboratory Diagnosis
- Primary Care Practice: Case Mgmt. & Treatment Optimization
- Advanced Diagnosis
- Clinical Pharmacology
- Clinical Research and Epidemiology
- Interprofessional relations and Integrated Care

After year one the candidate will complete a core competency exam. Students with successful completion may enter year two as well as start clinical rotations at determined sites. 500 hour clinical training will include rotations in neuro / orthopedic spine surgery, pain management, orthopedic & neurology practices. After successful completion of year two and the 500 hour clinical rotation training candidates may take the board certification exam.

YEAR TWO: combination of on-line, on-ground and clinical rotation.

Concentration: MS - Primary Spine Care

- Causes of Spinal/Musculoskeletal Pain & Differential diagnosis
- Case Management and Coordination of Care in Spinal Pain Patients
- Spinal Injuries (correlated with diagnostic imaging)
- Public Health Issues and Epidemiology of Spinal Conditions
- Pharmacology in Primary Spine Care/Musculoskeletal Conditions
- Nutrition for Musculoskeletal Health
- Interpreting Research and Applying Evidence in Spine Care Practice

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March 7, 2016

Rodney Lefler, DC
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Dear Dr. Lefler:

National University of Health Sciences supports the initiative of the Wisconsin Chiropractic Association to provide the people of Wisconsin with additional opportunities to seek out healthcare providers with advanced post-graduate education. Advancing the scope of these practitioners will lessen the already overburdened system with a well-trained group of physicians acting in concert with the established structure.

The proposed legislation will allow existing professionals the ability to bridge the gap of conservative medicine into a truly integrative healthcare system that serves an outcomes based focus by concentrating on the needs and satisfaction of the patient. National University of Health Sciences is certain that the people of Wisconsin will benefit enormously through the foresight of the Wisconsin Chiropractic Association and the State of Wisconsin, allowing for the opportunity of these practitioners to provide services with a broader scope afforded by the additional education.

Best regards,

Joseph Stiefel, MS, EdD, DC
President

Medical College of Wisconsin would consider master's for chiropractors

Bill before Legislature would create a new type of provider for chiropractors who get additional training

By Guy Boulton of the Journal Sentinel
Feb. 9, 2016

The Medical College of Wisconsin would consider developing a master's program for chiropractors if the state creates a new type of health care provider focused on basic spine and musculoskeletal conditions and with the authority to write prescriptions.

The medical school stressed that it is not endorsing the proposal.

"It's in everybody's best interest to ensure that those who would take advantage of the legislation receive appropriate training," said Joseph Kerschner, a physician and dean of the school of medicine at the Medical College.

The prospect of the Medical College's developing a master's program for chiropractors adds a twist to the bill to create a new type of health care provider known as a primary spine care practitioner.

It would mark the first time a medical school developed a program for chiropractors, according to the Wisconsin Chiropractic Association, which is backing the bill.

The bill has won the support of Sen. Frank Lasee (R-De Pere) and Rep. Joe Sanfelippo (R-New Berlin), chairman of the Assembly Committee on Health.

Chiropractors would have to complete an accredited master's program and 500 hours of clinical training to become primary spine care practitioners. They would be licensed by the Wisconsin Medical Examining Board and the Chiropractic Examining Board.

Chiropractors are licensed only by the Chiropractic Examining Board.

"Wisconsin will lead the nation in this sort of program," said Rod Lefler, the president of the Wisconsin Chiropractic Association.

New Mexico has an advance practice certification that allows chiropractors with additional training to administer a limited formulary of drugs intravenously and through injections.

The Wisconsin Chiropractic Association, which has about 1,200 members, also backed a bill last year to create a primary spine care practitioner.

Expanding the scope of practice for chiropractors who receive additional training would lessen the demands on primary care physicians to treat back and neck pain, said Lefler, who works for the Neuroscience Group, a large physician practice based in Neenah that includes neurosurgeons, neurologists and other specialists.

Both are common medical conditions.

The shortage of primary care physicians in Wisconsin, though, is limited largely to rural areas. The state also has a growing number of nurse practitioners and physician assistants who provide primary care.

Lefler estimated that 10% of the state's roughly 2,000 chiropractors might be interested in getting additional training and becoming primary spine care practitioners.

The program could consist of a mix of class work and online courses and the clinical work could be done one day a week for about a year.

The Medical Society of Wisconsin has yet to take a position on the bill.

But the proposal — and similar proposals in other states — have divided chiropractic trade groups nationally and in Wisconsin.

The Chiropractic Society of Wisconsin, a different trade group with about 700 members, opposes the bill.

No one in the public is clamoring for chiropractors to be able to prescribe medications, said Jay LaGuardia, president of the Chiropractic Society of Wisconsin.

Chiropractors are an alternative to traditional medicine, he said, and focus on a natural approach to healing.

"We don't need more people prescribing medications," LaGuardia said.

Chiropractors don't try to replicate what physicians do, he said, and the Wisconsin Chiropractic Association's proposal would result in "brand confusion."

He also suspects that the Medical College is interested in starting a program because of the additional revenue from tuition.

"My theory is a college is business," LaGuardia said.

Kerschner, of the Medical College, dismissed the contention.

"That's ridiculous," he said. "We've got plenty to do."

Most of the school's education programs break even or lose money.

Chiropractors with advanced training could be an adjunct to the teams that now provide care to patients, Kerschner said.

The Medical College employs chiropractors in its spine care program. So, too, do health systems.

"Health care has moved from a siloed approach to interprofessional approach," Kerschner said.

But he added, "We are not advocating for the chiropractors to have this enhanced role."

The Medical College has only agreed to look into developing a program if the proposed bill becomes law.

"We are good at this stuff," Kerschner said.

The Medical College has started a pharmacy school — at an estimated cost, he said, of $30 million — and it is starting a program for anesthesiologist assistants, who work under the direction of anesthesiologists.

It also has committed to developing a program for certified registered nurse anesthetists, a type of advanced practice nurse, with Marquette University.

"If we are going to have people in the state that need education," Kerschner said, "we will look at how we can partner with people to do it in a good way."