Improving Timely Access to Radiology for Nova Scotians

Access to necessary health care is a fundamental principle for Nova Scotians and is of critical importance for government, health care professionals and the public. Early detection, management, and intervention in many areas of neuromusculoskeletal health is a necessary component to delivering health care to patients suffering from acute trauma and/or increasing disability or chronic pain. Timely access to testing allows for proper diagnosis and facilitates proper treatment.

In July 2022, 100,000 Nova Scotians did not have a primary care physician/family doctor. (1) This represents approximately 1 in 10 of our community members who must access care via walk-in clinics or emergency room visits. This is neither an efficient nor cost-effective solution for managing and treating prevalent neuromusculoskeletal conditions.

Neuromusculoskeletal conditions represent a high proportion of visits to emergency rooms. They also represent a high proportion of physician visits overall, which is particularly concerning when there are fewer physicians available. During 1998-99, about 24% of Canadians made at least one physician visit for MSD (musculoskeletal disease). (2) 22.3% of Ontario's population saw a physician for an MSD in ambulatory settings. In hospital settings, person visit rates for MSDs were highest in the emergency department, followed by day surgeries and inpatient hospitalizations." (3). This is consistent with other studies that showed a 22% incidence of musculoskeletal issues for all emergency room visits. (4)

In addition to the immediate need of Nova Scotians to access appropriate radiology, delays in diagnosis and treatment can lead to increased incidence of chronic pain downstream. From a 2020 Academic Detailing report from Dalhousie University, Faculty of Medicine: "One goal of acute pain management is to prevent pain chronification. Preventative strategies include rapid, early identification and adequate treatment of acute pain or subacute pain, thereby preventing chronic pain. Primary care providers have a crucial role to play in avoiding diagnostic and therapeutic delays." (5) Chronic pain is also a highly correlated with opioid use. Preventing and managing chronic pain is a key aspect of reducing the opioid crisis in Canada and Nova Scotia. (6)

The data available underrepresents the current condition of MSD care. As noted by researchers, "MSD place a significant burden on Canada's ambulatory healthcare system. As the population ages, there will be an escalating demand for care. Careful planning will be required to ensure that those affected have access to the care they require." (2) Nova Scotia's aged population represents high consumers for neuromusculoskeletal health care. If 24% of our 100,000 Nova Scotians without a family doctor are accessing emergency facilities for MSD, we could experience an increase of 24,000+ person visits, overloading our system and the associated costs to our health care system. If those Nova Scotians are not accessing needed care because of the lack of family physicians, there are also longer-term costs to both patients and our health care system.

Chronic pain is expensive. “The annual per-person direct medical cost for a patient with chronic pain was more than 50% higher than a comparable patient without chronic pain.” (7) Musculoskeletal diseases affect more than one out of every two persons in the United States age 18 and over, and nearly three out of four age 65 and over. The cost of treating major musculoskeletal diseases, which often includes long-term pain and disability, is also greater than for treatment of many other common health conditions. With the aging of the US population, musculoskeletal diseases are becoming a greater burden every year.” (8)

These challenges to our health care system are complex and will require innovative thinking to solve. One simple step forward is to utilize existing regulated health professionals, like chiropractors, to their full scope of practice. Providing trained, regulated, community-based access to first line testing and treatment for MSD is one step that we can take immediately. Potential cost savings in additional emergency visits, as well as the additional financial burden of untreated and potentially chronic conditions, will provide significant benefit to the greater system.

Other Canadian provinces (Ontario, Saskatchewan, Newfoundland and Labrador, some areas of BC, pending PEI) do allow chiropractors to refer directly to hospitals and provincial facilities for basic radiographic studies. The Government in Alberta recently changed their policy to disallow chiropractors from direct referral for radiographic studies. Now a full year after this attempt to save budget dollars, data demonstrates a raised cost to their health care system. “Over a year into the implementation of this policy, data from Alberta Blue Cross and chiropractors demonstrates what was forewarned: Costs for DI [diagnostic imaging] referrals and reports have increased substantially; wait times for Albertans to receive musculoskeletal (MSK) care have increased, compromising the health of Albertans; and, this policy change has added red tape and administrative burden to the health system. (9)

Diagnostic imaging is already within a Chiropractor’s existing scope of practice in Nova Scotia by virtue of their training. It is frequently a critical component to the proper diagnosis, management, and treatment of many neuromusculoskeletal conditions that are seen by chiropractors daily as part of the health care team of Nova Scotians. Currently, registered DCs can take radiographs as well as to interpret radiographs and render a diagnosis within their current scope. However, it is often cost prohibitive for chiropractors to have in-office facilities for radiographic studies in Nova Scotia and currently refer patients for radiology services at NSHA. Services of chiropractors in Nova Scotia are non-insured for provincial health care reimbursement but may be paid for by private health insurance programs, national health care programs for Aboriginal/DVA/RCMP communities, or in MVA insurance claims.

In some areas of the province (HRM), chiropractic patients can be directly referral for basic radiological studies at local facilities and in other areas this requires an additional request for referral via a patient’s family doctor/most responsible health care provider (MRHCP). Radiographic studies are paid for by provincial health care programs when requested by a medical physician or some physiotherapists. (10) With 100,000 Nova Scotians living without a family physician/MRCHP there are a significant number of people in our communities who experience an additional barrier to access radiographic studies and thus appropriate health care. Chiropractors in Nova Scotia are willing to provide this request of radiology service at no additional cost to facilitate timely and appropriate patient care.

Nova Scotia’s Chiropractors initially brought this request to government in 2016 and the Provincial Access to Non-insured Diagnostic Imaging Working Group (NIDI Working Group) was initiated. This group was tasked to review the issue with inclusive representation from the professions, hospitals, and

government. Despite positive discussion, issues of funding remained a challenge to implementation. In 2020, Covid paused these discussions and now we are bringing this forward once again as there is an even greater urgency to aid Nova Scotians.

As direct access clinicians providing care to Nova Scotians across the Province of Nova Scotia, chiropractors are currently underutilized resources to aid in improving access to needed radiological studies for neuromusculoskeletal disorders. In 2022, there are even more Nova Scotians without a MRCHP, more limited in-person care and more delayed timelines to access existing MRCHPs. Plus, in a post-Covid effort to minimize exposure of patients to unnecessary public contact at multiple healthcare facilities, direct referral can eliminate unnecessary steps to access radiological services. Chiropractors in Nova Scotia are ready, willing, and able to be part of the solution.

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REFERENCES:

(1) https://atlantic.ctvnews.ca/nova-scotia-s-doctor-waitlist-hits-all-time-high-at-100-000-people-1.5984380
(2) Ambulatory Physician Care for Musculoskeletal Disorders in Canada J. DENISE POWER, et al. Rheumatol 2006;33:133–9
(3) Health care utilization for musculoskeletal disorders†Crystal MacKay,Mayilee Canizares,Aileen M. Davis,Elizabeth M. Badley, 08 January 2010 https://doi.org/10.1002/acr.20064
(4) Fontánez R, Ramos-Guasp W, Ramírez H, De Jesús K, Conde JG, González J, Frontera WR. Musculoskeletal Conditions in the Emergency Room: A Teaching Opportunity for Medical Students and Residents. P R Health Sci J. 2021 Jun;40(2):68-74. PMID: 34543564; PMCID: PMC9119411.
(5) https://cdn.dal.ca/content/dam/dalhousie/pdf/faculty/medicine/departments/core-units/cpd/academic-detailing/AcutePainHandout2021.pdf
(6) Hser YI, Mooney LJ, Saxon AJ, Miotto K, Bell DS, Huang D. Chronic pain among patients with opioid use disorder: Results from electronic health records data. J Subst Abuse Treat. 2017 Jun;77:26-30. doi: 10.1016/j.jsat.2017.03.006. Epub 2017 Mar 9. PMID: 28476267; PMCID: PMC5424616.)
(7) https://journals.lww.com/pain/Abstract/2016/08000/Incremental_health_care_costs_for_chronic_pain_in.11.aspx
(8) United States Bone and Joint Initiative: The Burden of Musculoskeletal Diseases in the United States (BMUS), Third Edition, 2014. Rosemont, IL. Available at http://www.boneandjointburden.org.
(9) https://s3.amazonaws.com/kajabi-storefronts-production/sites/2147529668/themes/2149030388/downloads/SokSyOmGTGKh5fq4EW45_Diagnostic_Imaging_FINAL_REPORT_-_First_Year_I.pdf
(10) http://policy.nshealth.ca/Site_Published/NSHA/document_render.aspx?documentRender.IdType=6&documentRender.GenericField=&documentRender.Id=95207