Accountable Care Organizations
Optimize Outcomes, Cost Savings And Patient Satisfaction With Chiropractic Care

2013

Foundation for Chiropractic Progress
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Introduction

“Begin with the end in mind,” the late Stephen Covey, educator, businessman and author of *The 7 Habits of Highly Effective People*, often advised his audiences.\(^1\) Architects of our new healthcare system may want to heed his advice as they implement a new structure built upon the principles of accountable care. With the end results of Accountable Care Organizations (ACOs) still unfolding, the U.S. now has a total of 428 ACOs as of January 10, 2013, including both Medicare and private ACOs, and every state but Delaware had at least one ACO.\(^2\)

The growth of ACOs appears to be in the category of those that are physician group-led, though they are generally smaller than hospital-run ACOs. Insurers or community-based groups sponsor some ACOs, as well, but there are fewer of them.\(^3\) While structures differ, private ACOs have a wider range of payment models – full or partial capitation, bundled payments, retainer agreements, in-kind services and subsidies, and pay-for-performance incentives.\(^4\)

Amid this wait-and-see phase of ACO performance, one thing remains clear: the “Triple Aim” to generate better patient outcomes, greater patient satisfaction and lower costs of care is still paramount. As Donald Berwick, M.D., former director of the Centers for Medicare & Medicaid Services (CMS), and his colleagues advised in 2008: “Improving

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1 Covey, Stephen R; *The 7 Habits of Highly Effective People*, Habit 2: Begin with the End in Mind; [https://www.stephen Covey.com/7habits/7habits-habit2.php](https://www.stephen Covey.com/7habits/7habits-habit2.php); Accessed May 27, 2013


3 Muhlestein D.; 2013

4 Muhlestein D.; 2013
the U.S. healthcare system requires simultaneous pursuit of three aims: improving the experience of care, improving the health of populations and reducing per capita costs of healthcare."  

As we move closer and closer to the implementation of ACOs and other major components of the Affordable Care Act (ACA) in January 2014, individuals at every level of healthcare — from policymakers to care providers, health economists and politicians — are in search of the elements that will help to bring about the promise and potential that the ACA holds for the American population and economy. With this vision, the nation’s doctors of chiropractic are positioned as a key element of the delivery system, and capable of contributing to the expected solution.

**ACOs: Incorporating a New Level of Thinking**

Clearly, the ACA is not intended to be the latest incarnation of managed care. Rather, it is expected to be a revolution in healthcare attitudes, delivery systems and payment systems on the part of every player in the process. The reforms envisioned in the legislation go far beyond making the current system more efficient, in terms of patient outcomes and costs to a revamping of the system from its traditional patriarchal, paternalistic model of care delivery, to a system of mutual respect and engagement of providers and patients alike.

Fresh thinking needs to accompany the legislative reforms, and inventive models should replace the time-honored approaches of the past. Innovation and egalitarianism should replace the stifling, silo-oriented system of turf protection and hierarchical engagement.

A significant part of this reformation process is to re-evaluate how various resources are deployed and made available to support the end-user of the system — the patient. These resources can no longer be expended in a limitless manner to treat the diseases and circumstances created by the lifestyles and behaviors of the patient population. Providers and patients alike must understand that it is a new day in healthcare — one that holds different responsibilities and requires novel strategies on everyone’s part.

At the core of this new era is the very configuration under which care is provided. The development of the ACO as a structure to bring new levels of involvement of administrators and providers to the table has advanced and is developing at a rapid pace. One of the key components of the ACO strategy is its “skin in the game” nature.

The Medicare Shared Savings Program will reward ACOs that reduce growth in healthcare costs while meeting performance standards for quality of care and for putting

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patients first. Some say it may be difficult, if not impossible, for ACOs to accomplish this without the ability to guide the care that their patients receive.\textsuperscript{6}

With a goal to allow patients complete freedom, CMS is expected to watch for any actions that limit patients’ ability to take advantage of the full range of benefits to which they are entitled under the traditional Medicare fee-for-service (FFS) program, including the right to choose healthcare providers and care settings.

In this accountable environment, the concept of value-based purchasing emerges as a concept that links payment directly to the quality of care provided. It is a strategy that can help to transform the current payment system by rewarding providers for delivering high quality, efficient clinical care. However, providers should only be accountable for components of clinical care over which they have control, while others are accountable for the components that they control.\textsuperscript{7}

The proposed rule also includes strong protections to ensure that ACOs do not limit patients’ care choices: Beneficiaries whose doctors participate in an ACO will still have a full choice of Medicare providers, such as doctors of chiropractic, because they will be allowed to choose to see doctors outside of the ACO. This provision is allowed despite the likelihood that communication and coordination with these outside providers will be difficult, if not impossible. Yet communication and coordination of care are foundations of efficient and effective care.

### Defining the ACO Care Continuum

ACOs are defined as: “A group of healthcare providers who give coordinated care, chronic disease management, and thereby improve the quality of care patients get. The organization’s payment is tied to achieving healthcare quality goals and outcomes that result in cost savings.”\textsuperscript{8}

\begin{itemize}
\item \textsuperscript{6} Stefanacci, Richard, DO, MPH; \textit{Accountable Care — But the Patient Isn’t Accountable}; Managed Care; MediMedia, July 2011. \url{http://www.managedcaremag.com/archives/1107/1107.acos.html}; Accessed May 27, 2013
\item \textsuperscript{7} Stefanacci, Richard, DO, MPH 2011
\item \textsuperscript{8} Healthcare.gov; \textit{Glossary}, May 17, 2013; \url{http://www.healthcare.gov/glossary/a/accountable.html}; Accessed May 27, 2013
\end{itemize}
The elements needed to fulfill the vision and definition of an ACO include:  
- Complete and timely information about patients and the services they are receiving from a robust Health Information Exchange (HIE)
- Technology and skills for population management and coordination of care
- Strengthened patient education and self-management
- Culture of teamwork
- Capability to measure and report on quality of care through a clinical information system rather than a billing system
- Leadership that improves value — continued performance improvement
- Voluntary participation
- Primary care, specialty care and inpatient care all have important roles — clinical integration with effective coordination is key to reduce costs

The last bullet, “…clinical integration with effective coordination is key to reduce costs,” captures the challenge that is at the heart of healthcare reform, in general, and in ACOs in particular.

If healthcare reform is about better ways of employing the same system, there will be efficiencies created and savings will occur. The problem is that those efficiencies and savings will yield a fraction of what is needed for the healthcare system to survive and serve the people of this country. Healthcare reform must not only include efficiencies, but it also must include a re-thinking of the entire process of healthcare in America.

All of the costs and the rewards for patients, providers and payers must be re-examined. Healthcare reform cannot be superficial or it will amount to simply rearranging the deck chairs on the Titanic: Everyone may have a much better view, but they are ultimately going to sink.

The first thing that needs to change in healthcare is a shift from disease management to a culture of health. Going forward, our nation simply cannot afford to take the same old approach. Everything must be re-examined through the lens of the “Triple Aim.”

It is precisely this vision which embodies the approach of the chiropractic community.

**Doctors of Chiropractic Tackle the Leading Causes of Disability and Burden of Disease: Low Back and Neck Pain**

Cancer, heart disease or malnutrition are often cited as the most challenging disease states and the leading causes of disability. The facts tell us differently. The World Health Organization (WHO) assesses the overall burden of disease using the disability-adjusted life year (DALY), a time-based measure that combines years of life lost due to premature mortality and years of life lost due to time lived in states of less than full health. Their
analyses provide a comprehensive and comparable assessment of mortality and loss of health due to diseases, injuries and risk factors for all regions of the world.\textsuperscript{10}

Following are a sample of WHO findings and other related studies:

\begin{itemize}
  \item The Global Burden of Disease Project 2010, comprised of a collaboration between WHO, the University of Queensland (Australia) School of Population Health, Harvard School of Public Health, Johns Hopkins Bloomberg School of Public Health, the University of Tokyo and the Imperial College of London, identified lower back pain (LBP) as the number one cause of disability worldwide, and neck pain was identified as number four worldwide.\textsuperscript{11} These findings also emphasize that musculoskeletal disability has increased considerably when compared to a mere 20 - 30 years ago. In addition, because people are living longer they run a higher risk of living with the burden of pain and disability than past generations.\textsuperscript{12}
  
  \item In 1990, LBP ranked as the 11th leading condition on the global burden of disease. By 2010, LBP moved up to the sixth most highly ranked condition contributing to the global burden of disease.\textsuperscript{13}
  
  \item In December 2012, The Bone and Joint Decade 2010 - 2020, an effort of the WHO, released a report observing: “The leading cause of disability worldwide is low back pain contributing 10.7 percent of all years lived with disability (YLDs).” Additionally, the report noted: “Disability from musculoskeletal disorders exceeds the disability caused by either infectious diseases or cardiovascular diseases.”
  
  \item In June 2010, the Minnesota Community Measurement not only corroborated that the number one cause of disability worldwide is LBP, but also reported that mechanical LBP remains the second most common symptom-related reason for seeing a physician in the U.S. Of the American population, 85 percent will experience an episode of mechanical LBP at some point in their lifetime. For individuals younger than 45 years, LBP represents the most common cause of disability and is generally associated with a work-related injury. It is the third most common reason for disability for individuals older than 45 years.\textsuperscript{14}
\end{itemize}

\begin{itemize}
  \item World Health Organization (WHO); Global Burden of Disease: \url{http://www.who.int/healthinfo/global_burden_disease/en/}; Accessed May 27, 2013
  
  \item World Health Organization (WHO); Back and Neck Pain: Number One Cause of Disability Worldwide: \url{http://www.who.int/healthinfo/global_burden_disease/en/}; Accessed May 27, 2013
  
  \item World Health Organization (WHO); Global Burden of Disease: \url{http://www.who.int/healthinfo/global_burden_disease/en/}; Accessed May 27, 2013
  
  
\end{itemize}
In a three-month period, about one-fourth of U.S. adults experience at least one day of back pain. It is one of society’s most common medical problems.\(^{15}\)

**Staggering Burdens of Cost**

It is evident that while many may regard LBP to simply be considered a plain, ordinary ailment, those who suffer from it report that there is nothing plain or ordinary about it. LBP is a particularly troublesome problem because while no one dies from the condition, those with LBP put an enormous load on the system resulting from their disability, and the reality is that they will often live for decades with that disability. This puts a strain not only on the individual and his/her family, but also the employers who are forced to address absenteeism/presenteeism that is often concomitant with the condition. Workers who reported arthritis or back pain had an average loss in productive time of 5.2 hours per week.\(^ {16}\)

An estimated 13% of the total workforce experienced a loss in productive time during a 2-week period due to a common pain condition:2,8

- Headache (5.4%)
- Back pain (3.2%)
- Arthritis pain (2.0%)
- Other musculoskeletal pain (2.0%)


Unlike other conditions, consider that there are no LBP telethons or foundations. The one-two punch of the condition itself, and the time over which it manifests itself, puts LBP in a unique epidemiological category. While the nation moves toward an information-based economy and away from a manual labor-based workplace, problems such as LBP are proliferating — rather than decreasing over time.


This was documented in a 2008 report published in *The Journal of the American Medical Association (JAMA)* which explored the economics of spinal pain: The cost of spinal pain from 1997 to 2005 increased by 65 percent — in eight years, the costs increased by two-thirds.\(^\text{17}\) This problem is not shrinking — it is expanding year after year.

Furthermore, the greatest percentage increases were associated with pharmacy costs. One of the realities of LBP is that it is a problem that “keeps on giving” because LBP is often treated with opioid drugs that lead to dependency and addiction, creating an entirely new cost center and suffering point for the American population. The prevalence of lifetime substance use disorders ranges from 36-56 percent in patients treated with opioids for chronic back pain; 43 percent of this population has current substance use disorder (SUD) and 5-24 percent has aberrant medication-taking behaviors.\(^\text{18}\)

Another report from *The Journal of the American Board of Family Medicine* advises that the prevalence and impact of chronic back pain have spawned a rapidly expanding range of tests and treatments — some of which have become widely used for indications

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17 Martin Bt; Deyo RA; Mirza SK; et al: *Expenditures and health status among adults with back and neck problems. The Journal of the American Medical Association*. 2008; 299:656-64

that are not well validated — leading to uncertainty about efficacy and safety, and increasing complication rates and marketing abuses. Recent studies document a 629 percent increase in Medicare expenditures for epidural steroid injections; a 42 percent increase in expenditures for opioids related to back pain; a 307 percent increase in the number of lumbar magnetic resonance images among Medicare beneficiaries; and a 220 percent increase in spinal fusion surgery rates. The limited studies available suggest that these increases have not been accompanied by population-level improvements in patient outcomes or disability rates.\textsuperscript{19}

In the U.S., patients with musculoskeletal conditions incur total annual medical care costs of approximately $240 billion, of which $77 billion is related to musculoskeletal conditions. According to a 2006 review, total costs associated with LBP in the U.S. exceed $100 billion per year, two-thirds of which are a result of lost wages and reduced productivity.\textsuperscript{20} Keep in mind this cost is associated only with LBP; the cost of all forms of spinal pain is considerably higher, and the cost of all forms of musculoskeletal pain is higher yet: In 2005, the average medical cost of treating back pain among those with spine problems was $6,096, compared with $3,516 among those without spine problems.\textsuperscript{21}

**Understanding the Issues, Defining the Problems**

In light of the magnitude of problems associated with LBP, it is important to examine what is collectively being done to resolve the issues. Spinal pain — and LBP in particular — are addressed with multiple clinical approaches and by many different types of providers:

- Approaches range from patient education and recommended lifestyle changes to prescription or over-the-counter medications and surgery.
- Providers span from primary care providers to neurosurgeons, doctors of chiropractic and personal trainers.

Unlike caring for a simple fracture, there is no one-size-fits-all approach to LBP and spinal pain. While providers may not like the idea of sharing responsibility for this condition, patient preferences might be one of the most useful factors to guide this care equation.

It may also be helpful to utilize the guidance of “Occam’s Razor” which comes from a 14\textsuperscript{th} century philosopher and theologian who asserted that the simplest answer is usually the best answer.\textsuperscript{22} When it comes to LBP and spinal pain in general, it may be wise to apply this approach for LBP, chiropractic care is among the least invasive, least dangerous and least costly approaches to be considered.

\textsuperscript{19} Deyo, Richard et. al; *Overtreating Chronic Back Pain: Time to Back Off?*; *The Journal of the American Board of Family Medicine*; January-February 2009 vol. 22 no. 1 62-68; [http://www.jabfm.com/content/22/1/62.full](http://www.jabfm.com/content/22/1/62.full); Accessed May 28, 2013


\textsuperscript{21} Martin BI; Deyo RA; Mirza SK; et al; 2008

\textsuperscript{22} *What is Occam’s Razor?*; [http://math.ucr.edu/home/baez/physics/General/occam.html](http://math.ucr.edu/home/baez/physics/General/occam.html); Accessed May 28, 2013
admonition: We should first seek the simpler answer and intervention, and then if necessary move to the more complicated and invasive answers.

In the spectrum of provider-assisted care for LBP, chiropractic care is among the least invasive, least dangerous and least costly approaches to be considered.

Armed with Occam’s advice, there is a more recent study that frames the value of taking the simplest approach first. It involved on-the-job lower back injuries among persons who worked for the state of Washington, and the injuries were risk adjusted—that is, the severity between cases was evaluated and found to be comparable.

If the injured worker’s first point of contact, in terms of the healthcare provider chosen, was a surgeon — the likelihood of the worker receiving surgery was 42.7 percent.

In contrast, if the first point of contact was a doctor of chiropractic, the likelihood of surgery was 1.5 percent.23

This means that patients with similar injuries were more than 28 times less likely to receive spinal surgery if their initial consultation was with a doctor of chiropractic.

The impact of this startling result becomes even more meaningful when one takes into consideration the cost of surgery. One report from the Minnesota Department of Labor and Industry focused on lumbar spine surgery, where the costs of hospitalization related to lumbar fusion was $40,620 - $89,686 and the cost for implants, if used, was $31,532 - $78,559.24 Please note that these costs do not include the costs of the surgeon’s services, post-discharge care, lost work time or other measurements.

In another scenario from the State of Tennessee, a 2010 article compared the cost of episodes of LBP under medical care versus chiropractic care.25 On a non-risk adjusted comparison of care, paid costs for episodes of care were almost 40 percent less than episodes initiated under medical care. When these data were further examined on a risk-adjusted basis, chiropractic care yielded a 20 percent savings versus medical care.

Moving away from the LBP question, the broader effect of chiropractic care is equally compelling. In 2004, The Archives of Internal Medicine published, “Comparative Analysis of Individuals With and Without Chiropractic Coverage: Patient Characteristics, 2004; 33:640-643

The study found that if patients had chiropractic coverage under their insurance, their total cost of healthcare was 12.5 percent or one-eighth less than their counterparts who did not have chiropractic coverage under their insurance.

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The addition of a chiropractic benefit to a person’s insurance profile did not increase the cost of healthcare; rather, it was associated with a lower cost of healthcare on a global level. This research drilled down a little deeper and examined the costs, not only on a global basis, but also in terms of the cost of X-rays, MRIs, surgeries and hospitalizations. In each of these areas were savings of 23 percent, 37 percent, 32 percent and 40 percent, respectively.

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Source: Archives of Internal Medicine, 2004: 164;18 1985-1992

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Apart from reducing costs, it is important to examine efforts to yield continued performance improvement. Maintaining a focus on spine-related problems, there is a wide range of outcomes for each intervention — from the least to the most invasive. Again, in this clinical environment one size does not fit all. Recognizing that spinal pain is a multi-variant problem, it is not unusual that the solutions would fall into the same category.

While it may be more difficult to assess what works and how well it works, there are outcomes-oriented data that can be used to inform this discussion. Arnold Milstein, M.D., M.P.H., and Niteesh Choudhry, M.D., Ph.D., completed an analysis of the cost and clinical effectiveness of chiropractic care in the neck pain and LBP environments entitled: “Do Chiropractic Physician Services for Treatment of Low Back and Neck Pain Improve the Value of Health Benefit Plans.”

The authors concluded that chiropractic care was not only more cost-effective in the low back and neck pain arenas, but also more clinically effective: “Chiropractic care is more effective than other modalities for treating low back and neck pain... chiropractic physician care for low back and neck pain is highly cost-effective and represents a good value in comparison to medical physician care and to widely accepted cost-effectiveness thresholds.”

In the neck pain scenario referenced, the comparison involved usual medical care, exercise and chiropractic care. In the LBP modeling, the comparisons involved physician care, physical therapy-led exercise, manipulation and physical therapy-led exercise, and chiropractic care. In both environments, chiropractic care was found to be more effective clinically and more efficient economically.

This is not the first instance of such documented conclusions. In 2007, the *Annals of Internal Medicine* published a paper outlining guidelines issued by the American College of Physicians and the American Pain Society with respect to back pain. For patients that do not respond to appropriate self-care and education, the only “proven” intervention in the acute setting was spinal manipulation. In the subacute/chronic setting, spinal manipulation was an accepted approach among others to address the problem.

The following year, a multi-national, multi-discipline-based report from the WHO Bone and Joint Decade’s Neck Pain Task Force found that in terms of non-specific neck pain, manipulation (mobilization) was associated with better pain and functional outcomes when compared to general practitioner care, medications and advice to stay active.

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In the area of patient satisfaction with chiropractic care, there are also numerous assessments reflecting a variety of patient settings ranging from civilian to military, managed care and patient-directed environments. The consulting firm, Birch & Davis of Falls Church, Virginia, evaluated an effort to include chiropractic services in the military health system and found: “Results from the empirical models indicate that patients who saw doctors of chiropractic were significantly more likely to show self-reported improvement in health over the four-week survey period than patients who saw traditional providers.” In terms of patient satisfaction with chiropractic care, the firm reported: “Patients were also more likely to give their provider excellent marks (a perfect score) if they were seen by a chiropractor.”

In a related report, Muse & Associates evaluated the same circumstances, reporting the feedback of persons who received chiropractic care and medical care and responded to the question: “How satisfied were you with improvement in your condition?” When assessing the responses “excellent” was found 81.5 percent of the time for chiropractic patients and 55.6 percent of the time for medical patients. When asked to respond to the simple statement: “I feel better now!” 78.5 percent of the chiropractic patients “strongly agreed” versus 49.2 percent of the medical patients.

**Chiropractic Care Positions ACOs to Address the Challenges**

The 65,000-member-strong chiropractic profession in the U.S. is very well positioned to help address the impending transitions in healthcare delivery in America. This report examines only two areas of chiropractic involvement—neck pain and LBP.

In the ACO and patient-centered medical home (PCMH) environments, doctors of chiropractic can bring the potential for greater clinical efficiency, patient satisfaction and cost savings than is currently available. The low-tech, high-touch nature of chiropractic care strengthens each of the desired outcomes of the “Triple Aim” cited earlier. The non-pharmaco-logic nature of chiropractic care also serves to offer a new and different approach to usual care that is heavily reliant on pharmaceutical interventions. Furthermore, doctors of chiropractic offer needed relief to providers that are poorly equipped or even ill-equipped to address patients with musculoskeletal problems of many types. The opportunity is to potentially free-up medical providers...
who are forced to deal with frustrating and time-consuming patients. This translates into a significant value proposition for every provider practicing in these settings.

Finally, there is the real potential to bring double-digit cost reductions to clinical areas that are experiencing dramatic increases. The inclusion of doctors of chiropractic and chiropractic services in these delivery models is being facilitated by credentialing processes being developed by URAC and the National Committee for Quality Assurance (NCQA). Insightful and savvy leaders in the ACO and PCMH settings will readily see the clinical and economic opportunities that the involvement of doctors of chiropractic represents to them and to their organizations.
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