Dynamic Chiropractic

BACK PAIN

Benchmarking -- Chiropractic Care and Quality Assurance in the 21st Century

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Three percent of patients consume 90 percent of all health care dollars, according to Robert Brook of the RAND Corporation.[1] Low back pain affects over 80 percent of our population at some time in their lives and has left nearly five percent of the US and British population disabled. Most people recover from back pain, but the minority who don't cost most of the dollars spent on this problem. According to Gordon Waddell, consultant to the low back pain guidelines of both the US Agency for Health Care Policy and Research, and the British Clinical Standards Advisory Group, the way to deal effectively with the low back epidemic is to redirect resources away from chronic treatment towards early, aggressive conservative care.[2] Mismanagement of the acute patient often results in preventable chronic pain and disability.

Brook, speaking at the recent chiropractic centennial in Washington, D.C., said the goal of health care is to provide necessary care to those who need it, eliminate waste, and improve the mean level of care.[1] The challenge is to be cost effective without sacrificing quality. James Weinstein, editor of Spine, said, "You can't manage what you can't measure."[3] To ensure quality he proposes that health outcomes and patient satisfaction be measured in our clinics. Echoing Paul Ellwood's famous Shattock lecture he recommends that we pool research data on back pain on a large scale and then analyze this data to ensure quality assurance and help continuously refine the standards of care.[4]

Weinstein says success in bringing down the cost of back pain without sacrificing quality depends on getting managed care organizations (MCOs) and the average health care provider to accept and follow the new "benchmark" of appropriate care. The new standard of care according to the AHCPR and CSAG is the following:[5,6]

1. Diagnostic Triage (red flags, nerve root pain, low backache)

2. Patient Reassurance/Education

3. Provide Pain Relief (non-prescription analgesics, manipulation)

4. Active Rehabilitation to Restore Function

Improving health care requires the development of standards, physician education, and progressive third-party payers. Unfortunately, MCOs have followed a short-sighted cost containment philosophy of reducing health care costs by limiting patient access to subspecialists (like chiropractors). This is unlikely to succeed since as Cherkin found out in a survey of nearly 3,000 medical physicians, their knowledge of appropriate care for low back pain is very poor.[7] For

instance, when asked to list treatments effective for back pain, a large number of respondents recommended treatments with little scientific evidence such as bed rest and narcotic analgesics. In contrast, spinal manipulation which has more evidence of effectiveness in the first month of care than any other modality was ignored by most.

According to Arthur White of the Spine Center in Daly City, California, new MCOs are emerging with a more enlightened approach.[8] They want to triage patients at the outset of a low back attack and steer them to the most appropriate care as quickly as possible.[2] White feels chiropractors can perform the diagnostic triage and be the provider of choice for most of the early care due to our expertise in manipulation. Waddell states that early care is where we can have our greatest favorable impact on the natural history of lower back pain. The longer a patient is in pain the harder it is to help them. Those disabled for six months have only a 50 percent chance of ever returning to work. He points to the danger of the myth of traditional teaching that 90 percent of LBP attacks recover in six weeks. But actually only 50 percent settle; 15-20 percent continue for up to a year; 20 percent have recurrent pain; and 3-7 percent develop chronic pain. Of those who do get better in the first 4-6 weeks, 70 percent have three or more recurrences in the next few years after the acute attack.

Both the AHCPR and CSAG encourage early, aggressive treatment following soft tissue rehabilitation guidelines. This involves:[2,5,6]

Low Back Guidelines

1) Diagnostic Triage

- Initial assessment to detect "red flags" of serious spinal or extraspinal disease.
- Imaging not necessary in the first month when no "red flags" are present.

2) Reassurance/Education

- No serious pathology
- Activity modification is important, but bed rest less than four days may be harmful.

3) Pain Relief

- Pain relief with nonpresciption medication and spinal manipulation is appropriate.
- "The evidence suggests that the first six weeks are crucial in preventing chronicity."

4) Active Rehabilitation

- Low-stress aerobic exercise can be started in first two weeks and trunk conditioning exercises after that.
- Patients are encouraged to return to work and ADLs as soon as possible.

- Symptomatic measures "should be used mainly to facilitate active rehabilitation rather than be seen as an end in themselves."

5) Time Scale

- Further evaluation is appropriate if symptoms persist beyond four weeks.
- Sciatica patients recover slower, but evaluation can also be delayed.
- Surgery is reserved for those with evidence of severe, debilitating sciatica and physiologic evidence of spinal nerve root compromise corroborated on imaging.
- 80 percent of patients with sciatica recover with or without surgery.
- Psychologic and socioeconomic factors may be discussed as impacting reasonable expectations for recovery.
- Some patients who don't respond within 4-6 weeks may require referral for further measures for pain relief and psychologic distress.

6) Multidisciplinary Rehabilitation Services

- If primary care fails multidisciplinary care is needed.
- This should be low-tech, low-cost.
- It should address the biopsychosocial needs of the patient and focus on functional restoration.

7) Outcomes Assessment

- Clinical outcome measures are essential to judge clinical effectiveness and future standards of care.
- Measurements are needed of pain, distress, ADL disability, work capacity, time off work, analgesic intake, and health care consumption.

According to 1995 standards published by the Commission on Accreditation for Rehabilitation Facilities (CARF), time limited passive care followed by active care is the key.[9] This is the benchmark for care of spinal disorders. Manipulation has more evidence for its effectiveness than any single modality for pain less than four weeks old.[10] Chiropractors perform over 95 percent of all

manipulations and are the most qualified to perform this service. As MCOs begin to incorporate the new guidelines they will want DCs to serve both as primary care triage doctors and subspecialists for acute/subacute care. Patient dissatisfaction with limited access to quality care will certainly facilitate this transition.

But where do chiropractors fit in after the first month of care? Can we manage the full spectrum of conservative care, including rehabilitation? LACC's diplomate course in rehabilitation fully prepares chiropractors to be active rehabilitation specialists. The knowledge and especially the skills to expertly run a rehabilitation clinic are taught over a three year period. Soft tissue rehabilitation principles, human performance testing and training skills, outcomes assessment, identification of psychosocial risk factors, and assessment and treatment of the functional pathology of the motor system are all taught.

There is no reason why our profession should be left behind in the era of managed care. If we are willing to adhere to the guidelines then we can greatly improve the value of care offered by the MCOs. By receiving the necessary training in active rehabilitation and a biopsychosocial approach, DCs can expand their ability to manage a case. Even in the multidisciplinary area DCs can serve a powerful role. Dr. John Triano of the Texas Back Institute performs primary care duties, offers manipulative therapy and pain relief services, and supervises the rehabilitation. This has led to great cost savings in terms of decreased overutilization of excessive passive modalities and improved efficiency in the delivery of rehabilitation services.

The chiropractic centennial proved that the benchmark for appropriate musculoskeletal care includes chiropractic at every level of conservative intervention. From diagnostic triage and patient reassurance to multidisciplinary care of the chronic patient chiropractors can reduce costs without sacrificing quality. If we can learn to utilize manipulation as a tool to facilitate active rehabilitation, rather than seeing it as an end in itself, then chiropractic will find itself sought out rather than shut out by MCOs.

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