Dynamic Chiropractic

A Moment of Mercy and a Clinical Compass

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Doctors of chiropractic in California recently had reason to celebrate a minor victory. After the devastating effects of recent legislative reform of the state's workers' compensation laws all but crippled many doctors' practices, the news was welcome, even if it came from an unexpected source.

Two California Chiropractic Association members, Dr. Deborah Sampley and Dr. Adam Orzag, provided the California Workers' Compensation Appeals Board with the ammunition to overcome draconian treatment guidelines that were being used to limit chiropractic care. Since last year, the American College of Occupational and Environmental Medicine (ACOEM) guidelines[1] have been presumed correct with respect to treatment of injured workers.[2] They have little to say that supports chiropractic care outside a brief trial of treatment for neck or low back pain. Unfortunately, utilization review doctors have been using those guidelines to deny almost all care, particularly care for injured workers with chronic pain who require periodic supportive care. According to California law, the ACOEM guidelines can only be overcome by demonstrating a more reasoned approach based on "nationally recognized, peer reviewed, scientifically based alternative guidelines."[2]

Casillas v San Luis Obispo County was the first time the Appeals Board had ruled on appropriate treatment outside the ACOEM guidelines.[3] Dr. Sampley was Ms. Casillas' primary treating physician and provided recommendations for treatment when her pain level elevated significantly, as well as appropriate documentation of the necessity for care and the effects of the treatment. Dr. Orzag provided the independent qualified medical evaluation (QME) to address the disputed medical care.

The board was swayed by Dr. Orzag's recommendations for supportive care, based on the principles for treatment of chronic pain articulated by the *Guidelines for Chiropractic Quality Assurance and Practice Parameters* - the so-called Mercy document.[4] The effect for the chiropractic profession, and more importantly our injured worker patients, is that we may yet be able to continue to provide them with necessary care for exacerbations of their condition under workers' compensation.

Mercy Revisited

The irony is that the oft-derided *Mercy Guidelines* once again come to the rescue of the profession. Problematic? Of course. The guidelines are now 12 years old and are considered dated. The problem for the profession is the lack of reasonable alternatives.

While the Council on Chiropractic Practices (CCP) guidelines,[5] touted by a small fringe group in the profession, are listed on the National Guidelines Clearinghouse,[6] they are used by almost no one in the profession, and are completely ignored by those in authority outside the profession, including third-party payors and regulatory and state agencies. Their authors often refer to their listing in

the National Guidelines Clearinghouse as evidence of their merit, but unfortunately, the NGC is merely a collection of guidelines less than 5 years old, and does not imply validity simply because it is listed. In fact, the NGC annotated bibliography notes that the CCP guidelines are "unsuitable for use in clinical practice,"[7-10] while finding that Mercy remains a usable document.[4,7-10] An additional assessment study found the ICA guidelines [*Recommended Clinical Protocols and Guidelines for the Practice of Chiropractic*] "unsuitable for use in clinical practice" as well.[9]

California has often proven to be a bellwether of things to come for the rest of the country. Our experience in workers' compensation is spreading to other states, including Hawaii, Texas and others. What we experienced was that a small number of outlier physicians were responsible for the vast majority of charges in the system, and the rest of the profession will pay the price. Ten years ago, Hawaii had an excellent personal injury reimbursement policy. A handful of greedy DCs plundered the system, and every DC on the islands paid the price when reimbursement for personal injury cases was capped at $1,500.

The *Casillas* case is a chink in the armor of outsiders foisting treatment guidelines on our profession, written by non-chiropractors, and used to limit legitimate care for our patients. Given that ICA, WCA and Mercy have all published guidelines, it is clear that virtually no one in the profession disputes that we need to describe what defines appropriate chiropractic practice. Unfortunately, all have had shortcomings.

The *Chiropractic Clinical Compass*

We have learned a lot in the past 12 years, and the world of guideline development has matured. First, the current state of the art is the "Best Practices" model, which embraces the concept, articulated by Sackett, the father of "evidence-based medicine," that optimal care combines the best scientific evidence with the wisdom and experience of the clinician and the desires and beliefs of the patient.[11] We also have learned that guidelines are rarely used as guides, but rather, are often inappropriately used by bean counters as end points of care.

Recognizing the pressing need for a "Best Practices" document to counter limitations imposed by non-chiropractors, the Congress of Chiropractic State Associations commissioned the Council on Chiropractic Guidelines and Practice Parameters (CCGPP) to develop a dynamic best-practices document, termed the *Chiropractic Clinical Compass*.[12] It is to be updated on a continuing basis. As a first step, the council retained respected researcher Monica Smith, DC, PhD, of Palmer Research Consortium, to survey the entire profession to find out what it is that doctors of chiropractic are actually doing in their practices: whom they see, what conditions they treat, and how they treat them.

The CCGPP then set out to develop a document that describes the practice of chiropractic in America, coupled with the best available research evidence so that doctors, patients and others can make informed decisions about how to approach the conditions we commonly see in our patients. It is to be a *Clinical Compass* that doctors of chiropractic of all stripes can use to provide their patients with the best possible care and empower patients to find that care.

Developing Best Practices

Internationally, reasoned approaches to the evolution of "best practices" have been developed. These include using a well-defined process, which requires specifying in advance the criteria for inclusion of research, then a process for throwing as wide a net as possible to capture all appropriate literature. Using predefined criteria, each research paper is then ranked to provide a

measure of appropriateness or utility. Frequently research papers are conflicting, inconsistent or inconclusive, and sometimes there simply is no valid literature on a topic. Under such circumstances, established protocols spell out how the process of consensus development is undertaken. The procedure provides the reader with a transparency of process that allows one to trace the recommendation back to the raw literature.

International experts in best practice and other guideline development have established what are termed the AGREE criteria, a "scorecard" used to grade any best-practices or guideline document. CCGPP is committed to strict adherence to the AGREE principles, which will make the *Clinical Compass* relevant and useful to field doctors, as well as scientifically defensible.[13]

Our goal is to provide a tool that is useful to doctors, patients, third-party payors and government agencies. To do so, it must be valuable and applicable, have broad input, and be resistant to scientific scrutiny or challenge.

To achieve the latter, we must be careful to follow the internationally accepted standards, such as AGREE, or risk the fate of the CCP and ICA guidelines, which fared poorly under their requirements. To achieve the former, we intend to seek input from any interested stakeholder by soliciting input following the release of each draft chapter.

The new *Clinical Compass* will assist clinicians in determining the most effective choices for treatment of specific conditions, while providing third-party payors and regulators with realistic and supportable treatment paradigms. As a profession, we can continue to allow outsiders or outliers to define what we do and who we are as a profession, or we can take charge of our own destiny, to benefit our patients.

Centuries ago, voyagers learned to use a compass to point the right way. *The Chiropractic Clinical Compass* will point the profession and providers towards rational, supportable care that will optimize patient outcomes and enhance the profession's public image. Please consider contributing to the *Compass* today by visiting www.ccgpp.org.

References

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12. For more information, visit the Council on Chiropractic Guidelines and Practice Parameter Web site: www.ccgpp.org.
13. The AGREE Collaboration. Appraisal of Guidelines for Research & Evaluation (AGREE) Instrument. www.agreecollaboration.org.

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Editor's note: This is the latest in a series of articles on the CCGPP best practice initiative. The first article (www.chiroweb.com/archives/22/23/08.html), written by Dr. Ronald J. Farabaugh, COCSA representative to the CCGPP, provided background on the initiative; the most recent article (www.chiroweb.com/archives/23/15/03.html), written by Dr. Mark Dehen, CCGPP treasurer, also discussed the *Chiropractic Compass*.

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