Dynamic Chiropractic

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Outcomes Assessment in Chiropractic Practice

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In the modern health care environment, chiropractors are required to be effective and efficient. We must do all we can to help decrease acute and chronic pain, as well as increase structural integrity. Our treatment plans must move from passive care (adjustments and unassisted physiotherapy modalities) to active care (adjustments and conditioning/work hardening exercise programs), with appropriate structural support.

We now are very aware of the importance of assessing and reporting the outcomes of our treatment procedures. The hallmark of an outcome assessment is that it is quantifiable and comparable to previous and future evaluations. This process has become an essential part of health care services and especially of rehab programs.

From the doctor's standpoint, we need to know whether our care is improving the patient's well-being, and if so, by how much. This helps us plan for further care or referral. The patient also should have some form of assessing the benefits (if any) of our treatment regimen in order to make an informed decision about whether to continue treatment. And finally, whoever is paying for this care deserves to be provided with an evaluation of the progress of the patient under our care.

Briefly, an outcome assessment is defined as "a form of measurement of progress toward a specific goal." The many and varied types of evaluations that are done to assess the outcomes of chiropractic rehabilitation fall into two general areas: subjective and objective determinations. Both can be very helpful in evaluating progress; they provide an insight into two different components of the healing process.

For subjective evaluations, the patient is given the Quadruple Visual Analogue Scale, the Neck/Back Bournemouth Questionnaire, and the new Pain Disability Questionnaire (better than the Oswestry Questionnaire) to complete the assessment. In the objective realm, I like to use postural and gait evaluations as primary indicators of a patient's progress. These assessments need to be performed on a regular schedule, generally no more than on a monthly basis.

Quadruple Visual Analogue Scale (QVAS)

The Quadruple Visual Analogue Scale (QVAS) is a reliable and valid method for pain measurement. The QVAS is based on four specific factors:

- pain level at the time of the current office visit;
- typical or average pain since the last visit (or since the initial visit or since the onset of the condition) depending on the chronicity of the condition;
- pain level at its best since the last visit, time of intake or onset of the condition; and
- pain level at its worst since the last visit, time of intake or onset of the condition.

The scores from factors 1, 2 and 4 above are averaged and then multiplied by 10 to yield a score from

zero to 100. The final score is then categorized as "low-intensity" (pain < 50) or "high-intensity" (pain > 50).

Neck/Back Bournemouth Questionnaire

The Bournemouth Questionnaire is a comprehensive outcome measure for back pain. The instrument has established validity, consistency and reliability, and demonstrated responsiveness to clinical change. It is practical for both the efficacy and effectiveness of back pain treatments. It measures the following seven back pain model traits: pain intensity, daily activities, recreational/social/family activities, anxiousness, depression, work activities and pain control.

A score of zero to 10 is possible for each of the seven categories, which provides a total possible score of 70, where 70 represents the highest disability score possible and zero represents the best spinal health score.

Pain Disability Questionnaire

The Pain Disability Questionnaire (PDQ) is a comprehensive psychometric evaluation of functional status. The focus primarily is on disability and function. This instrument is designed for the full array of chronic disabling musculoskeletal disorders, rather than low back pain alone. The psychometric properties of the PDQ are excellent, demonstrating strong reliability, responsiveness and validity.

The PDQ is made up of two factors: a Functional Status Component, comprising a maximum score of 90, and a Psychosocial Component, comprising a maximum score of 60. This yields a total functional disability score ranging from zero to 150.

Progress Appraisal

The use of adjustments, rehabilitative exercises and subjective/objective outcome measures are critical when a functional approach is taken. Outcome assessments keep everyone apprised of the progress (if any) of the patient in response to health care services.

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