



Chiropractic Care for Low-Back Pain

A New US Clinical Practice Guideline

A Introduction

IN THE PAST HEALTH CARE WAS clinician-centered and based upon accumulated clinical experience and wisdom. The doctor knew best.

In this era of controlled trial research and clinical guidelines it is increasingly evidence-based and patient-centered. There is a doctor-patient partnership. Further than that there is commonly a third partner – the payer.

These realities are reflected in a new, national, clinical practice guideline titled Chiropractic Care for Low-Back Pain from the US Council on Chiropractic Guidelines and Practice Parameters (CCGPP) just published in the Journal of Manipulative and Physiological Therapeutics (JMPT)¹.

Why does the chiropractic profession need such a guideline when there are national, multidisciplinary guidelines in the USA and other countries? Several reasons include:

- Multidisciplinary guidelines provide broad recommendations (e.g. which interventions to use, major elements of assessment and measurement of outcomes/results) but not profession-specific details (e.g. exact assessment methods, frequency and duration of care, content of clinical records).
- Chiropractic guidelines address issues of significance to chiropractors and their patients, such as alternative treatment options and avoidance of unnecessary reliance on medications and surgery.
- Profession-specific guidelines can be valuable in navigating third party payer rules and requirements, and providing a basis for justifying appropriate continuing care.

2. Examples of the significance of the new Guideline are:

- It makes a clear commitment to evidence-based practice (EBP), defined as the use of “clinical methods that generally reflect the best available evidence, combined with clinical judgment, experience, and patient preference.”

- The Guideline explains that this means that chiropractic management, in addition to spinal manipulation and other manual therapies, should include exercises (“active care”) and patient education aimed at patients’ taking responsibility for their own health

- For care to be considered “beneficial”, “it must be substantive, meaning that a definite improvement in the patient’s functional capacity has occurred”. This means there must be measurement of functional capacity and improvement to justify and support care. Examples given of measurement methods include pain scales; validated measures of activities of daily living and disability such as the Oswestry, Roland Morris and Bour-nemouth Disability Questionnaires; increases in work capacity; improved functional capacity testing using validated measures; and reduction in the use of medications.

- New features include a recommendation against routine use of imaging or other diagnostic tests for patients with nonspecific low-back pain (LBP). There are recommendations on when such imaging/tests should be considered.

Reflecting the overall move in health care to patient-centered care the Guideline gives this definition of the goal of chiropractic care: “It is the ultimate goal of chiropractic care to improve patients’ functional capacity and educate them to accept independently the responsibility for their own health”.

From this it can be seen that this Guideline speaks not only to doctors of chiropractic but also to patients and all other

Professional Notes

Cost-Effectiveness – Chronic LBP Seniors

In the US, as in most countries, seniors (age 65 and older) with chronic back pain give rise to large health care costs of increasing concern to third party payers. This is particularly true for those with comorbidities – 62% or the majority in the US.

As this population is covered by the US federal government’s Medicare program there have been urgent calls for new models of care for these comorbid patients.

This explains the importance of a new study of Medicare data by health policy experts, funded by the National Institutes of Health (NIH) which:

- had the goal of determining whether the use of chiropractic treatment vs medical treatment was associated with lower costs in multiply-comorbid patients – specifically those with chronic LBP, an additional musculoskeletal disorder and a mental health disorder diagnosis
- found that, after weighting to make

continued on page 4

stakeholders in the health care system. It demonstrates that the profession is here to work as equal partners with others in mainstream health care to deal with the massive problem of poorly-managed patients with spinal pain and disability.

This issue of The Chiropractic Report reviews the background to the new Guideline, the process by which it was developed, and features of particular significance to clinicians.

B Background

3. In 1995 the chiropractic profession in the USA established the Council on Chiropractic Guidelines and Practice Parameters (CCGPP) to develop national clinical guidelines and other publications “to facilitate best practices specific to the chiropractic management of patients with common, primarily musculoskeletal disorders.”

This was to continue the ground-breaking work of the Mercy Center Consensus Conference, led by Dr Scott Haldeman and supported by the American Chiropractic Association, the International Chiropractors’ Association, the Congress of Chiropractic State Associations (COCSA) and other organizations, which had produced the profession’s first ever national clinical guidelines in 1991.

The CCGPP was hosted and formed by COCSA which was seen by all as the most representative body in the US with member state associations of every philosophical stripe. COCSA continues to retain that inclusive and representative membership.

Since 1995 COCSA’s CCGPP has produced best practice documents on chiropractic management of various conditions (e.g. spinal; upper and lower extremities; fibromyalgia; tendonopathies; shoulder pain and disorders; osteoarthritis of the hip, non-musculoskeletal conditions), sub-groups (e.g. older adults; infants/children/adolescents) and of care to promote health and wellness. These are referenced in the new Guideline and may be found at the CCGPP’s website www.clinicalcompass.org.

With respect to low-back pain (LBP) the CCGPP has produced:

- A 2010 clinical guideline on management of chronic spine-related pain
- In 2012 a companion document with

algorithms for the management of each of acute and chronic pain

- Now this 2016 update clinical guideline for acute and chronic LBP.

The 2010/2012 guidelines are at the website. The new one will be in due course after print publication in JMPT.

C Process

4. The CCGPP panel for the Guideline was led by Gary Globe DC, PhD, MBA, an experienced and expert clinician who was formerly a senior member of the clinical faculty at Cleveland Chiropractic College, Los Angeles and is now Senior Manager, Global Health Economics, Amgen Inc, Thousand Oaks, California. The process for development of the new guideline, following what has become established procedure in clinical guideline development, was:

a. **Literature review.** A systematic review of the research published since the last guideline in 2010 – up to February 2014. Three expert reviewers determined what new literature was of acceptable quality and relevant to the central question: “What is the effectiveness of chiropractic care including spinal manipulation for non-specific, low-back pain?” Sixteen studies were accepted, 12 systematic reviews and 4 new randomized, controlled trials (RCTs). Main areas of new information found in the new trials were standards for assessment of LBP and appropriate dosage (frequency and duration of care).

b. **Delphi Panel.** Summaries of these new publications and the past 2010/2012 CCGPP Guideline were sent to a 37-member review panel, comprising 33 doctors of chiropractic (including 29 experienced clinicians representative of the profession) most of whom had participated on past CCGPP panels. Some were added by the CCGPP Steering Committee, and there were 4 clinicians from other relevant professions who were expert in the management of LBP. These were a medical physician also qualified as an acupuncturist, an orthopedic surgeon, a physical therapist and a massage therapist. All panelists are named in the new guideline. Importantly, the panel worked via email identified only by ID numbers, so that members were not aware of each other’s identity during their review of the evidence and seed statements. Such

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a review panel is known as a Delphi panel.

c. **Seed Statements.** Also sent to the panel were 51 seed statements, potential statements for the new Guideline, based on the background guidelines and the new information. These seed statements were produced by a two-step process:

- Development through unanimous agreement of the Steering Committee, which comprised authors of the previous guidelines, then
- Review by the clinical and academic faculty at the Logan University College of Chiropractic, St Louis, Missouri, which led to several relatively minor amendments.

d. **Consensus Process.** Panel consensus on which statements to include in the new guidelines, and any necessary amendments, was reached using the RAND-UCLA (RAND Corporation – University of California at Los Angeles) methodology for consensus. In summary:

- Each seed statement is ranked from 1 (highly inappropriate) to 9 (highly appropriate) with ‘appropriateness’ defined as “the expected patient health benefits are greater than expected negative effects by a large enough margin that the action is worthwhile, without considering costs.”

- Consensus that a statement is appropriate is reached if the mean or average rating is 7 or higher, and at least 80% of the panelists ratings for the statement are 7 or higher.

- If consensus is not reached on any statement in the first round the Steering Committee, having received median scores, percentages and comments from the Project Coordinator, revises the statement after consideration of comments and any evidence in support given. Such revised statements go out to the panel on another round. There can be several rounds, and there is provision for a minority report if consensus cannot be achieved.

- There was consensus after two rounds – the initial one and a second one addressing comments received.

e. Public Comment. Next the draft Guideline was posted at the CCGPP website for public comment. This was for a 2-week window of time that had been advertised in press releases and the chiropractic media reaching all licenced chiropractors in the USA, and by direct email to all members of state associations and state licencing bodies, all US chiropractic colleges, and various other groups including chiropractic attorneys, practice managers and vendors. From comments received some statements were added or modified. These then received consensus from the Delphi panel in a further round of consultation.

D The Guideline

5. The great majority of the text of the new publication in JMPT is the text of the 51 guideline statements, which should be read in full. Here are significant features of the Guideline:

a. Definitions of Pain. It is quite amazing that the health care community has not yet agreed upon standard definitions of what is acute, sub-acute and chronic pain. Here the definitions are:

- Acute – symptoms persisting for less than 6 weeks
- Subacute – symptoms persisting for between 6 and 12 weeks
- Chronic – for at least 12 weeks
- Recurrent/flare-up – return of symptoms perceived to be similar to those of the original injury at sporadic intervals or as a result of exacerbating factors.

Pain may be mild, moderate or severe. Mild recurrent pain should be treated as chronic pain. Moderate or severe recurrences should be treated as acute pain. See more on this below.

b. Examination. A thorough history and “evidence-informed examination procedures” are “critical components of chiropractic clinical management” to provide “the clinical rationale for appropriate diagnosis and subsequent treatment planning”. Assessment should include:

- Health history (e.g. pain characteristics, red flags, review of systems, risk factors for chronicity)
- Assessment for specific causes of LBP (e.g. aortic aneurysm, inflammatory disorders)
- Examination (e.g. reflexes, dermatomes, myotomes, orthopedic tests)

- Diagnostic testing (e.g. imaging, laboratory tests) where indicated, for example for red flags (e.g. suspected fracture) or for persistent LBP accompanied by signs or symptoms of radiculopathy or spinal stenosis). As already mentioned there is a recommendation against routine imaging for patients with non-specific LBP, which is consistent with other LBP guidelines such as those by the American College of Physicians and American Pain Society.

c. An Initial Course of Chiropractic Treatment. Components of an initial course of chiropractic treatment for low-back disorders for the typical patient, “to be consistent with an evidence-based approach”, should include:

- spinal manipulation and/or mobilization, which are the manual therapies with the most evidence of effectiveness, and other manual therapies
- exercises/active care. This means that exercise, now established as the most proven method of primary and secondary prevention of LBP, has now joined joint adjustment as a core component of chiropractic care
- patient education, designed to reassure the patient and instill optimal strategies for independent, self-management.

These additional treatment methods are mentioned in the Guideline’s review of the components of an initial course of chiropractic management:

- Physiotherapeutic modalities (e.g. ultrasonography, electrical stimulation). Although the evidence does not support the use of these alone, their use for pain reduction “as part of a passive-to-active care multimodal approach to LBP management may be warranted based on clinician judgment and patient preferences.” In other words, the first arm of EBP, published research, does not support the use of these modalities as a primary treatment approach. The second and third arms, clinician judgment/experience and patient preference, may support their use as part of a wider package of care with a primary emphasis on manual therapy, exercise and advice. This demonstrates a feature generally found in all professional guidelines – support for commonly used and reimbursed treatment methods where appropriate. The challenge, answered well in this Guideline, is to strike the right balance between respecting clear messages from the research evidence on one hand, and practice experience on the other.

- Lumbar supports (e.g. bracing, taping, orthoses). These are not recommended for routine use because of lack of supportive evidence, and because “these orthopedic devices may interfere with conditioning and return to regular activities of daily living (ADLs)”. However “there may be some utility in both acute and chronic conditions based upon clinician judgment, patient presentation, and preference”.

Clinical yellow flags, psychosocial factors such as anxiety, depression or catastrophizing, “should be identified and addressed as early as possible as part of a comprehensive approach to clinical management.”

d. Frequency and Duration – First Trial of Care. The Guideline presents nothing new here. A typical therapeutic trial of chiropractic care for all patients, whether presenting with acute, sub-acute or chronic non-specific pain, is 6 to 12 visits over 2-4 weeks. Fewer treatments may be necessary for patients with acute, uncomplicated conditions, whereas “addi-

continued on page 6

The Chiropractic World

Cost-Effectiveness – Chronic LBP Seniors

continued from page 1

sure that patient groups were truly comparable, overall costs of care, back surgery rates and pharmaceutical costs were substantially lower for those receiving chiropractic treatment

- reported that these findings suggested first line use of chiropractic treatment for the management of older, comorbid, chronic LBP patients.

Principal investigator in the joint medical and chiropractic research team was William Weeks MD, PhD, MBA, Professor, Geisel School of Medicine, Dartmouth Institute for Health Policy and Clinical Practice, Lebanon, New Hampshire, who now holds a cross appointment as Director, Health Services and Clinical Research, Palmer College of Chiropractic.

This was a retrospective study of Medicare fee-for-service reimbursement data for the period 2006-2012, for 73,326 multiply-comorbid patients with chronic LBP episodes who fell into one of four treatment groups: chiropractic manipulative treatment (CMT) alone; medical care alone; CMT then medical care; and medical care then CMT.

Medicare Part A expenses cover hospital and home health expenditures. Medicare Part B expenses cover doctors' services and other outpatient expenses. Part D covers prescription medications.

- Patients using CMT alone had the shortest back pain episodes
- Compared with those receiving medical care alone, those receiving CMT alone had "about 80% lower" Medicare Part A expenditures, and "about 50% lower" Parts B and D expenditures.
- Higher expenditures for CMT resulted in lower expenditures for "psychiatric, physical therapist (PT), or DO services and substantially lower pharmaceutical (and particularly pain medication) costs." Further, back surgery rates were "substantially lower" for patients who only used CMT.

Weeks et al. looked at comorbidities that included mental health disorders because, as they note, "it has become increasingly evident that chronic pain is associated with high rates of diagnosable psychopathology, and that unrecognized and untreated psychopathology can interfere with rehabilitation". Anxiety decreases pain tolerances. Depression worsens treatment outcomes. For older US adults, undiagnosed mood disorders are "reaching levels of 75% among those with chronic LBP".

(Weeks WB, Leininger B et al. (2016) The association between use of chiropractic care and costs of care among older Medicare patients with chronic low-back pain and multiple comorbidities, *J Manipulative Physiol Ther* 39:63-75.)

Other Research

WFC Award-Winning Papers

The January 2016 issue of JMPT published the four award-winning original research papers presented at the World Federation of Chiropractic's 13th Biennial Congress held in Athens, Greece

last May, and these illustrate the range and quality of contemporary chiropractic research. These leading papers come from research teams in Canada, the UK and the USA.

Subclinical Neck Pain (SCNP) Compromises Mental Function.

First prize in the NCMIC Louis Sportelli Original Research Competition at the WFC Congress, known as the Scott Haldeman Award, went to Canadian researchers Julianne Baarbé, Michael Holmes et al. for a study demonstrating that subjects with subclinical neck pain (mild to moderate pain for which they were not seeking care) had less mental agility than subjects with no pain.

Those in each group were shown an item on a computer screen a number of times – the letter R normally and backwards in various orientations/angles – and asked to identify whether the image was normal or backwards. Mental rotation ability was compromised in individuals with SCNP when compared with healthy controls, and remained worse when re-measured after 4 weeks with no intervention. Reduced ability was not considered to be related to pain because subjects had minimal pain on the testing days.

This study is part of a continuing line of chiropractic research commenced by Bernadette Murphy and Heidi Haavik, both of whom were co-authors, which is looking at the impact of joint dysfunction or subluxation on sensorimotor integration - the processing of sensory information within the nervous system to formulate appropriate motor outputs.

(Baarbé J, Holmes MWR et al. (2016) Influence of subclinical neck pain on the ability to perform a mental rotation task: a 4-week longitudinal study with a healthy control group comparison. *J Manipulative Physiol Ther* 39:23-30.)

Big Data on Results and Cost of Chiropractic Care using PROMS

Dave Newell, Emily Diment and Jenni Bolton from the Anglo-European College of Chiropractic in the UK won second prize for a study testing the feasibility of using a web-based process for collecting big or aggregated data on the results and costs of chiropractic care.

Using the Care Response system (care-response.com), based in the UK but now used by individual chiropractors internationally, and its patient-reported outcomes measures (PROMS – such as the Bournemouth Questionnaire) as reported by 844 patients in 33 participating chiropractic clinics, Newell et al. demonstrated:

- The implementation of PROM collection using a web-based system is feasible in chiropractic clinical practice.
- Most patients undergoing chiropractic care experienced substantial clinical improvement at reasonable cost, and the level of care exceeded their expectations.
- Collecting and aggregating routine patient outcomes can generate information that may be used by and valuable to patients, clinicians, the profession as a whole and third party payers.

(Newell D, Diment E et al. (2016) An electronic patient-reported outcome measures system in UK chiropractic practices: a feasibility study of routine collection of outcomes and costs. *J Manipulative Physiol Ther* 39:31-41)

Basic Science – Spinal Manipulation Reduces Inflammation and Pain

Third prize went to Song XJ, Huang ZJ et al. from the Parker University Research Institute in Irving, Texas in the USA for a sophisticated animal experiment with laboratory rats showing that spinal manipulation:

- reduced neuropathic pain due to intervertebral foramen compression
- reduced postoperative pain after relief of nerve compression
- reduced neural inflammation and nociceptive neural hyperexcitability
- increased endogenous anti-inflammatory cytokine IL-10 in the spinal cord.

Neuropathic and postoperative pain were mimicked by chronic compression of dorsal root ganglia (CCD) then decompression (de-CCD). Behavioral pain after CCD and de-CCD was determined by the increased thermal and mechanical hypersensitivity of the affected hindpaw. Various methods were used to examine the neural inflammation, neural excitability, and expression of inflammatory and anti-inflammatory cytokines. An activator adjusting instrument was used to deliver force to the spinous processes of L5 and L6.

(Song XJ, Huang ZJ et al. (2016) Attenuation effect of spinal manipulation on neuropathic and postoperative pain through activating endogenous anti-inflammatory cytokine interleukin 10 in rat spinal cord. *J Manipulative Physiol Ther* 39:42-53)

Success with NHS-Referred Patients in the UK

The Private Practice Award went to Jonathan Field, the UK chiropractor who has developed the Care Response online clinical records and outcomes system (care-response.com) which is available to all chiropractors at no or minimal cost. Since 2014 the UK National Health Service (NHS) has provided funding for chiropractic services for patients referred by general medical practitioners (GPs) on NHS pathways. The purpose of this study was to examine and compare the outcomes of NHS and private patients following chiropractic care.

There was a population of 8,222 private (4,851 – 59%) and NHS (3,371 – 41%) patients, with one or more musculoskeletal complaints. Approximately 75% had back pain, 24% shoulder pain, and 10% and 40% upper and lower extremity pain respectively. Primary outcome measure was patient-reported improvement on the Bournemouth Questionnaire, with data collected via the Care Response system.

Both groups of patients, whether private or referred via their NHS GP, experienced excellent outcomes across a range of patient-reported outcome and experience measures. The study supports the contention that chiropractic services as provided in UK are appropriate for both private and NHS-referred patient groups and should be considered when GPs make decisions concerning referral routes and pain pathways for patients with spinal and other musculoskeletal pain and disability.

(Field J and Newell D (2016) Clinical outcomes in a large cohort of musculoskeletal patients undergoing chiropractic care in the United Kingdom: a comparison of self- and national health service-referred routes. *J Manipulative Physiol Ther* 39:54-62)



Lindsay Rowe 1956-2016

Lindsay Rowe DC, MD, DACBR of Newcastle, Australia, the distinguished radiologist, author and international lecturer, passed away on January 25, 2016 at the age of 60 after a brave and inspiring 15 month battle with cancer. He survived by his wife Anne and children Ryan and Hannah.

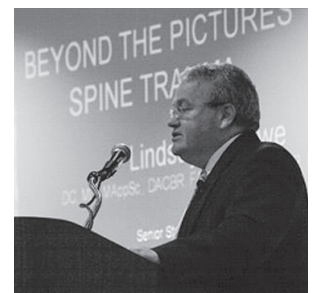
The chiropractic profession has lost one of its most loved and respected sons. Messages poured in from around the world. "Lindsay is one of those people who have made a difference," wrote US neurologist and chiropractor Dr Scott Haldeman, "not only personally to anyone who spent time with him but also professionally and to society at large. He was a world-respected spine radiologist who none-the-less was willing to donate his time, energy and expertise to help people with lesser qualifications, knowledge or resources."

"His lecturing ability was incomparable" said Dr Glynn Till of South Africa. "He influenced the lives of many, many people around the world and it is an honour to have known him," wrote Dr Jean Moss, Past President of the Canadian Memorial Chiropractic College (CMCC).

"Lindsay reached out to and transformed the hearts and minds of so many people and our lives are enriched because of him," said Australian colleague Dr Dein Vindigni, who noted "Lindsay's passion for life and learning . . . the great love, encouragement and support he wholeheartedly gave to family and friends" and "his unforgettable laugh, cheeky smile and readiness to lend all a helping hand."

Dr Rowe received his DC degree with honours from the Royal Melbourne Institute of Technology in 1979, subsequently became board certified in radiology while practicing chiropractic, and chaired the Department of Radiology at CMCC in Toronto from 1982-84. With Dr Terry Yochum he co-authored the internationally respected *Essentials of Skeletal Radiology*, widely used as a text in both chiropractic and medical schools.

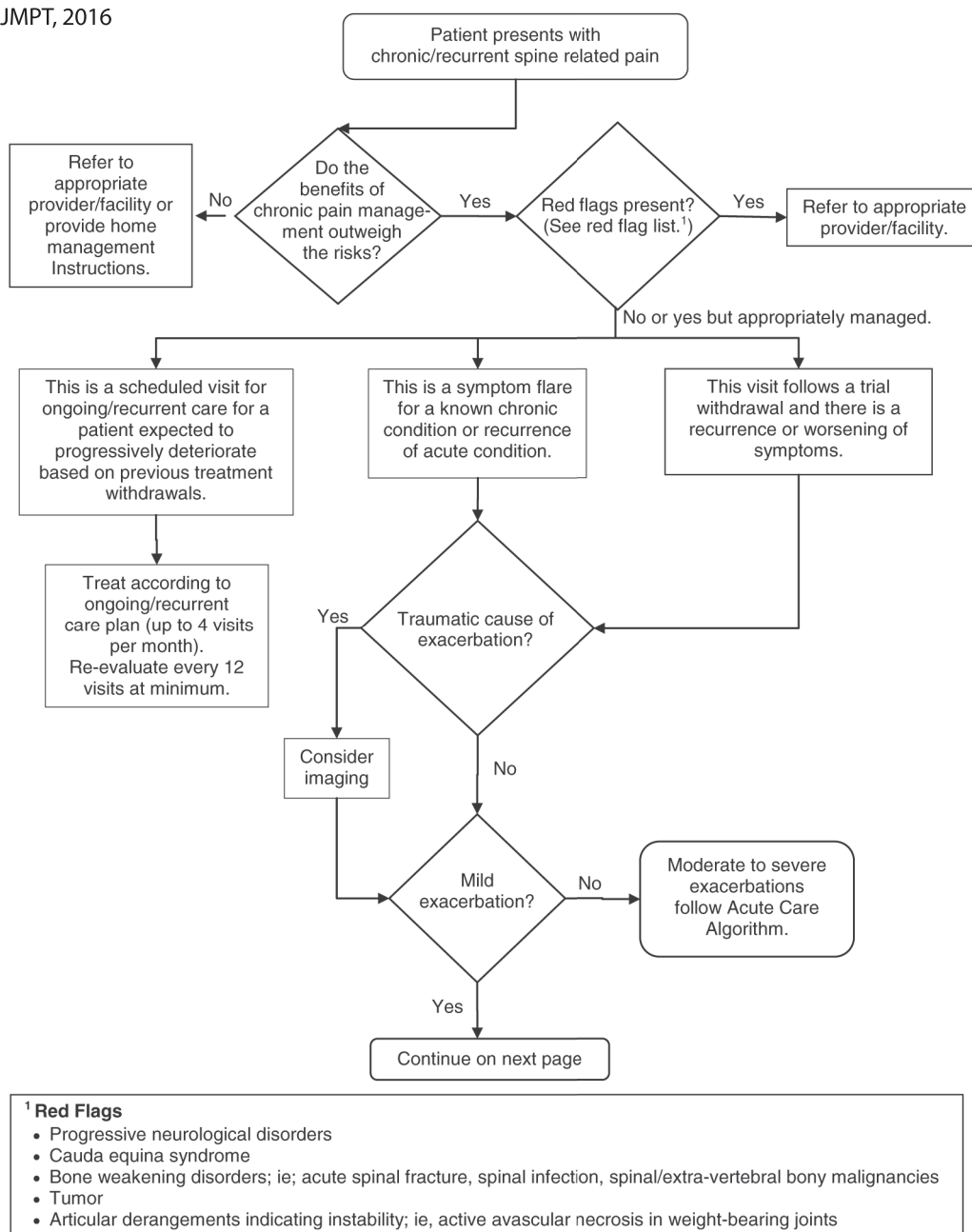
In the 1990s he completed a medical degree at the University of Newcastle in New South Wales, Australia, a residency program in general and emergency medicine and surgery, then a fellowship in interventional and diagnostic radiology. He became an associate professor at the University of Newcastle and embarked upon a distinguished career in medical radiology. He continued to lecture internationally for the chiropractic profession, being an automatic and much-anticipated keynote speaker at each biennial congress of the World Federation of Chiropractic.



Dr Rowe at the podium.

Figure 1 Chronic Care Algorithm

From Globe et al., JMPT, 2016

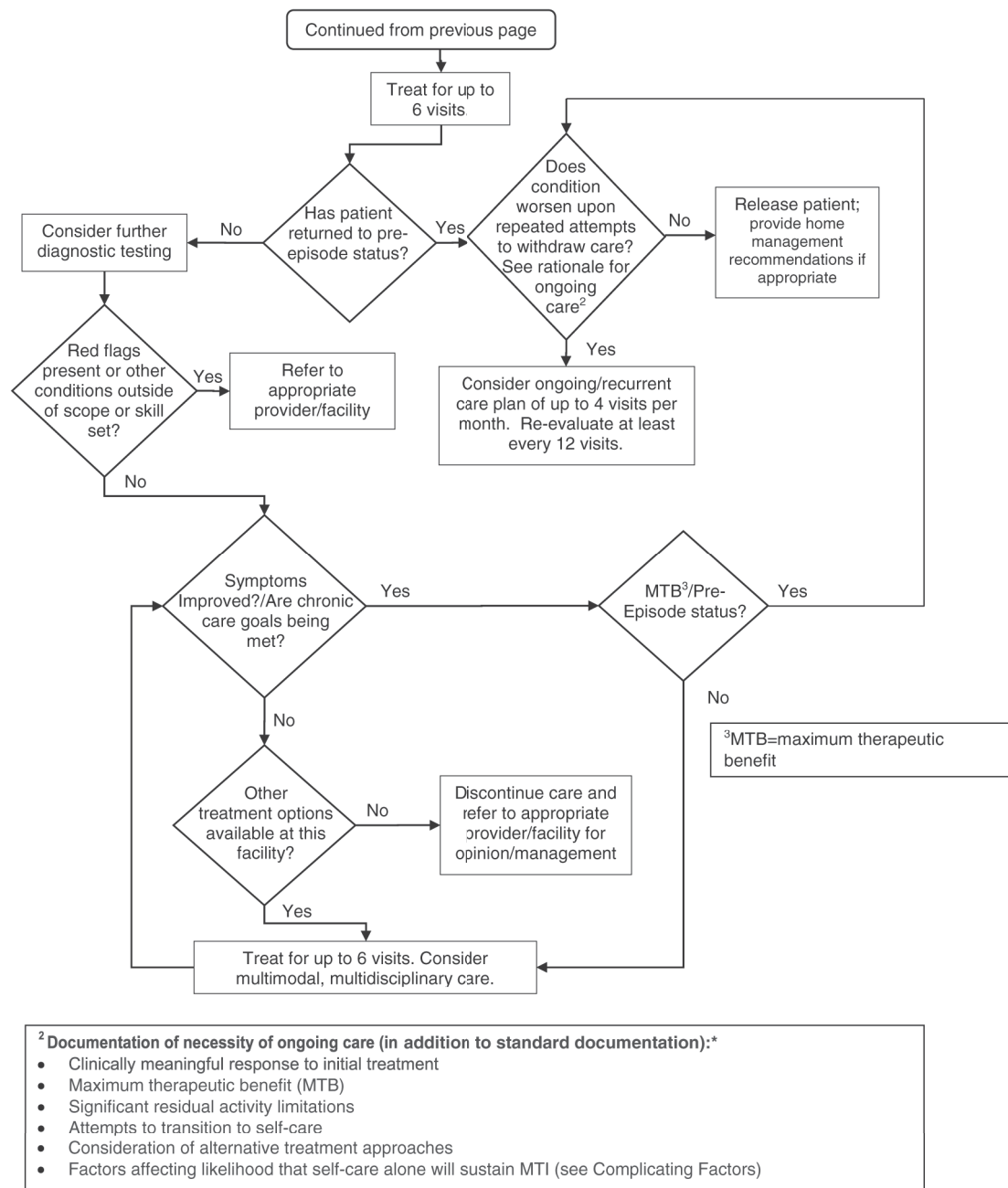


tional time and treatment to observe a therapeutic response” may be needed for individual patients with specific barriers to recovery (e.g. co-morbidities, yellow flags) which should be recorded.

e. Reevaluation. After this initial trial or course of care a focused reevaluation should be performed “to determine whether the patient has made clinically meaningful improvement”. Need for additional treatment is based upon response to care and potential for additional gains.

For there to be clinically meaningful improvement or response to care there must be “a definite improvement in the patient’s functional capacity” as demonstrated by appropriate, measurable results found upon reevaluation and documented in the patient’s clinical record. These results or outcomes may include:

- Pain scales such as the visual analogue scale and the numerical rating scale
- Pain diagrams that allow the patient to demonstrate the location and character of their symptoms
- Validated activities of daily living (ADL) measures, such as the Revised Oswestry Back Disability Index, Roland Morris Back Disability Index, RAND 36, and Bournemouth Disability Questionnaire
- Increases in home and leisure activities, in addition to increases in exercise capacity
- Increases in work capacity or decreases in prior work restrictions
- Improvement in validated functional capacity testing, such as lifting capacity, strength, flexibility and endurance.



The evidence does not support spinal range of motion assessment as a reliable method of determining functional status.

f. Frequency and Duration – Additional Care. The Guideline addresses additional or further care in these forms:

- Continuance of initial care through to maximum therapeutic benefit (MTB), with treatment tapered then discontinued and with there having been a continuing transition to active care and patient self-management. The criteria for this continued care are “substantive, measurable functional gains” achieved but “remaining functional deficits.” At MTB “the DC should perform a final examination, typically following a trial of therapeutic withdrawal, to verify that MTB has been achieved and provide any necessary patient education and instructions in effective future self-management and/or the possible need for future chiropractic care to retain the benefits achieved.”

- Management of flare ups/recurrent episodes. When these involve moderate or severe pain they are to be managed on the same basis as an acute episode, when mild pain only on the same basis as chronic pain

- Chronic pain management – see below.

- Wellness care. Formerly called maintenance care, this is optional care which may be offered to and chosen by the patient, defined in the Guideline as “care to reduce the incidence or prevalence of illness, impairment, and risk factors and to promote optional function.”

6. Chronic Pain Management. There are many detailed recommendations on chronic pain management, and a warning about taking specific statements out of context, so it is important to read the full Guideline. Having said that, here is a summary of significant points.

a. Definition of Chronic Pain Patients. These are “those for whom supervised treatment/care has demonstrated clinically meaningful improvement with a course of management and who have reached MTB, but in whom substantial residual deficits in activity performance remain or recur upon withdrawal of treatment.”

b. Chronic Care Goals. These are listed as:

- Mimimize lost time on the job
- Support patient’s current level of function/ADL
- Pain control/relief to (level of) tolerance
- Minimize further disability
- Minimize exacerbation frequency and severity
- Maximize patient satisfaction
- Reduce and/or minimize reliance on medication.

c. When Medically Necessary. Chronic pain management through continuing chiropractic treatment may be “both medically necessary and appropriate” when the benefits outweigh the risks, which are “physician dependence, somatization, illness behavior, or secondary gain.” Such management is appropriate when:

- “rehabilitative and/or functional restorative and other care options, such as psychosocial issues, home-based self-care and lifestyle modifications have been considered and/or attempted”
- “withdrawal/reduction (of the treatment) results in the exacerbation of the patient’s condition and/or adversely affects their ADLs.”

Need for care is established when there is “minimal clinically important change” for more than 24 hours in pain and/or pain-related difficulty in performing tasks and actions. For

example, increase on a numerical rating scale for pain of more than 2 points out of 11 is such a change for chronic LBP.

d. Frequency and Duration of Care. Even when necessary, care is much less frequent than for an initial course of care. The Guideline suggests “a reasonable therapeutic trial” of ongoing care is “up to 4 visits” after a therapeutic withdrawal and loss of prior functional gain. If reevaluation then indicates further care this may be “up to 4 visits per month” with routine monitoring/evaluation of changes in pain and function to determine appropriateness of continued care. This caution is given:

“The majority of chronic pain patients can self/home-manage, be managed in short episodic bursts of care, or require ongoing care at 1-2 visits per month. . . . It is rare that a patient would require 4 visits per month to manage even advanced or complicated chronic pain.”

e. Documentation. Such care requires considerable documentation. In addition to standard elements (e.g. date, history physical evaluation, diagnosis, treatment plan) “the clinical information typically relied upon to document the necessity of ongoing chronic pain management includes”:

- Documentation of having achieved a clinically meaningful, favorable response to initial treatment, or documentation that the plan of care is to be amended
- Documentation that the patient has reached MTB
- Substantial residual deficits in activity limitations are present at MTB
- Documented attempts to transition to primary self-care
- Documented attempts and/or consideration of alternative treatment approaches
- Documentation of those factors that self-care alone will be insufficient to sustain or restore MTB

f. Chronic Care Algorithm. The General, Acute Care and Chronic Care algorithms are unchanged from those appearing in the CCGPP’s 2012 algorithms and may be found at www.clinicalcompass.org. The chronic care one, illustrating how an algorithm is easier for clinicians to follow than text, is shown as Figure 1.

E Conclusion

7. As the CCGPP Guideline is based upon the international literature, and as chiropractic education and practice have a similar basis worldwide, this new Guideline is of global significance. For chiropractors outside the USA it defines the clinical direction of the US profession. In the same way that the past practice of medicine has frequently been paternal and doctor-centered and neglectful of alternative approaches to management that the patient might prefer and benefit from, the practice of chiropractic has often been chiropractor-centered and neglectful of the possibilities of co-management or a team approach or patient self-care. This Guideline documents the significant, evidence-based, patient-centered evolution well underway in the profession. **TCR**

Reference

1 Globe G, Farabaugh RJ et al. (2016) *Clinical Practice Guideline: Chiropractic Care for Low Back Pain* J Manipulative Physiol Ther 39:1-22.

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