The Chiropractic Report

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The Miami Conference

The Changing Healthcare Environment Reviewed

A. Introduction

DURING THE 20th CENTURY healthcare systems and delivery were increasingly monopolized and dominated by the medical profession.

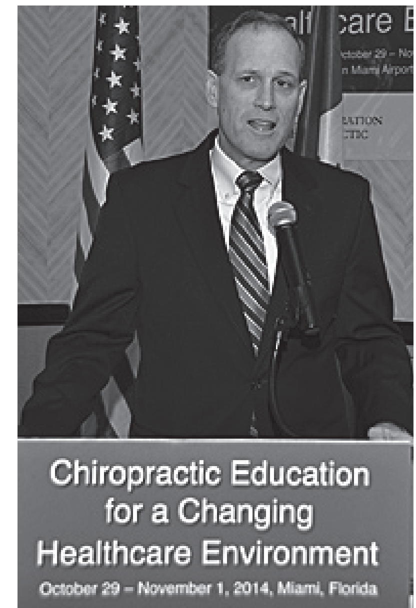
On one hand medical science and practice brought amazing new achievements. On the other hand the roles and perspectives of patients, other health professionals and the third parties who paid for healthcare – be they employers or governments – were suppressed. The medical profession and its trade organizations made the rules.

A strong reaction was becoming evident by the 1990s. This was seen in the rise of managed care in Europe and North America, and patient empowerment and demands for more choice. It was seen in the rise of other health professions, but an overall loss of freedom of health professionals. They were now asked to follow increasingly specific care pathways and protocols and to demonstrate good results if they were to have access to patients and be reimbursed for their services. Just ten years ago successful American physicians and surgeons could sell their practices for very substantial prices because of their control of healthcare. Today a practice has little value because so much of the market of potential patients is controlled by payers rather than the physicians and surgeons themselves.

All of this provides challenges for chiropractors and other health professionals, caught up in a seismic change of authority, power and management in healthcare. However, it also provides huge opportunity as never before for the chiropractic profession, given the prevalence of spinal and other musculoskeletal disabilities and the unsatisfactory and inefficient management of these problems under standard medical and surgical models of care.

2. This was the message heard from experts and discussed by the profession's leaders at a high-powered conference in Miami from October 29 to November 1, 2014. The theme of the conference, held by the World Federation of Chiropractic (WFC) and Association of Chiropractic Colleges (ACC) and jointly hosted by the American Chiropractic Association (ACA) and International Chiropractors' Association (ICA), was *Chiropractic Education for a Changing Healthcare Environment*. Speakers included:

- Health systems experts such as Steven Lipstein, President and CEO of the multibillion dollar healthcare system BJC Healthcare in the US midwest; Robert Jesse MD PhD, supervisor of healthcare in the vast US Veterans Health Administration system, which now includes chiropractic services and residency training; and Professor Ronald Harden from the UK, General Secretary of the Association for Medical Education in Europe.



ACC President Brian McAulay opens the conference.

Professional Notes

Acetaminophen Ineffective for LBP

Guidelines for the management of acute low-back pain all recommend acetaminophen, also known as paracetamol (e.g. Tylenol) as a first line analgesic. As Williams, Maher et al. explain in a major new trial published November 1 in the Lancet, "no direct evidence supports this universal recommendation." In particular:

- The few trials performed are small and "had substantial methodological flaws."
- No trial has compared paracetamol with placebo or compared as-needed dosing with the regular recommended dosing.

Accordingly Williams, Maher et al. performed a large, well-designed, multicenter trial "to establish whether regular or as-needed paracetamol improved short-term pain (1-12 weeks), disability, function, global rating of symptom change, sleep, or quality of life compared with placebo." They report that it does not – and question the endorsement of paracetamol for this patient group. This represents a major challenge to current guidelines and practice.

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Main Article *continued from page 1*

• Chiropractic clinicians, policy makers, researchers and educators from throughout the world describing the accelerated new integration of chiropractic services in their healthcare systems and what this means in terms of new requirements in chiropractic education – not just in undergraduate education but also in continuing education for practicing chiropractors in a rapidly changing world.

There were speakers from countries where the profession is strong such as Canada, Denmark, Switzerland, the UK and the USA, but also from countries where the profession is less established but still being invited into new clinical environments. Dr Ana Paula Facchinato and Dr Marta Casagrande from Brazil described the provision of chiropractic services in local government health units in their country. Dr Edgar Rivera-Ortiz from Puerto Rico, spoke of opening his private practice and soon being invited to work in the local hospital, where quickly learned skills and attitudes of interprofessional cooperation and ability to use common language have led to permanent chiropractic services welcomed by patients and medical staff.

Accordingly, this issue of The Chiropractic Report reports on the Miami Conference, focusing on issues of prime relevance and significance to clinicians.

B. The Program

3. **Opening Keynote Addresses.** These came from Mr. Lipstein, who obtained his Masters in Health Administration from Johns Hopkins University, and Dr Jesse, both chosen because they serve on the 19-person board of the Patient-Centered Outcomes Research Institute (PCORI), Lipstein as Vice-Chair. They were introduced by Dr Christine Goertz, Vice-Chancellor for Research and Policies at Palmer College, who also serves on the PCORI Board.

PCORI was established by the 2010 Patient Protection and Affordable Care Act, colloquially known as Obamacare, as a principal advisory body during a period of major change and realignment in America's healthcare system. It is charged with examining the relative health outcomes, clinical effectiveness, and appropriateness of different treatments, by evaluating existing studies and conducting its own. Its role is to give the federal government advice that will influence which healthcare services should be covered and reimbursed under federal programs, principally the Medicare program for citizens over age 65. Decisions there will, of course, influence employer-paid private health plans also. Therefore, the Conference was hearing from leading health policy experts.

• Mr Lipstein did not beat about the bush. He explained that changing demographics meant that Medicare and health costs generally were growing at an unacceptable rate in the US under present reimbursement policies. There was no option but to reduce costs. The future will not be governed by the preferences of health professionals but by delivery of value. Those who can deliver good results and patient satisfaction at better cost will be covered and rewarded. While this is a challenging era for all providers, Lipstein said, the chiropractic profession has a much more level playing field and new opportunity in the costly area of musculoskeletal health, currently not managed well.

• Dr Jesse, Chief Academic Affiliations Officer at the VHA and overseeing healthcare in the largest and most sophisticated hospital and health system network in the US, reinforced Mr Lipstein's message. This was from the point of view of a VHA system that has a broad range of health professionals, now including 65 doctors of chiropractic at 54 VHA facilities. In 2013 they saw over 10,000 patients and the number of chiropractors and patients is increasing steadily. Key points from Dr Jesse included:

• Choice of care in the VHA today is not just patient-centered but 'patient-driven'. Patient choice and welfare are major factors in choosing which initial and continuing care are offered and received.

• Given the range of services available in the VHA, this means that interprofessional education (IPE), cooperation and care are of central importance

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Steven Lipstein

Christine Goertz

Robert Jesse

• Therefore the era of dominance of one profession and its perspective is gone. Care is given according to the best available evidence and patient preference rather than professional designation of the provider.

4. **Session 1 – Change in Three Countries.** As the theme of the Conference was the change in healthcare environment for the chiropractic profession, Session 1 delivered case examples from invited speakers from three countries illustrating the opportunities now available to the profession.

• From Denmark Dr Jan Hartvigsen (*right, with microphone*) described the development of the profession since he returned from Palmer College 25 years ago. At that time chiropractic had no status, building a practice was difficult, as was recovering his large investment in his education. Today Danish chiropractic students study at a public university without tuition fees, the profession is fully integrated into mainstream care in the community and hospitals, and all practices are busy and well-rewarded.

Jan Hartvigsen and Silvanor Mior

This has been the result of a focus on research (4% of chiropractors in Denmark have a PhD and the whole profession funds research through a matching contribution partnership with the government), quality in education and practice, and an identity as experts in spinal and musculoskeletal health. Paradoxically, their focused identity gives Danish chiropractors access to a broader range of patients and scope of practice than the profession elsewhere, from newborns to cardiac patients to the elderly, because of the fundamental trust and respect that has been established.

• From the VHA in the US Dr Anthony Lisi (*right*), Director of Chiropractic Services, reviewed the very significant current and future impact of inclusion of chiropractic education and clinical services in the VHA since 2004. His points included:

• The majority of medical students received their medical training in VHA facilities. Today this includes rotations through the VHA chiropractic service, appreciating the role and value of chiropractic care. At Dr Lisi's practice at the New Haven VHA facility these are Yale Medical School students.

• Likewise, many chiropractic students have clinical training rotations in VHA facilities currently from 11 chiropractic colleges at 19 facilities.

• This year the VHA has commenced 12-month full time funded residencies for graduate chiropractors.

• From Canada Dr Silvano Mior, from the Canadian Memorial Chiropractic College in Toronto and a consultant to the Ministry of Health and Long-Term Care in the Province of Ontario, described the recent integration of chiropractors in government-funded primary healthcare teams and hospitals, and the models of care involved. Essential qualities in these models, as all five opening speakers had reported were:

• evidence-based, according to explicit pathways or protocols

• patient-centered rather than doctor-centered

• interprofessional

• delivery of value in terms of improved clinical outcomes, patient satisfaction and overall cost

These factors were identified as "the principal drivers of the changing healthcare environment" in the consensus statements agreed by participants at the end of the Miami Conference.

5. **Session 2 – Specific Examples.** Session 2 had presentations describing specific examples of interdisciplinary education and practice and the lessons learned. These were from chiropractors from colleges or private practice who had submitted papers for presentation.

• Dr Deborah Kopansky-Giles and Dr Carlo Ammendolia of Toronto described their delivery of chiropractic services and their role in the education of medical interns at two University of Toronto teaching hospitals, respectively St Michael's Hospital and Mount Sinai Hospital.

Deborah Kopansky-Giles

• Dr Beth Dominicis of the Southern California University of Health Sciences in Los Angeles described her successful dental and chiropractic co-management project for patients with temperomandibular joint disorders.

Carlo Ammendolia

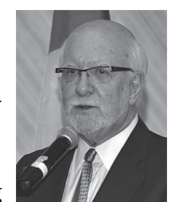
• Dr Maria Browning of the Anglo-European College of Chiropractic in the UK outlined a similar co-management project for midwives and chiropractors for infants and their mothers.

• Dr Edgar Rivera-Ortiz of Puerto Rico presented the interesting experience of a recent young graduate from an American college, in his case Parker University in Texas, confidently commencing private practice but then receiving an invitation he had not anticipated – to provide chiropractic services at his local Castaner General Hospital in Lares, Puerto Rico. A year later he had an established part time practice there, well-received by patients and the medical staff. However, this had required new skills and attitudes, the ability to use common language to describe the role and potential of chiropractic services, and ongoing education of all parties including himself to build the necessary professional cooperation and trust.

Beth Dominicis

Edgar Rivera

• Dr Arlan Fuhr, known as the founder of Activator Methods, spoke of his experience in two clinical settings where he was the first to provide chiropractic care – a Neighborhood Christian Clinic and the VHA facility in Phoenix, Arizona. Two main lessons learned were to be flexible, not demanding privileges but receiving them over time on the basis of demonstrated results of the chiropractic care he gave, and to be evidence-based. Reference to clinical research was the common currency for all the health professionals, and understanding and explaining the research supporting chiropractic care was fundamental to his success and that of the several


Arlan Fuhr

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Acetaminophen Ineffective for LBP

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This was a multi-center, randomized controlled trial in primary care medical centers in Sydney, Australia performed between November 2009 and March 2013. Points are:

a) Subjects were 1,652 patients with acute low-back pain – pain for less than six weeks, preceded by one month with no pain. Current pain had to be of at least moderate intensity – in fact it was an average of 6.3 on an 11 point pain scale.

b) Patients were randomly assigned to one of three groups:

- Regular Group (550). These patients received four weeks of regular doses of paracetamol, three times daily being the equivalent of 3,990 mg daily.
- As-needed Group (549). Paracetamol was taken as needed for pain relief during the four weeks.
- Placebo Group (553). These patients received placebo pills.

There was a double-dummy design to help blind patients and clinicians and to provide a consistent protocol. Under this design participants received two boxes of tablets – one from which they took tablets regularly every six to eight hours, and one from which they took as-needed tablets for pain relief. The Regular Group had paracetamol tablets in the regular box and placebo tablets in the as-needed box, the As-needed Group vice versa. In the Placebo Group placebo tablets were in both boxes.

For patients in all three groups the treating clinician provided guideline recommended advice to remain active and avoid bed rest, and reassurance concerning the favourable prognosis of acute low-back pain.

c) The primary outcome measure was time until recovery from pain, with recovery defined as the maintenance for seven consecutive days of 0 to 1 pain intensity. This was based on the research hypothesis that "regular paracetamol would improve recovery by decreasing pain intensity and allowing people with acute low-back pain to remain active and resume normal movement as soon as possible."

Secondary outcomes were pain intensity, disability (Roland Morris), function, global rating of symptom change, sleep quality and quality of life.

d) On the primary outcome measure median days to recovery were 17 for the Regular Group, 17 for the As-needed Group and 16 for the Placebo Group. By 12 weeks 466 (85%) in the Regular Group had reached sustained recovery, 452 (83%) in the As-needed Group and 461 (84%) in the Placebo Group.

Time to the first day of recovery – the first day of 0 to 1 on the pain scale – "did not significantly differ between groups… lending support to the robustness of the primary analysis."

"Consistent with primary results, paracetamol also had no effect on pain, disability, function, global symptom change, sleep or quality of life."

In discussion at the end of the paper Williams, Maher et al. point out that NSAIDs are no more effective than paracetamol and have a less favourable safety profile. Their results "suggest that advice and reassurance, rather than analgesics, should be the focus of first line care."

(Williams C, Maher C et al. (2014) *Efficacy of Paracetamol for Acute Low-Back Pain: A Double-Blind, Randomised Controlled Trial.* Lancet;384:1586-96)

Chiropractic Care for Seniors

Two significant new studies from Paula Weigel PhD, Jason Hockenberry PhD and others, health policy researchers from the University of Iowa, report positive findings for chiropractic management of patients aged 70 and older in the US government's Medicare program for all seniors.

- The first, published in JMPT six months ago, reports that episodes of chiropractic care are superior to medical care for patients with back pain, specifically in protecting them from two-year declines in activities in daily living (ADLs) and lower body functions (LBFs).
- The second, just published in the October issue of JMPT, reports a significant protective effect against one-year decline in ADLs and self-rated health, and that chiropractic users "are more satisfied with their follow-up care and with the information provided to them."

These studies were not clinical trials but retrospective analyses of data from two large databases, not a strong research method for establishing effectiveness. The papers are important as independent, expert, health policy/public health study of the potential value of an expanded role of chiropractic care in improving the health and quality of life of seniors – an area in which there is little research but clearly much potential value for patients and the chiropractic profession. As Weigel, Hockenberry et al. say:

"Slowing the rate of functional decline, disability, and dependency among community-dwelling older adults reduces the threat of institutionalization and preserves autonomy and well-being, both of which are long-standing public health policy goals in the United States."

Data in the first study came from two sources:

- A large nationally representative survey on Assets and Health Dynamics among the Oldest Old (AHEAD). This has rich data on health, function and treatment on over 7,000 participants who were age 70 years or older in 1993 and were interviewed then and every two years since.
- Medicare Part B claims with respect to chiropractic and medical treatment.

All 1,057 patients in the study had one of 29 specific back conditions and various rules were adopted to ensure that all had one uncomplicated back condition each and were truly comparable ("clinically homogenous"). An episode of care was all visits for

up to 60 days coded for any of the specific back conditions. The health outcomes compared were:

• Declines in 5 ADLs between consecutive interviews – getting across a room, getting dressed, bathing or showering, eating and getting in and out of bed.

• Declines in instrumental ADLs (IADLs) – difficulties of using a telephone, taking medication, handling money, shopping, and preparing meals.

• Declines in lower body functions (LBFs) – coming up and down one flight of stairs, walking several blocks, pushing or pulling heavy objects, and lifting or carrying 10 pounds or more.

• Self-rated overall health.

• Depressive symptoms.

174 of the 1,057 (16.5%) had chiropractic episodes of care, averaging 9 visits, which compared with an average of 2.4 visits for episodes of medical care only. There were "significant differences between type of care episode *(i.e. chiropractic only, chiropractic and medical, medical only)* and declines in function and wellbeing". For example:

• More than 30% of individuals with medical-care-only episodes declined in ADLs (i.e. lost functioning ability), as opposed to only 19% of persons with chiropractic care episodes.

• Declines in lower body function were reported by 38% of individuals with medical-only episodes, versus 30% of those with chiropractic care episodes.

• On lifestyle factors, "40% of the chiropractic care group reported engaging in vigorous exercise, relative to only 27% in the medical only care group," yet more persons in the chiropractic group were overweight or obese than in the medical only group – 59% vs. 47%.

Weigel and Hockenberry's second paper uses a different database, the Medicare Current Beneficiary Survey (MCBS) "a continuous, rotating panel survey of a nationally representative sample of Medicare beneficiaries sponsored by the Centers for Medicare and Medicaid Services", linked to provided claims between 1997-2006.

Average annual use of chiropractic between 1997-2006 by a nationally representative sample of 7,969 to 8,898 beneficiaries was 7.4% (6.3%-8.9% - with 8.9% in the latest year of 2006) – *but was the much higher figure of 34.5%* (32.4%-36%) *among those patients with spine conditions.*

Average annual Medicare spending on spine-related conditions "roughly doubled over the 9-year period" but "Medicare spending on chiropractic remained flat between 1999-2006 decreasing from 71% of total spending… to 48%", and "our results suggest Medicare payments for chiropractic services (at least among those with spine conditions) are relatively less of a payment vulnerability for the Medicare program than has been implied in the past."

In overall summary, here is preliminary evidence from independent health policy experts suggesting that chiropractic care for seniors, particularly for spine-related conditions, satisfies what is known as the "triple aim" of the Patient Protection and Affordable Care Act or Obamacare – improved patient health, improved patient experience/satisfaction, and decreased cost per person.

(Weigel PA, Hockenberry J et al. (2014) *The Comparative Effect of Episodes of Chiropractic and Medical Treatment on the Health of Older Adults.* J Manipulative Physiol Ther. 37:143-154. Weigel PA, Hockenberry J et al. (2014) *Chiropractic Use in the Medicare Population: Prevalence, Patterns, and Associations With 1-Year Changes in Health and Satisfaction With Care.* J Manipulative Physiol Ther. 37:542-551.)

Medical Endorsements Become Stronger

In an October 15 article for consumers titled *Back Pain Cured! No Drugs…No Surgery* in the newsletter Bottom Line Personal, Dr Jack Stern, a surgeon who specializes in spine neurosurgery and is on the clinical faculty at Weill Cornell Medical College in New York City, explains that "the ability to diagnose and treat the different types of back pain has improved tremendously over the years" with the rise of complementary forms of management and integrative care. The result is that "the vast majority of patients don't need invasive procedures or powerful drugs."

He then reviews conservative treatments with which the majority of people can make full recovery – acupuncture, Alexander technique, chiropractic, exercise and lumbar stabilization. Here is his advice on chiropractic:

"Many conventional doctors view chiropractic as an unproven treatment…. But that's not true. Spinal manipulations and "adjustments" by chiropractors are meant to restore the spine's structural integrity and stimulate the body's natural ability to reduce pain. I've had a number of patients with herniated disks who reported significant improvement after getting chiropractic treatments.

A randomized, double-blind study conducted last year found that back pain patients who were treated with chiropractic therapy in addition to standard medical care had less pain and better physical functioning than those who received standard care alone.

Bonus: People who see chiropractors tend to rate their care as very good or excellent. Most chiropractors spend a lot of time with patients. They take a detailed history, watch how patients move and give advice on using the back in healthier ways. It's possible that patients who receive the extra attention are able to change their perceptions of pain – a phenomenon known as the *attention placebo effect.*

My advice: Chiropractors are the frontline treaters of low-back pain. They are knowledgeable, and a qualified chiropractor will know when your specific problem requires additional attention."

Bottom Line Personal (www.bottomlinepublications.com) is an American bimonthly print newsletter for consumers published for the past 34 years that claims to be the most widely ready consumer newsletter ever. It has a companion newsletter Bottom Line Health.

Main Article *continued from page 3*

Figure 1

The Keele STarT Back Screening Tool

Patient name: ______________________________ Date: ____________

Thinking about the last 2 weeks tick your response to the following questions:

		Disagree 0	Agree 1
1	My back pain has spread down my leg(s) at some time in the last 2 weeks	☐	☐
2	I have had pain in the shoulder or neck at some time in the last 2 weeks	☐	☐
3	I have only walked short distances because of my back pain	☐	☐
4	In the last 2 weeks, I have dressed more slowly than usual because of back pain	☐	☐
5	It's not really safe for a person with a condition like mine to be physically active	☐	☐
6	Worrying thoughts have been going through my mind a lot of the time	☐	☐
7	I feel that my back pain is terrible and it's never going to get any better	☐	☐
8	In general I have not enjoyed all the things I used to enjoy	☐	☐

9 Overall, how bothersome has your back pain been in the last 2 weeks?

Not at all	Slightly	Moderately	Very much	Extremely
☐	☐	☐	☐	☐
0	0	0	1	1

Total score (all 9): ____________ **Sub Score (Q5-9):** ____________

© *Keele University 01/08/07 - Funded by Arthritis Research UK*

Comments:

The Keele SBST 9-item tool is available in a number of languages, including English, Dutch, French, Spanish, Danish and Welsh. The questions it includes were selected because they are established predictors for persistent disabling back pain.

They include radiating leg pain, pain elsewhere, disability (2 items about difficulties with dressing & walking taken from the Roland Morris Disability Questionnaire), fear (1 item from the Tampa Scale of Kinesiophobia), anxiety (1 item from the Hospital Anxiety and Depression Scale), pessimistic patient expectations (1 item from the Pain Catastrophising Scale), and low mood,(1 item from the Hospital Anxiety and Depression Scale) and how much the patient is bothered by their pain (from Dunn & Croft 2005).

All 9-items use a response format of 'agree' or 'disagree', with exception to the bothersomeness item, which uses a Likert scale.

The Keele SBST produces two scores: overall scores and distress subscale scores. The *distress subscale score* is used to identify the high-risk subgroup. To score this subscale add the last 5 items; fear, anxiety, catastrophising, depression & bothersomeness (bothersomeness responses are positive for 'very much' or 'extremely' bothersome back pain). Subscale scores range from 0 to 5 with patients scoring 4 or 5 being classified into the high-risk subgroup.

The *overall score* is used to separate the low-risk patients from the medium-risk subgroup. Scores range from 0-9 and are produced by adding all positive items; Patients who achieve a score of 0-3 are classified into the low-risk subgroup and those with scores of 4-9 into the medium-risk subgroup.

For the Keele SBST 6-item version and SBST clinical measurement tool, which enables objective measurement of change over time, and instructions on their use, go to www.keele.ac.uk/sbst

chiropractors who have now followed him in these clinical settings.

6. **Session 5 – Specific Skills.** Sessions 3 and 4 included workshops on items such as interprofessional education (IPE) and preparing students for integrative care. In Session 5, opening the second day, speakers from the UK and the US dealt with clinical management protocols that were required and were being used successfully in reimbursed chiropractic care.

- Dr Brian Justice (*right*), in private practice in Rochester, New York for 28 years until recently, is now a full time consultant to Excellus BlueCross/BlueShield. This large insurer of health-care, with a past reputation of restricting access to chiropractic services, now has Dr Justice writing its spinal care pathways which give a large and central role to chiropractic care if delivered with appropriate protocols and measurement of outcomes and value.

- These protocols and the results achieved and now published, were then further described by Massachusetts chiropractor Dr Ian Paskowski (*right*), Spine Care Medical Director, Beth Israel Deaconess Hospital (formerly Jordan Hospital) in Plymouth, Massachusetts[1]. (For a review of this research see the May 2012 issue of this Report, available online at www.chiropracticreport.com under Past Issues). A key feature of his management protocols, and of this era of patient-centered care that all speakers were describing, is the use of patient questionnaires. At the Beth Israel Deaconess Spine Care Program these are used not only for assessing clinical results (patient-reported outcome measures (PROMS) such as the Bournemouth, Oswestry, and Roland Morris disability questionnaires, and pain and satisfaction scales) but also to help identify subgroups of patients requiring different care pathways.

A validated and practical tool used for that by Dr Paskowski is the 9-question STarT Back Screening Tool (SBST) recently developed at the Arthritis Research UK Primary Care Centre at

Keele University in the UK. This differentiates back patients into those with high, medium or low risk for chronic pain and disability, allowing appropriately tailored treatment approaches. It is shown and described more fully in Figure 1. A recent trial by Hill, Whitehurst et al., selected as one of the 15 most significant physiotherapy trials ever published internationally, has demonstrated that stratifying patients according to the SBST, and providing matched clinical care, produces superior and cost-effective overall results[2].

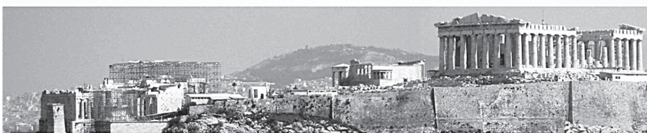
• Next, Dr Dave Newell from the UK described an impressive new patient management and clinical outcomes system called CareResponse (www.care-response.com) developed by British chiropractor Dr Jonathan Field and endorsed by the UK Royal College of Chiropractors. This is available for free to chiropractors worldwide, has already been adopted by several hundred in European countries, Australia, New Zealand and South Africa, and has these attractive features:

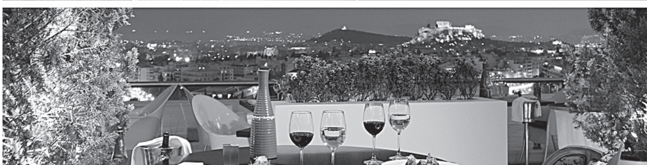
• CareResponse is cloud-based and runs on a database accessed by any internet browser – there is no program to install and it works on any device that can access the internet including smart phones.

• It has a choice of validated PROMS, and patient satisfaction questionnaires (brief and comprehensive).

• Patients can complete PROMS and other forms online with results delivered by email. This and other features minimize work for practice staff. Data are secure, numbered and anonymous.

• Chiropractors using CareResponse may view graphs showing patient progress, collated results for all their patients, and how results compare with all others using the system.

The Alpha and Omega of Spinal Healthcare
ATHENS HILTON AND MEGARON INTERNATIONAL CONVENTION CENTRE




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European Chiropractors' Union

• The initial assessment completed by patients includes a brief background medical history, and for those with lower back pain, the STarT Back screening questionnaire (SBST). A summary is provided for their practitioner. This includes calculation of the SBST ranking of the patient's risk of having disabling pain in three months.

• Outcome forms are routinely sent to patients by email 14, 30 and 90 days after starting care. These times are felt to be useful in providing information during care as well as assessing how well any benefits last up to three months on. During care a practitioner may add extra assessments for a patient whenever they feel appropriate; such as at a formal review or discharge.

• CareResponse produces a 'to do list' of GP/family physician letters due, and can create draft letters which may be edited in word processors or clinic management software.

• With the explicit consent of those to whom the data relates, information collected is being used for academic and research purposes.

If you are not using PROMS, or are using them in an uncoordinated way, here is an established and practical way to improve clinical governance and research data in your practice, and to promote your practice to patients and referring health professionals. For full details go to www.care-response.com and its link to a training and support site[3].

At the Conference a subsequent speaker, Dr David Byfield, head of one of the two leading chiropractic schools in the UK, at the Welsh Institute of Chiropractic at the University of South Wales, explained that CareResponse had now been successfully incorporated into the clinical training of final year students at his school. Currently it is used at four schools.

• Final Session 5 speaker was Dr Steven Kraus, CEO of the US electronic health records (EHR) software corporation Future Health. He reported a survey showing that all North American chiropractic colleges have adopted or are planning adoption of EHR technology, which will be the standard for delivery and reimbursement of healthcare tomorrow. In the US currently 95% of hospitals, 80% of MDs and 45% of DCs are using EHRs.

7. **Day 3 – Non-clinical Careers.** The third day of the Conference considered new career options other than clinical practice for chiropractors – opportunities for careers in education, policy and research. For example:

• Kathy Dooley DC, MSc (*left*) who has her Masters degree in Clinical Anatomy, explained how she was teaching anatomy at the renowned Albert Einstein College of Medicine, as well as to dental, physical therapy and podiatry students at three other universities in New York.

• Dr Robert Mootz (*right, without microphone*), Associate Medical Director for Chiropractic at the Department of Labor and Industries, Washington State for the past 15

Bob Mootz and André Bussières

years, described his work in policy and research, demonstrating the type of policy positions now open to chiropractors but also the degree to which evidence-based care and cost determine policy and reimbursement decisions for all healthcare services today. He was co-leader of a pilot project that produced a 20% reduction in chronic disability in injured workers in the state – an approach now to be implemented as a best practice model for all injured workers. Increasingly, gone are the days when professional background and the letters after your name govern access to patients in large healthcare systems such as state workers compensation schemes. Adoption of proven and mandated pathways, and delivery of good results and value, rule the day.

• Christine Goertz DC, PhD, with a doctoral degree in health services research, administration and policy from the University of Minnesota, was formerly a Health Services Administrator at the National Institutes of Health (NIH), and is now Vice-Chancellor for Research and Policies at Palmer College and a member of the PCORI Board. She confirmed the new opportunities for the chiropractic profession in this era, but the absolute requirement of producing documented good results/outcomes/data.

• In an impressive presentation André Bussières DC, PhD (*above right*) from McGill University in Montreal, and leader of the Canadian Chiropractic Association's Clinical Practice Guidelines Initiative, spoke of Canada's research program and its profound significance for the current growth and success of the profession in Canada.

Twenty-five years ago Dr David Cassidy was the one chiropractor with a PhD in Canada, one of only two in North America. Today Canada has 30 DC PhDs in full time research, 15 of them in research chairs in prestigious universities across the country, and 21 DC PhD candidates.

This is the result of recommendations from a CCA Task Force on Chiropractic Research in Canada in 1995 and a plan followed since then supported by funding from the profession and the federal government – in many ways similar to the plan in Denmark that had been described by Dr Hartvigsen.

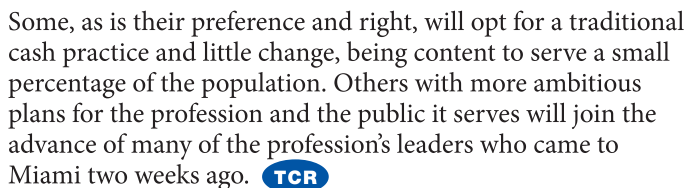
Phase 1 focused on building capacity and performing relevant research. Phase 2, with a focus on knowledge, translation and uptake by the profession through clinical practice guidelines (CPG), is now well-advanced. Other current developments are creation of an endowment fund for future research, and a practice-based research network amongst Canada's 8,200 doctors of chiropractic.

C. Conclusion

The Miami Conference was directed principally at the chiropractic educational community, addressing the new needs of chiropractic students given the changed healthcare world in which they will practice, and identifying the changes required in education programs as a result. In this Report, principally for practicing chiropractors, much of the important educational content has not been discussed.

What is the fundamental significance of the Miami Conference? This is that it brought together appropriate international expertise to demonstrate that the chiropractic profession now has the position and external healthcare environment to gain access to and serve a much larger patient population than it does at present, patients who are much in need of its services. In some communities this movement is underway.

Does the international profession, do you in your individual practice, have the will to take the necessary steps to travel that road?



Some, as is their preference and right, will opt for a traditional cash practice and little change, being content to serve a small percentage of the population. Others with more ambitious plans for the profession and the public it serves will join the advance of many of the profession's leaders who came to Miami two weeks ago. TCR

References

1 Paskowski I, Schneider M, Stevens J et al. (2011) *A Hospital-Based Standardized Spine Care Pathway: Report of A Multidisciplinary, Evidence-Based Process.* J Manipulative Physiol Ther 34:98-106.

2 Hill JC, Whitehurst DG et al. (2011) *Comparison of stratified primary care management for low back pain with current best practice (STarT Back): a randomised controlled trial.* Lancet:378(9802):1506-71.

3 For a review of PROMS for chiropractic practice see the September 2012 issue of The Chiropractic Report titled *The Role of Patient Questionnaires* available under Past Issues at www.chiropracticreport.com.

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