

[IMAGE]

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The Chiropractic Rehabilitation Specialist and Quality Care

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Introduction

Taking the steps necessary to make rehabilitation a key part of your office procedures will protect your practice from the overwhelming restrictions of managed care. Chiropractors will want to adhere to cost effective management strategies for neuromusculoskeletal disorders. By combining traditional chiropractic care with modern rehabilitation you can position your practice for the future. The "sports medicine" approach of spinal rehabilitation will add a unique dimension to any chiropractic office and give you a marketing niche.

Quality care involves four key components. First, the use of passive modalities in a time-limited fashion. Second, a gradual transition to active care methods which promote self-reliance. Third, utilization of outcomes assessment tools which quantify progress and provide return to work or pre-injury goals. And fourth, identification of the high risk patient -- such as those with abnormal illness behavior -- which may require multidisciplinary care or referral.

Manipulation and Passive Care

Using passive modalities, including spinal manipulation, in a time-limited manner will assure that you are practicing within the emerging guidelines for care.¹⁻³ Utilization parameters do not allow for prolonged care without objective evidence of improvement with reliable and valid outcome measurements.

Uncomplicated back pain is considered a self-limiting condition with a natural history of spontaneous resolution within six weeks for the 80-90 percent of patients.^{2,3} After a thorough meta-analysis of the scientific literature, manipulation has been shown to speed recovery by 34 percent over other methods.⁴ Since the 10-20 percent of patients who continue to have symptoms are at increased risk of developing chronic symptoms then disability management strategies must necessarily change for these patients.

Active Care and Functional Restoration

The subacute stage -- between one and four weeks -- is the appropriate time to begin assessing and treating functional pathologies with active care. The Mercy document says on page 110, "It is beneficial to proceed to rehabilitation phase as rapidly as possible, and to minimize dependency upon passive forms of treatment/care."³ And on page 125, "All episodes of symptoms that remain unchanged for 2-3 weeks should be evaluated for risk factors of pending chronicity. Patients at risk for becoming chronic should have treatment plans altered to de-emphasize passive care and refocus on active care approaches."³

SOAP notes and billing codes should reflect this gradual transition from manipulation and physical agents to active exercise and patient education. Whereas our initial clinical evaluation at the outset of care includes orthopedic, neurologic and special tests for "red flags"; when the patient reaches the subacute stage a functional evaluation is necessary to identify specific functional pathologies or deficits.

This functional evaluation involves tests which assess function of the entire locomotor system (muscular, articular, and motor control).⁵ The goal is to find key functional pathologies which are perpetuating factors of the patient's pain complaint. New treatment targets such as weak or tight muscles may be identified. Often a chain reaction can be found which correlates a joint dysfunction (e.g., talonavicular) with a poor movement pattern (e.g., altered hip extension during gait), a muscular imbalance (e.g., tight hip flexors and weak gluteus maximus), and the pain generating tissues (e.g., lumbar facet or paraspinal trigger point).^{6,7} Thus, the functional evaluation links the exercise prescription to the manipulable lesion.

Fortunately, the exercise prescription can often be based on identification of specific functional deficits by inexpensive yet reliable testing procedures.⁸ Comparison to a normative data base is also possible.⁹ A set of simple non-dynametric strength tests (trunk extension, trunk flexion, squatting) were shown to correlate better with disability than expensive, dynametric tests.¹⁰ Trunk extension endurance is a particularly valuable outcome since it has been found to be predictor of recurrences.¹¹

Outcomes Assessment

The third component of a rehabilitation practice is the use of objective outcomes assessment methods. Insurers and other third parties require that you demonstrate that your patient is indeed improving under your care. This can occur without significant financial expense. Questionnaires which measure pain level (visual analog scale), patient satisfaction, or functional impairment (Oswestry) take little time and are reliable and valid. They can be collected from the first day of treatment. A more advanced type of outcomes assessment involves the use of functional capacity tests which measure items listed in the Dictionary of

Occupational Titles (DOT).¹² These tests have excellent validity, as they measure functions which are crucial to the performance of a specific job.¹²⁻¹⁴ Such testing is valuable between the 4th and 6th week of care to identify specific return to work outcomes. Basic job traits are sitting, standing, climbing, stooping, crouching, walking, balancing, etc. Lifting and carrying have a special place in the DOT because they are the major job traits which are used to determine work restrictions. A job demands questionnaire has been formulated to identify which job traits are most important to evaluate for each individual.¹⁴

Risk Factors for Chronicity

The fourth area which rehabilitation specialists must be proficient in is the identification of patients who are at high risk for chronicity. These are primarily patients with psycho-social problems. Patients with fear-avoidance, depression, excessive anxiety, job dissatisfaction, or drug or alcohol dependency should be identified. Abnormal illness behavior can be screened with a few simple examination techniques validated by Waddell.¹⁵ Short form questionnaires can also be given to screen for such behavior as one for fear-avoidance behavior.¹⁶

Conclusion

Appropriate clinical evaluation, functional evaluation, outcomes assessment, and risk prediction provide the core assessment competencies required for the neuromusculoskeletal specialist of the future. Subsequently, manipulation, exercise and patient education then complete the highest quality of care for locomotor system dysfunction. In a chiropractic practice the highest quality treatment is possible. This is within the reach of chiropractors more so than any other health care providers. Hopefully, our profession will seize this opportunity and become expert in quality care for neuromusculoskeletal disorders.

The rehabilitation paradigm represents the cutting edge of neuromusculoskeletal care. In an age of quality management, this paradigm is emerging as the most consistent, scientifically supported approach to the goal of cost containment.

Quality Care Time Line

1. Use of Outcomes Assessment (begins at first visit)

2. Time Limited Passive Care (with manipulation, first six weeks)

3. Early Transition to Active Care (begins no later than four weeks)

4. Identification of Risk Factors for Chronicity (within first six weeks)

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