DEPARTMENT OF VETERANS AFFAIRS

RECOMMENDATIONS OF THE CHIROPRACTIC ADVISORY COMMITTEE

November 3, 2003

INTRODUCTION:

Public Law 107-135, Section 204 established the Department of Veterans Affairs (VA) Chiropractic Advisory Committee "to provide direct assistance and advice to the Secretary in the development and implementation of the chiropractic health program" within Veterans Health Administration (VHA). The Committee is charged to advise the Secretary on protocols governing referrals to doctors of chiropractic, protocols governing direct access to chiropractic care, protocols governing scope of practice of chiropractic practitioners, and definitions of service to be provided, as well as to provide advice in the development and implementation of the chiropractic health program.

Secretary Principi appointed Committee members in August 2002. The Committee has met 4 times to discuss the specific charges to the Committee. The Committee also has extensively discussed how chiropractic care can effectively be integrated into the existing VA healthcare system, and this document includes recommendations regarding implementation of the chiropractic health program.

The Committee will, in a later report, provide input on other matters including the educational training and material required by P.L. 107-135 as well as evaluation and quality measures for the chiropractic care program.

This document reflects all opinions as expressed by the members of the Committee. When the Committee did not reach complete consensus on a recommendation or Committee members expressed concerns regarding the recommendation, a *Comment* section following the rationale for the recommendation presents the other opinions expressed. In instances where Committee members strongly disagreed, a dissenting recommendation follows the recommendation endorsed by the majority of the Committee. A summary of the public comments received and reviewed by the Committee is attached as Appendix D.

This document relates only to the provision of chiropractic care and is not intended to restrict other qualified healthcare providers from the use of manipulation in the care of patients when licensed and privileged to provide such care.

BACKGROUND:

Doctors of chiropractic in private practice are responsible for providing appropriate care within the scope of their licensure, education and competency and for making appropriate referral to other health care providers when necessary. Coverage of chiropractic care by health insurance plans varies as do access requirements. Some health insurance plans require referral by a primary care provider, others require only that the patient use a doctor of chiropractic within the plan, and some permit self-referral to chiropractic care. Individuals who pay for the care themselves may directly access chiropractic care. Collaborative professional relationships between doctors of chiropractic and allopathic and osteopathic physicians exist and continue to increase in the private sector as more patients become interested in chiropractic care and more insurance plans provide coverage.

In 1995, the Department of Defense (DoD) initiated chiropractic care through the Chiropractic Health Care Demonstration Project (CHCDP). CHCDP demonstrated that chiropractic care was accepted best when the doctors of chiropractic were incorporated within a traditional medical team housed within the main medical facility, rather than functioning as a separate entity. As in VHA, organizational structures in DoD vary among facilities and thus several different organizational models have been used to integrate chiropractic care into its healthcare delivery system on a permanent basis. The Committee visited the National Naval Medical Center, Bethesda, where chiropractic was organizationally placed within a musculoskeletal service line that also included Rheumatology, Orthopedics, Physical Medicine and Rehabilitation, Physical Therapy, Occupational Therapy, and Podiatry. This arrangement has provided an organizational structure that reflects functional working relationships in the care of patients with neuromusculoskeletal conditions.

Within DoD, the Navy's experience indicated that hiring and placement by local commanders, coupled with a strong, visible commitment to success from senior leadership, resulted in a smoother integration of chiropractic care into an established traditional medical setting. The DoD experience may be instructive as VHA determines how to integrate doctors of chiropractic into its system.

VHA is a comprehensive, integrated care system encompassing 163 hospitals, 850 ambulatory care and community-based outpatient clinics, 137 nursing homes, 43 domiciliaries and 73 comprehensive home-care programs. VHA endorses a primary care model of healthcare delivery, in which each patient has an assigned primary care provider who is accountable for addressing a large majority of the patient's personal healthcare needs, with referrals to specialists when needed. While complete implementation of the model has not yet been achieved, in part due to the large influx of new patients that VHA has experienced in recent years, it remains VHA's goal.

VHA's health care system encourages an integrated, interdisciplinary, interdependent and collaborative team approach. The composition of health care teams in VHA varies among sites as a result of differences in the size and configuration of VHA facilities, staffing patterns, and local business and medical practices, but the team approach to care serves veteran patients well, as many have multiple health care needs that overlap and influence each other.

The Committee has discussed extensively how doctors of chiropractic can be integrated successfully into the VHA health care system. While local variations in services and organizational structures will play a role in this, the Committee believes the key to successful implementation is a collaborative, cooperative approach to the integration of care. Doctors of chiropractic should be an integral part of an integrated team of providers. The composition of such an integrated team may vary between sites, and members of the Committee have provided several descriptions of integrated settings that may assist VHA in its decision-making process (Appendix B).

The goals for VHA's new chiropractic care program should include:

- Patients have access to chiropractic care.
- Doctors of chiropractic, physician providers and other clinicians develop collaborative relationships in order to provide the concurrent patient care necessary to meet the needs of veterans.
- Chiropractic care is fully integrated into all of VHA's missions – patient care, education, research and response to disasters and national emergencies.

RECOMMENDATIONS AND RATIONALE:

A. Qualifications for Employment

Recommendation 1: Education requirement.

Degree of doctor of chiropractic resulting from a course of education in chiropractic. The degree must have been obtained from one of the schools approved by the Secretary of Veterans Affairs for the year in which the course of study was completed. Approved schools should be:

(1) Schools of chiropractic accredited by the Council on Chiropractic Education Commission on Accreditation or equivalent agency recognized by the U.S. Secretary of Education, **or**
(2) Schools (including foreign schools) accepted by the licensing body of a State, Territory, Commonwealth, or the District of Columbia as qualifying for full or unrestricted licensure.

Rationale: The Council on Chiropractic Education Commission on

Accreditation (CCE) is currently the accrediting body recognized by the U.S. Secretary of Education for Doctor of Chiropractic programs and single-purpose institutions offering the Doctor of Chiropractic program. CCE has been recognized by the Department of Education since 1974 and P.L. 106-117 (the Veterans' Millennium Health Care Act), Section 303, defines the term chiropractor as an individual who "holds the degree of doctor of chiropractic from a chiropractic college accredited by the Council on Chiropractic Education." However, prior to 1993, a second organization, the Straight Chiropractic Academic Standards Association (SCASA) was also recognized by the Department of Education and 13 state licensing boards. Limiting recognition to CCE accredited schools excludes from VA employment licensed doctors of chiropractic who graduated from SCASA accredited schools, those who graduated from chiropractic school prior to the creation of CCE, those who graduated from a school of chiropractic before it achieved full CCE accreditation status, and those who, in the future, might graduate from a school accredited by a new chiropractic accrediting organization recognized by the U.S. Secretary of Education.

H.R. 2414, introduced June 10, 2003 to amend title 38, United States Code to provide for the full-time permanent appointment of chiropractors in VHA, states the educational qualification of chiropractors as "hold the degree of doctor of chiropractic, or its equivalent, from a college of chiropractic approved by the Secretary." This language, which models that used for other professions in Title 38, if passed, will override the current limitation to CCE accredited schools contained in P.L. 106-117. The language of H.R. 2414 was incorporated into H.R. 2357 and passed by the House of Representatives on July 21, 2003

VA currently accepts graduation from an accredited school or a school accepted by a state licensure board for several health care professions (physician, dentist, optometrist), while the qualification standards for other professions permit education from a school accepted by a state licensing board only for graduates of foreign schools.

Given the history of accreditation of chiropractic educational programs, and the existence of a second accrediting body that was recognized by the US Department of Education until 1993, the Committee recommends the acceptance of the broader education standard that will not exclude experienced doctors of chiropractic because of variations in the accreditation of chiropractic schools in the past.

Comment: Some members of the Committee expressed concern that the level of training may not be the same between non-accredited programs and those accredited by an agency recognized by the Secretary of the Department of Education.

Recommendation 2: Licensure requirement.

Current, full and unrestricted license to practice chiropractic in a State, Territory, or Commonwealth of the United States, or in the District of Columbia. A doctor of chiropractic who has, or has ever had, any license(s) revoked, suspended, denied, restricted, limited, or issued/placed in a probationary status should be appointed only in accordance with existing VA provisions applicable to other independent licensed practitioners.

Rationale: Doctors of Chiropractic are licensed as independent practitioners in all US jurisdictions. While some variation in licensure law exists among U.S. jurisdictions, doctors of chiropractic are responsible for providing appropriate care within the scope of their licensure, education and competency and making appropriate referral to other health care providers if necessary.

P. L. 106-117 (the Veterans' Millennium Health Care Act), Section 303 defines the term "chiropractor" as an individual who is "licensed to practice chiropractic in the state in which the individual performs chiropractic service." H.R. 2414, introduced June 10, 2003, to amend title 38, United States Code, defines the licensure qualification of chiropractors as "be licensed to practice chiropractic in a State." This language, which models that used in Title 38 for other professions, if passed, will override the current in language in P.L. 106-117 and allow VA to use the same criteria as used for other Title 38 professions, i.e., licensure in any US jurisdiction. The language of H.R. 2414 was incorporated into H.R. 2357 and passed by the House of Representatives on July 21, 2003.

Recommendation 3: Other requirements

Doctors of chiropractic should be expected to meet the other employment requirements, such as citizenship, English language proficiency and physical requirements, established by VA for all other Title 38 employees.

Rationale: Doctors of chiropractic should meet the general employment criteria expected of all other Title 38 employees.

B. Scope of Practice

Recommendation 4: Scope of Practice Doctors of chiropractic shall provide patient evaluation and care for neuro-musculoskeletal conditions including the subluxation complex[1] within the boundaries set by state licensure, VHA privileging and the doctor's ability to demonstrate educational training and clinical competency in the areas necessary to provide appropriate patient care.

Rationale: P.L. 107-135 states: "The chiropractic care and services available

[1] "A subluxation is a complex of functional and/or structural and/or pathological articular changes that compromise neural integrity and may influence organ system function and general health." The Chiropractic Paradigm, Association of Chiropractic Colleges.

under the program shall include a variety of chiropractic care and services for neuromusculoskeletal conditions including subluxation complex."

VHA Handbook 1100.9, Credentialing and Privileging, states: "The term independent practitioner is an individual permitted by law (the statute which defines the terms and conditions of the practitioner's license) and the facility to provide patient care services independently, i.e., without supervision or direction." The VHA privileging process includes verification of educational training and clinical competency.

Examples of neuromusculoskeletal conditions appropriate for chiropractic care include, but are not limited to, subluxation, back pain, neck pain, headache, and joint sprains and strains. A more comprehensive but not all-inclusive condition list routinely used in chiropractic education is included in Appendix A.

Comment: The term "subluxation" as used by allopathic practitioners refers to the slippage of one bone on another, (i.e., a partial dislocation) which is measurable on a radiograph. "Subluxation complex" or "vertebral subluxation complex (VSC)" are terms specific to chiropractic. These terms are used by doctors of chiropractic to describe a joint that they judge is no longer in proper position and/or is not functioning properly and the adjacent tissues associated with the malposition or altered motion of the joint. Subluxation complex may or may not be visible radiographically and may or may not have specific symptoms associated with it. Not all practitioners agree that the subluxation complex is a clinically definable entity.

C. Services to be Provided (Privileges):

Recommendation 5: Minimum Initial Privileges

Minimum initial privileges, based on the state licensure of the doctor of chiropractic, should include:

1. History taking
2. Neuromusculoskeletal examination and associated physical examination
3. Ordering of standard diagnostic plain film radiologic examinations to include spine, pelvic, skull, and rib series and chest (PA and lateral)
4. Determine appropriateness of chiropractic care for the problem(s) for which the patient is being managed.
5. Provide chiropractic care
   a. Adjustment
   b. Manipulation/mobilization
   c. Manual therapy
6. Manage neuromusculoskeletal care
7. Referral to appropriate provider when chiropractic care is deemed inappropriate or when patient conditions outside the scope of chiropractic care are suspected or detected through examination or as a result of diagnostic testing.

Recommendation 6: Other Initial Privileges

When permitted by the state licensure of the doctor of chiropractic and the privileging process for the VA facility, additional initial privileges may include:

1. Ordering of additional diagnostic studies
    a. Imaging studies (e.g., CT, MRI, ultrasound, bone scan)
    b. Clinical laboratory (e.g., Urinalysis, SMA 24, Arthritis Panel, CBC)
    c. Other appropriate tests (e.g., EMG, nerve conduction)
2. Order or provide other treatment modalities:
    a. Physical modalities (e.g., heat, cold, electrical, ultrasound)
    b. Ergonomic evaluation, posture management
    c. Orthotics, supportive bracing, taping
    d. Counseling/education on body mechanics, nutrition, lifestyle, exercise, hygiene.

Rationale: There is some variation in licensure law among the U.S. jurisdictions, and a doctor of chiropractic may not practice beyond the scope of his/her individual licensure. The Committee, in Recommendation 5, has identified privileges that all doctors of chiropractic are licensed to provide and recommends that these be permitted throughout VHA in order to provide baseline consistency in practice as chiropractic care is integrated into VHA. In Recommendation 6, the Committee has identified additional privileges that some doctors of chiropractic are licensed to provide, and recommends that these be included in initial privileges when permitted by the licensure of the doctor of chiropractic and the employing facility. The Committee understands that having different privileges for the same category of practitioner within a facility may be confusing, but believes that when consistency in practice within a facility is not an issue, doctors of chiropractic should be used to their fullest legal capability in providing care for neuromusculoskeletal conditions in order to reduce the degree to which patients are inconvenienced by having to see multiple providers for ordering of necessary diagnostic tests or treatments. The Committee also understands that some VA facilities require prior authorization for some diagnostic tests, such as MRIs, and believes prior authorizations required of doctors of chiropractic should be consistent with, but not exceed, existing facility policies.

Comment: Two members of the Committee wished to have surface electromyography and thermography added to the list of privileges. Doctors of chiropractic wishing to use these modalities could request them in their privileges, but the majority of the Committee does not believe they should be recommended for inclusion in initial privileges.

Recommendation 7: Additional Privileges

After the initial annual evaluation, the doctor of chiropractic may request additional privileges, which may be granted by the privileging facility consistent with the needs of the facility and the licensure held by the doctor of chiropractic,

upon demonstration of appropriate training and competency.

Rationale: The Committee understands that the privileges granted doctors of chiropractic will reflect not only the scope of the doctor of chiropractic's license, but also the mission and resources already available within the facility. In the event that a facility does not initially grant privileges up to the scope of the doctor of chiropractic's license, training and competency, Recommendation 7 suggests a timeframe for consideration of additional privileges after the facility has had experience in providing chiropractic care. Recommendation 7 also provides for additional privileges not included in Recommendation 6.

Recommendation 8: Publication of Information Letter

VHA should publish an Information Letter providing guidance to facilities regarding the recommended privileges approved by the Secretary.

Rationale: The chiropractic profession is new to VHA and most doctors of chiropractic practice in private practice settings rather than in health care organizations. An Information Letter that provides information regarding privileging of doctors of chiropractic will assist in providing some degree of consistency in process within VHA. An Information Letter provides guidance rather than a mandated policy.

D. Access to Chiropractic Care

Recommendation 9: Access to Chiropractic Care

Access to chiropractic care should be in consultation with the patient's primary care provider or another VA provider for the condition(s) for which chiropractic care is indicated. VHA facilities should establish processes that will ensure patients are adequately informed about treatment options, including chiropractic care, when presenting to urgent care with acute neuromusculoskeletal conditions appropriate for chiropractic care, when calling to request a primary care appointment for acute neuromusculoskeletal conditions, or when receiving care for difficult, chronic and otherwise unresponsive neuromusculoskeletal conditions. Patients presenting with neuromusculoskeletal complaints who prefer chiropractic care as their treatment option should be referred to a doctor of chiropractic for evaluation and care.

Veterans who have been referred to and have received care from a doctor of chiropractic should continue to have access to the doctor of chiropractic for the continuation of care or treatment, consistent with facility policy for specialty care access.

Rationale: VHA uses a primary care model of healthcare delivery, with access to almost all specialty care through referral. Allowing direct access to chiropractic care would create a specific exception to that overall model. It has not been VHA's practice to permit a patient to receive specialty care upon request; rather, another clinician, usually the patient's primary care provider,

must refer the patient.

All of the chiropractic members of the Committee believe veterans should be able to select and have easy access to chiropractic conservative care interventions for neuromusculoskeletal conditions.

Most of the members on the Committee have concerns that some existing VA practitioners may have biases, may not refer patients, and may continue to impose barriers before referring patients for chiropractic care. The doctors of chiropractic have concern that requiring the veteran to obtain a primary care appointment and referral may result in the veteran being unable to obtain chiropractic care in a timely manner.

As local facilities' experience with integrated doctors of chiropractic matures, they may wish to explore protocols for direct access at their facility.

Dissenting Recommendation: Two members of the Committee offer the following dissenting recommendation:
VHA facilities shall offer information on, and availability of, chiropractic services and offer all patients with neuromusculoskeletal conditions the option of direct access to chiropractic care.

Rationale: VHA has had the ability to refer to doctors of chiropractic for years, but has seldom made such referrals in the past. It is doubtful such an ingrained institutional culture will be altered from within by directives. Indeed this is the reason Congress mandated that this Committee give advice on protocols for direct access. It is much more likely to happen if the changes are driven by the ultimate beneficiaries, the patients; this is most certain to occur only if patients have true choice: direct access.

VHA Notice 99-02, Shared Decision Making, dated June 15, 1999, defines shared decision making as "…the case for letting patients decide which choice is best….A process by which patients are educated about likely treatment outcomes, with supporting evidence, and engaging with them in deciding which choice is best for them, taking into account their preferences, values and lifestyles.[2]"

Patients who present to urgent care or who call for a primary care appointment for acute neuromusculoskeletal conditions, as well as patients with difficult, chronic and otherwise unresponsive neuromusculoskeletal conditions should be provided with complete and unbiased information regarding evaluation and treatment options, including chiropractic care, and be permitted to make a choice regarding their health care. Established patients known to the provider, who are absent any "red flags" or overt contraindications for receiving chiropractic care,

---

[2] Woolf, S. Shared Decision Making. The Case for Letting Patients Decide Which Choice is Best. The Journal of Family Practice, 45 (3), 1997: 205-208.

and who prefer chiropractic care should be referred appropriately. New patients presenting to urgent care, or established patients who come in after normal hours and are seen by a provider who does not know them, will be examined by the provider on duty, provided information on treatment options, and then referred according to their preference for treatment. Other treatment regimes should not be required before referral for chiropractic care when that is the patient's preference. Then, if chiropractic care is selected, the doctor of chiropractic will conduct an evaluation and, if chiropractic care is appropriate, provide treatment as indicated.

While VHA endorses and is moving toward a primary care model of healthcare delivery, with access to almost all specialty care through referral, local variations still exist. These variations result from differences in the size and configuration of VHA facilities, staffing patterns, and local business practices. Currently, patients experience lengthy delays for enrollment for primary care and/or availability of primary care appointments. While VHA is diligently striving to reduce those delays, they remain a fact of life. The result is that patients may be unable to access chiropractic care in a timely manner.

Comment: It is the opinion of the two dissenting members of the Committee that VHA will see increased productivity for the following reasons:

1) The cost for the visit to the primary care provider just to get a referral will be eliminated;
2) The back up in accessing a primary care provider will be reduced by elimination of requirement for referral, freeing up the primary care provider to see others, and reducing the number of new primary care providers needed;
3) The costs for medications while waiting for a referral will be eliminated;
4) At least some of the treatment and medications now being prescribed will be eliminated and their costs saved.

Recommendation 10: Continuity of Care for Newly Discharged Veterans

Newly discharged veterans who have been receiving chiropractic care through the Department of Defense while on active duty, or who have service-connected neuromusculoskeletal conditions, or who are newly returned from a combat zone, or who have applied for service connection for the neuromusculo-skeletal condition for which DoD provided chiropractic care, should have direct access for continued chiropractic care at a VHA facility. Veterans accessing chiropractic care in this manner should be assigned a primary care provider at the earliest possible time.

Rationale: Newly discharged veterans who were receiving chiropractic care through the Department of Defense while on active duty should be able to receive continuing care from VHA without delays resulting from being placed on a waiting list for primary care enrollment. Any veteran who, at the time of discharge, is receiving chiropractic care for a neuromusculoskeletal condition, through a DoD provided source, is likely to become service connected for that

condition. Some veterans are receiving service-connected status at the time of discharge under the Benefits Delivery at Discharge program. Newly discharged veterans who did not have the opportunity to participate in the Benefits Delivery at Discharge program and who have applied for service connected status for the condition that was under treatment by DoD doctors of chiropractic also should be allowed to continue treatment without the delay created by the length of time required for adjudication of the claim. Newly discharged veterans returning from a combat zone are eligible for VA care for two years after leaving active duty even without a service connected disability.

The President's Task Force to Improve Health Care Delivery for Our Nation's Veterans recently recommended that VA and DoD improve their collaboration and sharing of information in order to improve the processes for transition from military service to veteran status. The need to share health information and improve continuity of care between DoD and VA has been a major focus of VA/DoD Joint Executive Council and has been included in the VA/DoD Joint Strategic Plan that was approved April 15, 2003 by the Joint Executive Council.

Recommendation 11: Inpatient Care

Doctors of chiropractic may see inpatients, including patients in VHA's long term care facilities, upon referral from another VHA provider, but will not have admitting privileges.

Rationale: Almost all chiropractic care in the private sector is provided in outpatient settings. If chiropractic care is indicated during an inpatient stay, the attending physician should request it through the consult process.

Recommendation 12: Chiropractic Care in Community Based Outpatient Clinics (CBOCs)

Chiropractic services should be provided in a CBOC when the parent facility determines that the need exists and when the resources are available to provide such services. The existing fee basis program can be utilized if staff or contract doctors of chiropractic are not available at the CBOC.

Rationale: VHA's CBOCs vary in size and resources. Decisions regarding provision of chiropractic care in CBOCs should be made as a part of overall facility/VISN planning for optimum provision of services. Chiropractic services provided at CBOCs will use the same guidelines and protocols as the parent facility.

Recommendation 13: Fee Basis Care

Chiropractic care should continue to be available through the fee-basis program. An evaluation may be required prior to authorization of fee-basis care; however, the authorization mechanism should be consistent with the requirements for all other fee basis authorizations within the facility.

Rationale: Chiropractic care should continue to be available to patients who live in areas distant from a VHA facility providing chiropractic services.

Recommendation 14: Occupational Health Programs

Doctors of chiropractic can be utilized in the VHA facility's occupational health program.

Rationale: At the National Naval Medical Center (NNMC), Bethesda, the doctors of chiropractic participate in the occupational health program by providing chiropractic care for work-related injuries, providing workplace ergonomic evaluations and recommendations, and providing classes in back care and ergonomics. The chiropractic staff believes that their initial involvement in treating NNMC staff played an instrumental role in acceptance of chiropractic care at that facility. This recommendation is offered as an option that individual facilities may wish to consider.

NNMC is different from VA facilities in that many of the NNMC personnel are active duty military, and receive all of their health care there. VHA personnel are civilian employees who are covered under the Federal Employee Compensation Act (FECA). While VHA would be able to bill Department of Labor for treatment of work-related injuries by VHA doctors of chiropractic, the chiropractic services that may be reimbursed are limited by the FECA to "treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist." [3]

Comment: Two members of the Committee do not agree that this recommendation should be included, as it does not pertain to providing services to veterans. While VA employees may receive treatment of work-related injuries at a VHA facility if they wish, availability of such care is limited by the capacity of the treating service to provide services to employees without interfering with the care of veterans. A number of Committee members believe it is unlikely the doctors of chiropractic will have time to evaluate or treat employees or to teach classes. There was strong disagreement from one member regarding the provision of ergonomic evaluations or classes by any provider, as there is no evidence that such evaluations and classes lead to any health gains and some randomized trial evidence indicates such classes lead to increased back pain claims.

E. Referrals to and from Doctors of Chiropractic

Recommendation 15: Screening of Patients

The doctor of chiropractic should screen patients to identify the following "red flags" or contraindications to manual therapy.

a. Possible fracture from major trauma, or minor trauma in an osteoporotic patient.

[3] 5 USC 8101(3)

b. Possible tumor or infection in patients with a history of cancer, recent fever, unexplained weight loss, recent bacterial infection, IV drug abuse or immune suppression
c. Possible cauda equina syndrome noted by saddle anesthesia, recent onset of bladder dysfunction, progressive neurologic deficit or major motor weakness in the lower extremity (not sciatica), unexpected laxity of the anal sphincter or perianal/perineal sensory loss.[4]

Rationale: The presence of these conditions suggests the need for medical consult prior to receiving chiropractic care.

Recommendation 16: Referral Service Agreements

VHA should encourage the development of referral service agreements between doctors of chiropractic and both primary care and other specialty providers regarding the types of conditions appropriate for referral to chiropractic care, and the pre-referral testing that will be useful to optimize the provider's time. The authorization mechanism for chiropractic referrals, follow-up, and recurrent care should be consistent with the facility's business practices for other referrals.

Rationale: In VHA models of health care delivery that do not allow direct access to specialty care, the goal of the referral process is appropriate access to chiropractic care for veterans with acute or chronic neuromusculoskeletal conditions (to include the subluxation complex) amenable to chiropractic care. A number of VHA facilities have developed service agreements to expedite the referral process.

Chiropractic patients typically present with a wide variety of neuromusculo-skeletal complaints; however, the large majority of patient complaints are related to back pain, neck pain, headaches and peripheral joint pain. (See Appendix A.)

While VHA's electronic medical record facilitates communication among multiple providers, development of service agreements can be used to clarify expectations regarding coordination of care and case management. Development of service agreements may also assist in the joint education of doctors of chiropractic and other VHA providers regarding the provision of care for neuromusculoskeletal conditions and the subluxation complex within VHA.

Comment: The subluxation complex (or vertebral subluxation complex) is an entity unique to chiropractic, as recognized by many State practice acts. Many chiropractic techniques are designed specifically to care for the subluxation complex, which may or may not be associated with neuromusculoskeletal symptoms (i.e., the subluxation complex may not be symptom specific or symptom dependent). Some members of the Committee do not agree that this is

---

[4] US Dept Health & Human Services, Agency for Health Care Policy and Research. Acute Low Back Problems in Adults: Assessment and Treatment. AHCPR Publication No. 95-0643, Dec. 1994, pg. 2.

a clinically definable entity.

Comment: Chiropractic members of the Committee believe that patients presenting with vertebral malposition, abnormal spinal segmental motion, soft tissue tenderness and compliance, and asymmetric or hypertonic muscle contractions are appropriate for referral to a doctor of chiropractic. Non-chiropractic members of the Committee believe that physical therapists, physiatrists or doctors of osteopathic medicine also are qualified to provide evaluation and care.

Comment: Chiropractic care often requires multiple patient encounters over a period of time. Patient response may range from complete recovery after a single treatment to a stabilization of the patient's condition without total resolution of the problem. It is the opinion of some chiropractic members of the Committee that, in the latter case, patients often benefit from periodic care over an indefinite period of time. They believe that while such an ongoing treatment regime may seem counter to effective case management, in many cases, the alternatives – no care or more aggressive care – may leave the patient in a more debilitated condition or involve more expensive or invasive medical care. Other non-chiropractic Committee members insist that there is no convincing evidence that periodic chiropractic care over an indefinite period of time provides any health benefit or can prevent the use of other health care procedures for any health condition.

Recommendation 17: Referrals from Doctors of Chiropractic
Doctors of chiropractic may make referrals to other VHA services and/or providers as appropriate, subject to facility protocols.

Rationale: In some cases, doctors of chiropractic may need to refer to other providers for specific services, e.g., orthotics or supportive bracing, if direct provision of those services are not within the privileges of the doctor of chiropractic, or social work service for family issues. The doctor of chiropractic also should have the ability to request further diagnostic evaluations and medical consultations with appropriate services (including specialists) within the VHA facility or system if potential contraindications to chiropractic care are identified. The doctor of chiropractic may encounter situations in which a patient presents with a medically urgent condition that requires immediate referral. Making such referrals directly when the need becomes evident during a patient visit will expedite appropriate intervention.

F. Integration of Chiropractic Care into VHA

Recommendation 18: Coordination of Care
The doctor of chiropractic and the patient's primary provider, in conjunction with other appropriate VHA providers, should develop a collaborative treatment regime when patients present with concurrent neuromusculoskeletal and non-

neuromusculoskeletal problems.

Rationale: The VHA health care system encourages an integrated, interdisciplinary, interdependent and collaborative team approach to patient care. A holistic, integrated approach is essential for many VA patients who have multiple health problems.

Recommendation 19: Co-management of Care

As a member of the VHA health care team, doctors of chiropractic should co-manage patient care for neuromusculoskeletal conditions as appropriate, along with the patient's primary provider, other team members, and specialists.

Rationale: Doctors of chiropractic should provide co-management of care when patients present with concurrent complex neuromusculoskeletal and non-neuromusculoskeletal problems.

Recommendation 20: Placement of Doctors of Chiropractic within a Health Care Team

Doctors of Chiropractic should be integrated into the VHA health care system as a partner in a health care team.

Rationale: The Department of Defense Chiropractic Health Care Demonstration Project demonstrated that chiropractic care was accepted best when the doctors of chiropractic were incorporated within a traditional medical team housed within the main medical facility, rather than functioning as a separate entity.

The Committee describes several models of integration in Appendix B. Decisions regarding placement should consider the functional working relationships appropriate to the care of patients with neuromusculoskeletal conditions in the facility. Teams may be organizationally defined or exist in a functional capacity. The doctor of chiropractic should be a part of whatever team is most likely to deal with initial presenting complaints related to the neuromusculoskeletal system.

Recommendation 21: Site Selection

The VISN Clinical Managers should provide recommendations for the initial sites they believe will be most successful in integrating chiropractic care into a facility while meeting the needs of veterans. The goal is to have chiropractic care at each of the major VHA facilities in each of the VISNs, consistent with the VHA distance and time standards for specialty access.

Rationale: P.L. 107-135 requires that chiropractic care be offered at a minimum of one VHA site in each VISN. Site selection for the initial placement of doctors of chiropractic, to the extent possible, should be driven by the interest and acceptance of chiropractic at facilities in each VISN, as well as by the most

advantageous use of resources.

Recommendation 22: Doctor of Chiropractic Staffing

Each facility providing chiropractic services should have enough doctors of chiropractic on staff to provide patient care. The goal is to have doctors of chiropractic at each of the major VHA facilities in each of the VISNS, consistent with VHA standards for waits and delay for specialty access.

Rationale: The DoD Chiropractic Demonstration Project provided two doctors of chiropractic at each selected site. Additional doctors of chiropractic may be required based on patient demand, subject to availability of VHA resources.

Recommendation 23: Support Staff

Personnel functioning as chiropractic assistants should come from existing job classifications, receiving additional on-the-job training from the doctor of chiropractic. Clerical staff for scheduling and other administrative clinic duties will also be needed.

Rationale: Chiropractic assistants provide assistance in patient care, similar to that provided by nursing assistants in other clinics. Facilities have the latitude to write new position descriptions, which are then locally classified under existing job series and titles. Clerical staff may be shared if the doctors of chiropractic are co-located with collaborating providers, but the addition of a new service and additional providers may require additional clerical support.

Recommendation 24: Space

Clinic space assignments should be consistent with existing provider space assignments. Each examination/treatment room should contain a sink and must be adequate to contain the standard chiropractic examination/treatment table (2 feet by 7 feet 5 inches) with sufficient space on all sides for the doctor of chiropractic to move about during treatment.

Rationale: The space required for a chiropractic examination/treatment table is larger than that required for most general medical examination rooms and more consistent with that found in a physical therapy or physical medicine area Desirable clinic space requirements include a reception/waiting area (which can be shared with other clinics) and two examination/treatment rooms per doctor of chiropractic. As has been noted for primary care clinics, an excess of two treatment rooms facilitates the ability to see a greater number of patients. Office space for the doctors of chiropractic should preferably be in close proximity to the patient care area.

Recommendation 25: Co-location with Collaborating Providers and Services

Where feasible, the doctors of chiropractic should be located with or near

collaborating providers or services.

Rationale: Co-location will facilitate communication and interaction with other providers and enable sharing of reception/waiting space, administrative support staff and space, and potentially some equipment. It is, however, important that providing space for chiropractic care not penalize or create hardship for other services.

Recommendation 26: Equipment

Chiropractic adjusting tables and specialized diagnostic evaluation equipment particular to chiropractic needs will be needed. See Appendix C for list of equipment and supplies needed for each examination room.

Rationale: In addition to standard office and examination equipment, some specialized equipment is needed for chiropractic evaluations. Chiropractic table types vary with some designed for specific types of care. Facilities should consult with the doctors of chiropractic before purchasing tables.

Comment: Two doctors of chiropractic on the Committee wished to have equipment for surface electromyography and thermography added to the equipment list in Appendix C. This equipment would be needed only if doctors of chiropractic received privileges to perform these tests. See Recommendation #6.

Recommendation 27: Orientation

A standardized orientation program on how chiropractic care is to be integrated into VHA should be developed and presented to clinical and administrative staff at each facility prior to the actual implementation of a chiropractic service.

VHA should develop a basic orientation program for doctors of chiropractic that can be modified for differences in facilities.

Rationale: VHA staff will need an orientation regarding the availability of chiropractic care, including how patients may access the care. Doctors of chiropractic will also require orientation to VHA, including orientation to the services provided at the facility and care processes, in addition to the general orientation all new employees receive. Assignment of mentors who are accepting of chiropractic care to the new doctors of chiropractic may assist in orientation and integration.

Recommendation 28: Ongoing Education of Providers

Doctors of chiropractic should participate in facility interdisciplinary educational activities in order to encourage collaboration and gain familiarity with the care provided by other services.

Rationale: Once the chiropractic service has been implemented, additional

interdisciplinary educational encounters will need to be provided to address new concerns or questions as well as to encourage collaboration among staff. Observation and participation in hospital rounds and patient care conferences may assist doctors of chiropractic in enhancing current skills as well as continuing to educate them regarding the variety of veteran patient conditions and needs. In addition, these educational encounters will serve to inform other professional staff regarding the services provided by doctors of chiropractic.

Recommendation 29: Education of Patients

VHA will provide standardized information to patients regarding the availability of chiropractic care. Each VISN will provide information to patients on how to access chiropractic services within the VISN. VISN Directors should assure the widest dissemination possible using multiple modalities.

Rationale: VHA published a patient education brochure regarding chiropractic care in May 2001 and distributed it through the VISN Clinical Managers. It is unclear how widely it was used, and many patients who have inquired about chiropractic care report that they have never seen it. VHA should make all veterans aware that chiropractic care is a part of its Medical Benefits Package.

The Committee will provide recommendations at a later time regarding content and methods of distributing educational materials.

Comment: One member of the committee stated that the information provided to patients should provide a “balanced perspective on the evidence” of the effectiveness of chiropractic care to insure patients are able to make informed decisions.

Recommendation 30: Quality Assurance

Chiropractic care should be incorporated into each facility’s quality assurance program.

Rationale: Chiropractic care should conform to VHA quality assurance processes in a manner that is consistent with other providers/services and the requirements of the Joint Commission on Accreditation of Healthcare Organizations.

The Committee will provide recommendations at a later time regarding quality measures for the chiropractic care program.

Recommendation 31: Performance Measures

VHA should develop performance/outcome measures for chiropractic care.

Rationale: VHA’s experience has shown that the use of performance/outcome measures is useful in improving the quality of care

provided to veterans.

The Committee will provide recommendations at a later time regarding performance measures.

Recommendation 32: Evaluation of Chiropractic Care Program

A formal evaluation of the challenges and benefits of providing chiropractic care within VHA should be completed by the conclusion of the third year of implementation. Formal progress reports should be completed at least annually and provided to the Secretary, the Under Secretary for Health, the Deputy Under Secretaries for Health, other members of the National Leadership Board, and made available to interested stakeholders.

Rationale: This evaluation should include the variations in organizational placement and models of delivery utilized across the VISNs and a determination of how these variations impacted the implementation of the chiropractic service. Data to be analyzed should include, at a minimum, the number and characteristics of patients receiving chiropractic care, waiting times for access to chiropractic care, and the impact on the use of the fee basis program for chiropractic care.

It is essential that evaluation factors be established and data collected in a prospective manner so VHA managers and doctors of chiropractic will be able to use the data for program improvement. Mechanisms should be established to enable the sharing of information regarding successful implementation strategies as well as lessons learned. The Committee anticipates that Members of Congress will request such data. Therefore formal progress reports should be produced at least annually.

Recommendation 33: Medical Staff Voting Privileges

All doctors of chiropractic, once credentialed and privileged by a VHA facility, should be members of the Medical Staff and have full voting privileges.

Rationale: To fully integrate chiropractic care into the VHA healthcare system, doctors of chiropractic should be full voting members of the Medical Staff. In most VHA facilities, both podiatrists and optometrists are voting members of the medical staff.

Comment: Two members of the Committee stated that medical staff voting privileges should be at the discretion of the local facility and consistent with existing VA guidelines.

Recommendation 34: Continuing Education

Doctors of chiropractic employed by VHA should be expected to obtain continuing education as required for the maintenance of licensure and competency. VA should fund such training in accordance with existing VA policy.

Rationale: VHA expects all professional staff to maintain and enhance competency through continuing education programs. Doctors of chiropractic should be able to access funding for educational programs in the same manner and to the same degree as other staff.

Recommendation 35: Oversight and Consultation for the Chiropractic Program

VHA should create a mechanism for providing oversight of and consultation on the implementation of chiropractic care. This may be accomplished through the appointment of a chiropractic advisor, similar to the position of the physician assistant advisor or the directors of podiatry and optometry, and a field advisory committee.

Rationale: All other professions have representatives to provide advice and input to the Chief Patient Care Services Officer and the Under Secretary for Health. A structure for obtaining input from practicing doctors of chiropractic is essential to the success of the chiropractic care program within VHA. All current occupational representatives within Patient Care Services are field-based and perform these duties on a part-time basis.

A full-time chiropractic advisor/director position could occur only as a VACO position, and there are distinct benefits in having a field-based practicing clinical doctor of chiropractic in this position. As a profession new to VHA, it will be important for the person in this position to have a hands-on working knowledge of VHA operations. In addition, field-based positions allow for the recruitment of the best-qualified individuals rather than just someone who is willing to move to Washington, DC.

Recommendation 36: Committee Membership

Doctors of chiropractic should be included in the membership of appropriate facility, VISN, and national clinical and administrative committees, work groups and task forces in a manner consistent with the participation of other providers.

Rationale: Doctors of chiropractic should provide input through membership on committees, work groups and task forces that discuss, evaluate or make recommendations regarding or otherwise impact the provision of chiropractic care.

Recommendation 37: Academic Affiliations

VHA should provide opportunities for educational and training experiences for senior chiropractic students and recent graduates from chiropractic programs, consistent with graduate preceptor programs sponsored by chiropractic educational programs. These educational experiences should expose the student to a wide range of services provided in the VHA facility to broaden the participant's understanding of clinical care and to help the student to experience

chiropractic care in a multidisciplinary setting.

Rationale: Health professional training is one of VA's missions. VHA is noted for its leadership in providing clinical experiences for a variety of health care professions.

Recommendation 38: Research

VHA, in conjunction with its chiropractic providers and chiropractic educational programs, should conduct clinical research relevant to the type of conditions and services provided by doctors of chiropractic. Emphasis should be placed on common service connected conditions. Research related to integration of multidisciplinary providers into teams should also be undertaken.

Rationale: Neuromusculoskeletal conditions are among the most common reasons for service-connected status. VHA has a unique opportunity to develop research programs to evaluate the efficacy of chiropractic care in the treatment of these conditions as well as to evaluate the dynamics of developing and integrating multidisciplinary teams.

APPENDIX A

CONDITIONS COMMONLY SEEN BY DOCTORS OF CHIROPRACTIC (Not all inclusive)

Chiropractic patients typically present with a wide variety of neuromusculo-skeletal complaints; however, the large majority of patient complaints are related to back pain, neck pain, headaches and peripheral joint pain. Doctors of chiropractic commonly manage the conditions on this list, which is provided as information for persons not familiar with the scope of chiropractic practice. This list does not imply that only doctors of chiropractic can manage these conditions or that other health care providers are not trained to manage these conditions.

One Committee member stated that there are no evidence-based studies to support the therapeutic value of spinal manipulative therapy for some of these conditions. A doctor of chiropractic on the Committee pointed out that a doctor of chiropractic may manage some conditions, such as osteoporosis, with dietary and exercise recommendations, rather than spinal manipulation.

The DoD Demonstration Project limited the doctors of chiropractic to treatment of "spine-related neuromusculoskeletal complaints or problems". Since completion of the Demonstration Project, DoD has expanded the scope of practice for the doctors of chiropractic to "neuromusculoskeletal problems."

1. Subluxation	16. Migraine
2. Chronic pain	17. Posterior facet syndrome
3. Strain/Sprain (traumatic)	18. Chronic daily headache (tension)
4. Lumbosacral strain/sprain	19. Vertebrogenic headache
5. Intervertebral disc syndrome	20. Scheurman's disease
6. Sacroiliac syndrome	21. Carpal tunnel syndrome
7. Cervical strain/sprain	22. Rotary cuff tendonitis
8. Symptomatic Scoliosis	23. Mechanical disorders (thoracic)
9. Thoracic sprain/strain	24. Chest wall syndrome
10. Torticollis (acquired)	25. Tendonitis (traumatic)
11. Myofascial pain syndrome	26. Disc syndrome (cervical)
12. Acute cervical pain	27. Bursitis (traumatic)
13. Osteoporosis	28. Compartment syndrome
14. Osteoarthritis	29. Patellofemoral syndrome
15. Peripheral neuropathies	

APPENDIX B

MODELS FOR INTEGRATED CARE DELIVERY

The following models of integrated care delivery may be useful to VHA administrators and clinical staff in planning to incorporate chiropractic care into VHA facilities. The Committee believes chiropractic care should be integrated into existing multi-disciplinary care delivery models, in a manner consistent with current business processes and the privileging and use of other health care providers.

While the different organizational structures and functional processes found among VHA facilities will influence how chiropractic care is integrated at any given facility, the Committee believes the following principles should be used:

- The systems and structures used to integrate doctors of chiropractic should facilitate the timely, efficient provision of care to veterans.
- Decisions regarding care delivery should focus on the provision of care, not the location of care.
- Decisions regarding care delivery should focus on the skills a person needs to provide that care, not the profession of the person.

The following models are provided for consideration in no specific order.

Model 1: Integration into primary care setting or service line.

This model replicates a method used for integrating psychiatry into the primary care setting at the West Los Angeles VA and other facilities.

A doctor of chiropractic (DC) would be physically located within the primary care area. The DC would see patients on referral from primary care providers, usually on a same day basis for initial evaluation. The DC also would be able to provide immediate evaluation and care for patients who call or walk in with acute neuromusculoskeletal complaints when it is the patient's choice to see a DC. Patients would be referred back to their primary care provider with specific recommendations if chiropractic care is not indicated. When chiropractic care is indicated, the patient would be scheduled for visits with the primary care clinic chiropractor. The patient's neuromusculoskeletal condition may be co-managed by the primary care provider and chiropractor, or for patients whose chief complaint is neuromusculoskeletal, the DC may become the principal provider of care with collaboration with other team members as needed. Organizational placement for administrative purposes may or may not be under primary care, and would depend on the overall organizational structure of the medical center (i.e., traditional services vs. service lines.)

Advantages:

- Doctor of chiropractic is available in the primary care area for short, informal consultations, which may obviate the need for a

formal consolation, thus increasing efficiency.
- Allows quicker access to chiropractic evaluation and initiation of care.
- Improved patient satisfaction as a result of immediate referral during one visit.
- Care is viewed as continuous over time rather than as discrete treatment episodes, improving coordination of care across disciplines.
- Allows more efficient utilization of the primary care providers.
- The doctor of chiropractic becomes a functional member of the primary care team, and as such, is present and provides appropriate input during educational sessions and patient care planning conferences.

Disadvantages:
- Finding space in existing primary care areas.
- The chiropractic area within the primary care setting would become the de facto chiropractic clinic with additional patients being referred from other providers (e.g., orthopedics.) increasing space needs.
- Need for duplicate equipment (e.g., chiropractic tables; other modalities such as electrostimulation, ultrasound, hot packs, if DC is privileged to provide these modalities) if there is a separate chiropractic clinic located elsewhere.
- Need to coordinate chiropractic visits with physical therapy if DC is not privileged to provide the modalities mentioned above.
- Staffing needed to maintain availability of DC if/when patient load increases.

Model 2: Integration into a specialty service or service line with liaison to primary care.

This model replicates the method used for integrating physical therapists into primary care at the VA Salt Lake City Healthcare System.

When veterans present to primary care, the emergency department, or call with an acute neuromusculoskeletal complaint, the provider would be able to page a DC who is available to evaluate the patients. Both providers might examine patients collaboratively and discuss options for care with the patient. When the patient chooses chiropractic care, the DC could then take the patient to the chiropractic clinic to provide care, and schedule follow-up appointments as necessary.

Advantages:
- Allows quicker access to chiropractic evaluation and initiation of care.

- Coordinates care.
- Allows more efficient utilization of the primary care providers.
- Enhances education of the providers involved.
- Improved patient satisfaction as a result of immediate referral during one visit.

Disadvantages:

- Need to move patient to chiropractic clinic for care.
- Staffing needed to maintain availability of DC if/when patient load increases and after duty hours.

Model 3. Integration into a specialty service or serviceline without specific liaison to primary care.
This model is similar to that used at the National Naval Medical Center.

Doctors of chiropractic would be organizationally placed in a specialty service or service line that provides the majority of specialty care to patients with neuromusculoskeletal conditions.

Specialty services such as Rehabilitation or Orthopedics involve the coordinated work of numerous professionals, including physical medicine and rehabilitation physicians, physical therapists, occupational therapists, nurses, and others. Doctors of chiropractic would become a part of such a team. Patients would come to the specialty service/serviceline by referral. In some instances, veterans would be evaluated and treated using a team approach, individualized to the specific needs of the patient.

Advantages:

- Placement of personnel is organizationally and functionally congruent.
- Uses existing specialty referral process.
- Enhances education of providers in specialty area.
- Can share some equipment if located near physical therapy.

Disadvantages:

- Referral process will delay care unless same-day appointments are available.
- Less patient satisfaction due to wait for care if same-day appointments are not available.
- Coordination of care and collaboration with patient's primary care provider more difficult.
- Does not enhance education of primary care providers regarding options for care of neuromusculoskeletal conditions.

APPENDIX C

CHIROPRACTIC EQUIPMENT REQUIREMENTS

Recommended equipment and supplies for each chiropractic examination room:

- Chiropractic examination/adjusting table
- Stethoscopes
- Sphygmomanometers
- Ophthalmoscopes
- Dynamometers
- Goniometers
- Tape measures
- Percussion and reflex hammers
- Penlights
- Scales with height measuring apparatus
- Tuning forks (126 HZ and 512 Hz)
- Pinwheels
- Plumb lines
- Disposable gowns, gloves and table covers
- Computer and chairs or stool

Depending on the privileges of the doctor of chiropractic, electrostimulation and ultrasound equipment and heat and cold application devices may also be needed.