Guidelines for Chiropractic Quality Assurance and Practice Parameters

Proceedings of the Mercy Center Consensus Conference

Scott Haldeman
David Chapman-Smith
Donald M. Petersen, Jr.

AN ASPEN PUBLICATION

8

Frequency and Duration of Care

Chapter Outline

Safety and Effectiveness

Safety: a judgment of the acceptability of risk, in a specified situation, e.g., for a given health problem, by a provider with specified training (at a specific stage of the disorder etc.).

Effectiveness: producing a desired effect under conditions of actual use.

VI. RECOMMENDATIONS

Note: Statistical descriptors of treatment frequency, such as mean/median/mode, should NOT be used as a standard to judge care administered to an INDIVIDUAL patient. The particular factors of each case will govern the course of recovery and need to be a part of the considerations in assessing clinical progress.

A. Short and Long Range Treatment Planning:

At the outset of treatment/care, a written estimated time frame for reaching intermediate functional milestones (short term goals, e.g., the ability to move the affected part, exert force, walk, etc.) and treatment/care outcomes (long term goals, e.g., return to work, renew sports, full activity, etc.) should be made. The length of time to reach these objectives can be affected by specific historical factors.

NOTE: These factors, when combined (two or more), do not necessarily imply combined delay in recovery, but must be evaluated on a case-by-case basis.

1. **Preconsultation Duration of Symptoms.** Pain less than eight days: No anticipated delay in recovery. Pain more than eight days: Recovery may take 1.5 times longer.
2. **Typical Severity of Symptoms.** Mild pain: No anticipated delay in recovery. Severe pain: Recovery may take up to two times longer.
3. **Number of Previous Episodes.** 0-3: No anticipated delay in recovery. 4-7: Recovery may take up to two times longer.
4. **Injury Superimposed on Preexisting Condition(s).** Skeletal anomaly: May increase recovery time by 1.5-2 times. Structural pathology: May increase recovery time by 1.5-2 times.

8.1.1 **Rating:** These recommendations are **safe** and have **limited effectiveness** in predicting recovery rate. They have a rating of **promising** based on Class II and III evidence.
Consensus Level: 1
Strength of Recommendation: Type B

B. Treatment/Care Frequency:

Specific recommendations related to acute, subacute and chronic presentations are given below. In general, more aggressive in-office intervention (three to five sessions per week for one to two weeks) may be necessary early. Progressively declining frequency is expected to discharge of the patient, or conversion to elective care.

8.2.1 **Rating:** The general approach to frequency is **safe** and **effective** provided it is carried out within the guidelines of natural history. The rating is **established** and is supported by Class II and III evidence.
Consensus Level: 1
Strength of Recommendation: Type B

C. Patient Cooperation:

The nature of the patient's disorder and the purpose and strategy of the treatment plan should be adequately explained to the patient. Patients who prove to be insincere or non-compliant to treatment/care recommendations should be discharged from care, with referral when appropriate.

8.3.1 **Rating:** This recommendation is **safe** and **effective**. The rating of **promising** is given when used in an effort to avoid physician dependence and overuse of services based on Class II and III evidence.
Consensus Level: 1
Strength of Recommendation: Type B

D. Failure to Meet Treatment/Care Objectives :

1. **Acute Disorders:** After a maximum of two trial therapy series of manual procedures lasting up to two weeks each (four weeks total) without significant documented improvement, manual procedures may no longer be appropriate and alternative care should be considered.

2. **Unresponsive Acute, Subacute, or Chronic Disorders:** Repeated use of passive treatment/care normally designed to manage acute conditions should be avoided as it tends to promote physician dependence and chronicity.

3. Systematic interview of the patient and immediate family should be carried out in search for complicating or extenuating factors responsible for prolonged recovery.

4. Specific treatment/care goals should be written to address each issue.

5. Continued failure should result in patient discharge as inappropriate for chiropractic care, or having achieved maximum therapeutic benefit.

8.4.1 **Rating: Safe** and **effective** procedures that are **established** and supported by Class I, II, and III evidence.
Consensus Level: 1
Strength of Recommendation: Type A

E. Uncomplicated Cases: (acute episode)

Observing the consistency of practice experience defined by the studies listed in the review of literature for passive care, *only* acute episodes can truly be considered uncomplicated. Acute episode (first occurrence, recurrent, or exacerbation of a chronic condition).

1. Symptom Response: Significant improvement within 10-14 days; three to five treatments per week.
2. Activities-of-Daily-Living (ADL): The promotion of rest, elevation, active rest, and remobilization, as needed, are expected to improve ADL followed by a favorable response in symptoms.
3. Return to Pre-episode Status: six to eight weeks; up to three treatments per week.
4. Supportive Care: Inappropriate.

8.5.1 **Rating:** These recommendations are **safe** and **effective** in meeting the desired objectives. It has an **established** rating based upon the relationship to natural history. It is supported by Class I, II, and III evidence.
Consensus Level: 1
Strength of Recommendation: Type A.

F. Complicated Cases:

Implementation of up to two independent treatment plans relying on repeated use of passive care is generally acceptable in the management of cases undergoing prolonged recovery.

1. Signs of Chronicity: All episodes of symptoms that remain unchanged for two to three 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.

8.6.1 **Rating:** Criteria for chronicity are **established, safe** and **effective** with Class I, II, and III evidence.
Consensus Level: 1
Strength of Recommendation: Type A

2. Subacute Episode:

a. Symptom Response: Symptoms have been prolonged beyond six weeks, and passive care in this phase is as necessary, not generally to exceed two treatments per week, to avoid promoting chronicity or physician dependence.
b. Activities of Daily Living (ADL): Management emphasis shifts to active care, dissuasion of pain behavior, patient education, flexibility and stabilization exercises. Rehabilitation may be appropriate.
c. Return to Pre-episode Status: 6-16 weeks.
d. Supportive Care: Inappropriate.

8.6.2 **Rating:** These recommendations are **safe** and **effective** in reaching the desired objective. They have a **promising** rating based upon the relationship to natural history and are supported by Class II and III evidence.
Consensus Level: 1
Strength of Recommendation: Type B

3. Chronic Episode

a. Symptom Response: Symptoms have been prolonged beyond 16 weeks, and passive care is for acute exacerbation only.
b. Activities of Daily Living (ADL): Supervised rehabilitation and life style changes are appropriate.
c. Return to Preinjury Status: May not return. Maximum therapeutic benefit and declaration should be considered.
d. Supportive Care: Supportive care using passive therapy may be necessary if repeated efforts to withdraw treatment/care result in significant deterioration of clinical status.

8.6.3 **Rating:** These chronic episode recommendations are **safe** and **effective** in reaching the desired objectives of sustaining the optimal health status under the circumstances. The rating is **promising**. Chronic disorder treatment/care is supported by Class II and III evidence.
Consensus Level: 1
Strength of Recommendation: Type B.

G. Elective Care:

Under specific circumstances for individual cases, elective care may be safe and effective. Elective care must be designed to avoid physician dependence and chronicity. Therapeutic necessity is absent by definition.

8.7.1 **Rating:** Unrated
Consensus Level: 1

VII. COMMENTS, SUMMARY, OR CONCLUSION

There are many unknown features that obscure our understanding of the nature of most musculoskeletal disorders. Manipulative/ adjustive procedures are an important option in the initial management. While efforts continue to be made to understand more completely the pathoanatomical and functional