

CHIROPRACTIC BEST PRACTICES A Systematic Review by the Research Commission of the Council on Chiropractic Guidelines and Practice Parameters

PREFACE

The Dissemination, Implementation, Evaluation and Review (DIER) Process

This document is solely a survey of existing studies, and only expresses the opinion of CCGPP. It is not intended to, nor does it establish a standard of care in specific communities, specific cases, or as to the care of any particular individual or condition. Each case must be determined on the basis of a careful clinical examination and diagnosis of the patient, giving due consideration to the specific condition presented and the individual's informed choice as to care and treatment. No part of this document is intended to support any litigation or proceeding involving the standard of care, medical necessity or reimbursement eligibility.

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History has shown that guidelines often sit on the shelf of stakeholders without much implementation. They fail to be utilized and, therefore, cannot be assessed as to their value. Like a good wine, it becomes aged. However, without updating the application, instead of improving over time it will become obsolete.

This was observed in chiropractic with the 1993 release of the "Mercy Guidelines".¹ Previous studies of other guidelines have revealed a serious deficiency in adoption of clinical practice guidelines in practice.² Tunis et al did a study of the American College of Physician members' attitudes toward guidelines. He found that familiarity was as low as 11%. Confidence in its potential to improve the quality of health care was as high as 70%, but 43% of the physicians believed it would increase the costs and 34% felt it would make practice less satisfying. There was concern noted regarding possible effects on clinical autonomy, and satisfaction in clinical practice.³ These same concerns were noted in the chiropractic physician comments from the initial draft review. In addition, a lack of motivation and confidence by stakeholder populations is commonly found as a deterrent to implementation in many studies⁴.

Implementation strategies for the Chiropractic Literature Synthesis and Stratification (CLSS) need to overcome these previous problems by means of a process to address the forces and variables influencing practice. One of the forces involved includes the recent socioeconomic movement in the United States to restrict practice in hopes of curtailing costs. Another force is that of the politics in healthcare and in the specific politics within Chiropractic. The diversity of opinions, vested interests, and various agendas all can converge and conflict in obtaining the goals of improved quality care. One of the variables includes the practice variations and subsequent individual patterns of care that become habit, ingrained and sometimes progressing to belief systems. The result of these many forces and variables is that previous clinical practice guidelines have been left to the individual practitioners to attempt to implement through various self motivated, self directed strategies which had a variety of results. The more ambitious practitioners would influence other clinicians and patients, and the less ambitious practitioners would hold firm to their entrenched practice patterns and belief systems.

The Council on Chiropractic Guidelines and Practice Parameters (CCGPP) realizes that, in order to promote improved quality of patient care, there must be a process in which all the stakeholders can access and utilize the research information. The stakeholders then must be able to translate it into practice by integrating it with appropriate clinical experience and judgment and the individual presentation of the patient, along with the patient's values and desires, to enhance the clinical decision making process. The Appraisal of Guidelines Research and Evaluation (AGREE) document specifically rates the "organizational, behavioral and cost implications" of the potential applicability⁵ in order to assess the quality of any guidelines, or best practices. In order for field practitioners, students, colleges, payers, governmental agencies, and independent medical review organizations to obtain the value of the information, the CCGPP realizes that there must be a concerted effort at changing current provider behavior. The potential for that change needs to be evaluated for the organizational tools needed, a means of education, and a fostering of the changes in practice, with a subsequent review of specific criteria that would measure those changes.

The initial draft of the literature synthesis and risk stratification (CLSS) is the first component of the process that has been named the "Chiropractic Clinical Compass." The CLSS is only a compilation of the evidence available to provide an informed approach to providing quality care. The Chiropractic Clinical Compass includes and describes the remaining process of Dissemination, Implementation, Evaluation and Review (**DIER**). The purposes of the additional processes are targeted to allow applications of the research as a guide to clinical decision-making, along with ongoing evaluation of the research and its utility, and reviewing and updating the document and the implementation process, or its utilization.

The CCGPP investigated the most productive means of dissemination of the document in order to be inclusive of all stakeholders. In addition, the Council investigated the different educational interventions to facilitate the implementation and to aid in the change in practitioners practice habits and behavior. Although dissemination is important, dissemination alone fails to change practice patterns or the process of care. Davis & Taylor-Vaisey found that a New Zealand survey (conducted by Arrol in 1995) showed only 40% of the physicians who were given a hypertension management guideline actually read the guideline,² indicating a dire need to go beyond the simple dissemination. In addition Rosser found that after the release of lipid lowering guidelines in Ontario, only 5% of the physician respondents actually followed the standards,⁶ indicating a need to go beyond dissemination and education of clinical practice guidelines.

Keeping in mind the ultimate goal of improved patient care, the Council is most interested in promoting the change in the process of care. In fact, this is what ultimately resulted in the change in design from a "Practice Guideline" to a "Best Practice" format for the document. Factors noted as being important in the change of the process of care have been found to include simplification of the CLSS, education, creating incentives, involvement of stakeholders, multiple learning approaches, multiple implementation approaches, reminder systems, and audits. The Council intends to respond with a number of different approaches.

Simplification of the basic research information will result in additional versions provided in various summary formats appropriate for the various stakeholders. This includes creating an easily referenced source for the field practitioner, along with a summary version.

Incentives for behavioral change are also of great importance. Many payers are already formulating incentives for change through pay-for-performance measures encouraging improved quality of care and better outcomes. It is the belief of the Council that the natural progression of financial incentives will produce increased implementation of the Chiropractic Clinical Compass.

A number of chiropractic colleges have expressed interest in pilot testing the implementation of the Chiropractic Clinical Compass in their clinics and are currently teaching evidence based care to their students. Graduating chiropractic physicians will find themselves in a unique position in which they will be better suited for the pay for performance practices than the established practitioners. This is a stark change from the earlier situation in which graduating doctors had difficulty in joining networks that were filled with the already established chiropractic physicians. It will also effectively create further incentives for the established practitioner to implement potential aids for improved quality of care. In addition to these external incentives, the Council must also consider creating

personal, meaningful internal incentives to reinforce the changes, such as academic recognition or certification.

The Council recognizes the importance of universal stakeholder involvement. A practitioner's background, ethics, personal goals, desires, motivation, educational background, philosophy and beliefs all affect his/her practice behavior. Chiropractic Physicians, like most physicians, are often set in their behaviors due to the extensive training, continuing education seminars, influence of past opinion leaders, mentors and peers, extensive testing, and having to conform to third party payer demands. In addition, the practitioner's behavior may be governed by their perceptions (right or wrong) and those perceptions may be manipulated by internal and external forces.⁷ These external forces include professional political influence. Soumerai and Weingarten indicated that opinion leaders were utilized successfully in changing physician behavior and facilitating implementation of guidelines to reduce unnecessary cesarean sections, improve blood transfusion practices, and improve appropriateness of length of stay of patients with chest pain.^{8,9}

The Council has addressed the external forces through a concerted effort to involve the most representative and influential chiropractic organizations as part of the process. Representatives of the organizations on the Council have been integrally involved in the entire process. In addition, meetings with the representatives of all state chiropractic associations through the Congress of Chiropractic State Associations (COCSA) recently provided a forum for post-review feedback regarding improving the format and implementation. These leaders will be continually involved in the process. Healthcare leadership can also create incentives to alter practitioners' behavioral changes by their influence on their peers.

The internal forces include intrinsic motivation of the practitioners. This can be approached through consensus building, and providing cognitive satisfaction to those rational information seekers by means of easy access to research findings. To address the intrinsic practice orientation of the chiropractors, their various practice patterns and philosophies, the Council engaged Tom Milus, DC, PhD. Dr. Milus created the "Chiropractic Pyradigm". The Pyradigm graphically illustrates how practitioners of all philosophic orientations collaborate in generating the chiropractic best practices. The chiropractic Pyradigm is described in detail in this introductory chapter.

Patient factors also influence the implementation of clinical behavior. As patients are a distinct stakeholder in the process, the Council will be developing a patient brochure in layman's language to allow the patient to become more involved as a partner in their care. An educated patient can also create further incentives as an increased demand is put on the clinician for implementation.

Slotnick, in his work on physician learning strategies, describes three stages of physician learning that bring the doctor through a process that precipitates good learning outcomes.

1. Stage 1: The doctor decides whether to take the initiative of the learning task. This is the stage in which the doctor is scanning for problems or a specific problem that comes up in practice in which the doctor decides to formulate an appropriate question and research the answer. The doctor evaluates the question and the potential necessary resources and work involved, and then decides whether the potential problem is worth pursuing.
2. Stage 2: The doctor gains skills and knowledge anticipated to resolve the problem. The doctor pursues the information through the resources available.
3. Stage 3: The doctor gains experience using what he/she has learned in a variety of settings. He/she learns the skills and knowledge and tries applying it to solve the problem in practice and evaluates the results¹⁰

Through the DIER process outlined below, the Council will attempt to provide the resources to address the many different aspects necessary to simplify the learning process, enhance the ability of the doctor to go through the learning strategies and optimize implementation.

The Compass actually consists of two parts. Part I consists of the research literature synthesis and stratification, the CLSS. The literature has been divided into seven major areas of the most common conditions treated in the chiropractic office as referenced by the NBCE job analysis. An initial literature search is conducted by the search strategies previously described. These are then reviewed for relevance to the four major questions to be addressed to determine the clinical outcomes. The remaining literature is then rated for quality and relevance according to the respective rating instruments. The resulting papers' conclusions are then summarized regarding the procedures evaluated. Respective ratings of the quality of research on the topics are rendered and then database tables are constructed for the literature ratings.

Part II consists of the process utilized to integrate and translate the literature into practice. This consists of plans to disseminate the information, implement the information into practice, and to evaluate the degree of implementation and the benefits of that implementation for all stakeholders, especially the patients. Subsequent to that there will be continual updates and revisions of the entire process in order to keep the research current. These revisions will also improve the process and benefit to all stakeholders as we strive to attain the ultimate goal of "improved patient care" throughout the chiropractic profession.

This dissemination process will utilize a variety of strategies, including DVD's, Website access, Flashcards, publication of the full literature synthesis and

stratification online and in hard copy. The final product shall also include a section on the previously mentioned Milus Pyradigm to enhance our appreciation of the experiential, experimental and clinically oriented practitioners.

The Introductory chapter will include a description and outline of the entire DIER process. There shall also be a consolidated summary, quick reference guide and a report of previous iterations stakeholder feedback. This will be distributed to the chiropractic profession through FCER, while other stakeholders will obtain their version through WLDI.

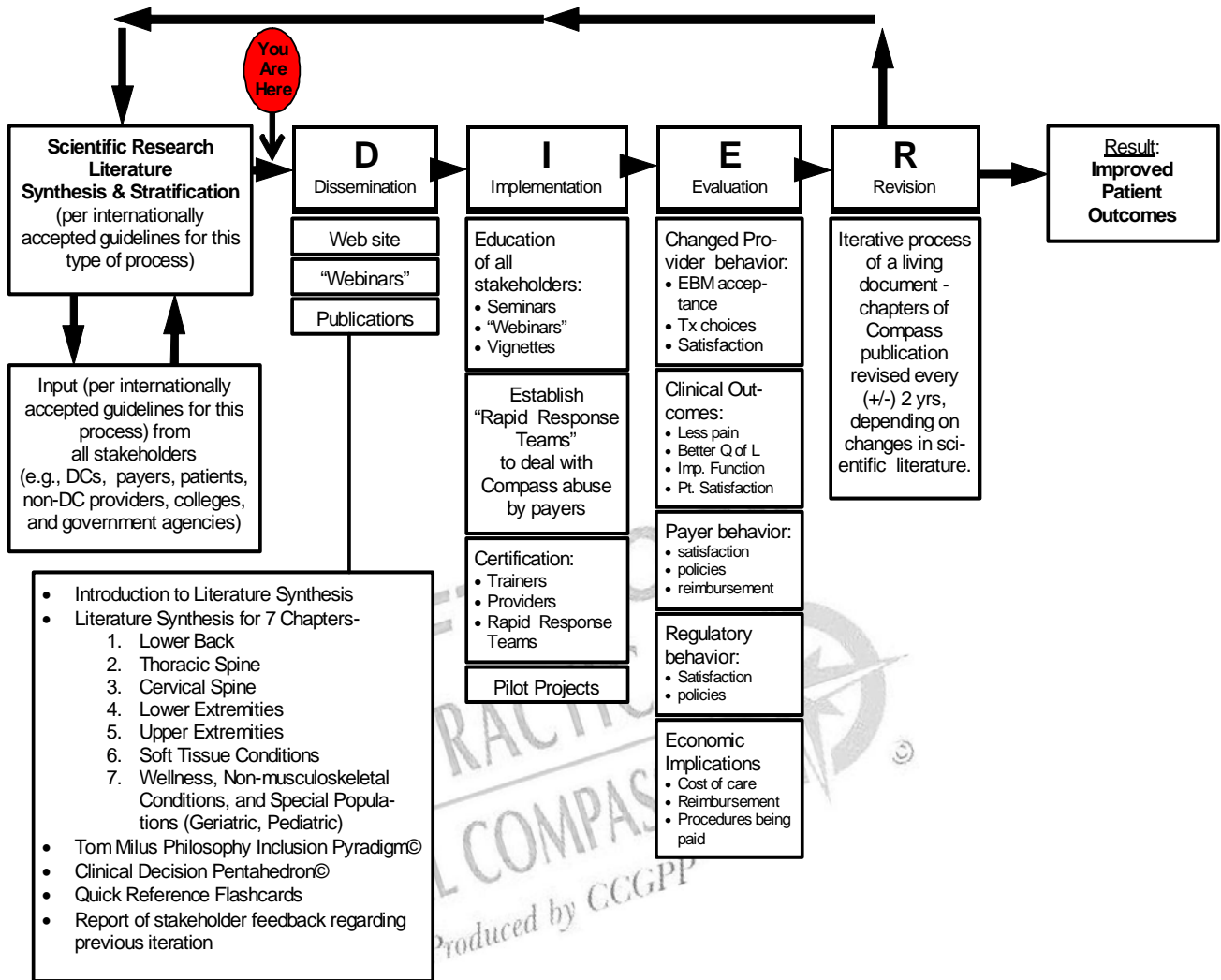
Implementation shall consist of, but not be limited to pilot projects with academic institutions and private organizations. An educational program will be constructed to train trainers in each state in coordination with the state societies and associations. A full certification course will be constructed to provide continuing education and certification to the practicing clinician. This course will employ clinical vignettes that are expected to continually expand along with the implementation process. A rapid response team and formal process shall be developed by the CCGPP to react to inappropriate use or abuse of the Chiropractic Clinical Compass documents.

Evaluation shall consist of, but not be limited to, a survey of the profession and a review of outcomes in the quality of care of the patient. In addition, there will be an evaluation of changes in provider clinical behavior and decision-making as well as provider satisfaction. There will also be evaluation of the subsequent economic implications regarding the cost of care; the effect on pay for performance programs; patient satisfaction; payer satisfaction, changes in behavior, policies, and utilization review; regulatory changes, changes in regulatory behavior and procedures; and, professional utilization of the Chiropractic Clinical Compass.

Once all this information is compiled, there will be subsequent biannual revisions with updates to the research database and appropriate changes made to hard data and the process.

It should again be emphasized that the goal of the entire process is to improve and optimize the quality of patient care.

The Chiropractic Clinical Compass
A Best Practices Development, Implementation, and Revision Process



References

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