

Oregon Chiropractic Practice and Utilizations Guidelines

Chapter IV Chiropractic Management Algorithm

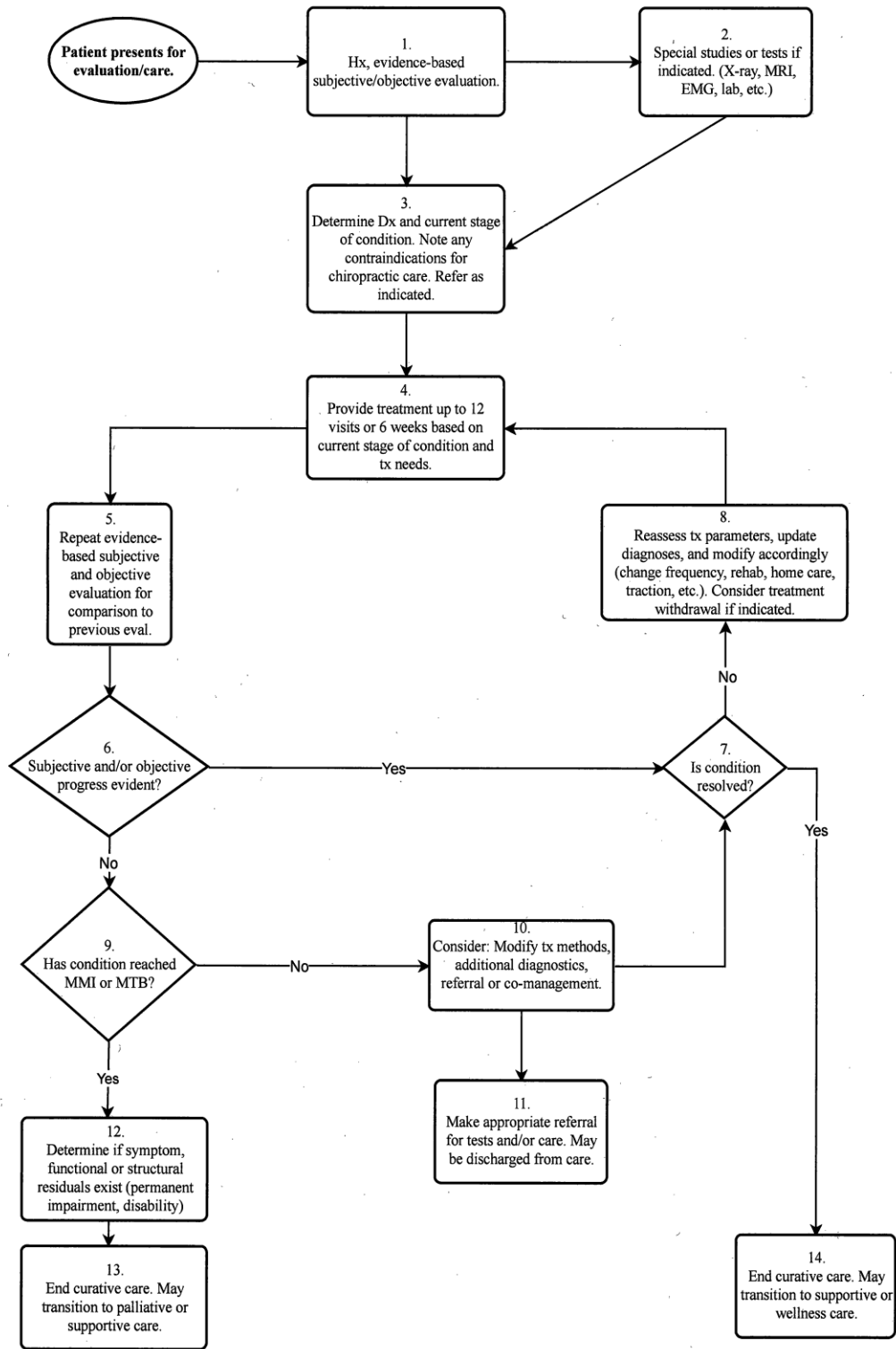
The following curative care algorithm, developed and accepted by a subcommittee of the OBCE (2014-2016), presents a clinical management path for the chiropractic physician to facilitate efficient patient recovery. The emphasis is on management of the patient, not on a specific pathophysiology.

Rehabilitation

Rehabilitation is treatment designed to facilitate the process of recovery from injury, illness, or disease. The goal of rehabilitation is to promote recovery, improve function, and to help the patient become self-reliant in management of their health. This generally involves transitioning the patient from passive to active care so as to achieve efficient patient recovery.

Pediatric patients

Pediatric evaluations require age appropriate inquiry and examination to determine treatment plans; this management may need to be modified.



Chapter IV

Chiropractic Management Algorithm

. The following recommendations correlate and refer to the steps in the algorithm:

<p>Box 1: History, Subjective/Objective Evaluation</p>	<p>Chiropractors should conduct a medical history of the presenting condition and a past medical history including illnesses, hospitalizations, surgeries and prior musculoskeletal conditions. The history should consider red flags and psychosocial risk factors. Subjective-based outcome assessment tools (OATS) of good reliability and validity should be used at this time to establish a baseline for pain, function and/or disability.</p> <p>Chiropractors should perform a physical examination appropriate to the presenting complaint(s). Procedures should be chosen according to specificity and sensitivity, and have a relatively high likelihood for ruling in or out a specific condition. A physical examination should be neither more nor less than the presenting condition(s) require(s).</p>
<p>Box 2: Imaging and Special Studies</p>	<p>Chiropractors should determine the clinical necessity of additional testing that would improve their ability to accurately diagnose and/or provide treatment for the presenting condition(s). This testing can include, but is not limited to: diagnostic imaging, radiographs, laboratory, EMG, functional capacity, etc.</p> <p>Clinical necessity should be reflected in the records including the concerns warranting the study and how the results will influence management.</p>
<p>Box 3: Determine Diagnosis, Stage of Condition and any contraindications to care</p>	<p>Based on history and examination, Chiropractors should determine and document a diagnostic impression expressed in generally accepted terminology. The diagnostic impression clarifies the details of the diagnosis, including stage of condition (acute, sub-acute, repair, remodeling, chronic), and contributing and complicating factors.</p> <p>If any of the patient's conditions are outside the scope of practice or clinical capacity of the specific chiropractor, or if treatment is contraindicated, then a referral to a different provider should be made and documented.</p>
<p>Box 4: Treatment Plan</p>	<p>Chiropractors should formulate a treatment plan appropriate to the diagnostic impression and the patient's presentation. This should include the frequency and duration of treatment, specific therapies, and goals for each. The treatment plan should not exceed 12 visits or 6 weeks before an updated evaluation for curative care (example: 3x/week for 4 weeks acute, or 2x/week for 6 weeks subacute).</p> <p>Proposed treatment plan(s) and prognosis should be discussed in the context of the report of findings and PARQ conference. Informed consent shall be documented.</p>
<p>Box 5: Re-Evaluation</p>	<p>An updated evaluation of the subjective OATS (outcome assessment tools) and objective/functional examination should be performed at regular intervals, or whenever clinically relevant, to determine patient progress, efficacy of care and necessity of additional treatment. Intervals between re-evaluations should not exceed 12 visits or 6 weeks, depending on the patient's current condition and treatment goals. See above examples.</p>
<p>Box 6: Determine if progress is shown</p>	<p>A comparison of the new evaluation findings (from Box 7) to the previous evaluation findings should be performed to determine progress (OATS, functional, etc.). Patient progress should be determined by comparing previous to current findings and assessed by the physician for clinically meaningful change. (OATS specific, ICA guidelines, etc.)</p> <p>If progress is shown, go to box #7. If no improvement, go to box # 9.</p>

Box 7: Is Condition Resolved?	The chiropractor should determine if the condition has resolved (subjectively, functionally, structurally, etc.). This should be goal-specific. Possible endpoints of care should be when patient is at pre-injury status or maximum medical improvement. If resolved, go to box #14. If not resolved, go to box #8.
Box 8: Modify Treatment if indicated.	As treatment continues, the diagnoses should be amended based on the patient's clinical presentation. If indicated, the doctor should modify treatment, including but not limited to: changing the frequency of visits, modifying modalities, updating home care instruction, etc. If appropriate, treatment frequency may be proportionately decreased in order to determine the patient response to daily living without care prior to the next evaluation.
Box 9: Has condition reached Maximum Improvement or Therapeutic Benefit?	If the patient is not showing progress with care, then the chiropractor should determine whether the patient has reached maximum medical improvement (MMI) or maximum therapeutic benefit (MTB). MMI refers to a date from which further recovery or deterioration is not anticipated. MTB refers to when provided care no longer provides benefit, but other options may still exist for improvements. If MMI, then go to box #12. If not, go to box #10.
Box 10: Modify Case Management	If the patient is not progressing and is not considered MMI or MTB, the chiropractor should consider psychosocial factors and other treatment options. Examples of other or additional treatment options include, but are not limited to: referral to another provider, referral for additional testing, adding or removing therapeutic modalities from the treatment plan, etc. If referral is indicated, go to box #11. To continue care, go to box #7 (May do both)
Box 11: Referral and/or Discharge	See box #2 and #3 to determine appropriate referral needs. It is possible that chiropractic care is terminated at this time, even if the patient's condition can benefit from a different care provider. Any referrals should be documented in the patient records.
Box 12: Residual Findings/ Permanent Impairment	When a patient's condition has reached MMI or MTB, if any residuals are still evident (subjective, functional, objective, structural, etc.) the chiropractor should determine if a permanent impairment evaluation and/or disability rating is indicated. All residuals should be documented and discussed with the patient. MTB patients may be referred out.
Box 13: End curative care with residuals.	Curative care should be ended after MMI or MTB has been determined and residuals (if any) should be documented. The patient may be transitioned into supportive care or palliative care if indicated.
Box 14: End curative care.	When ending curative care, the patient may be transitioned to supportive or wellness care, if indicated.

Maintenance Care:

The term "maintenance care" is not well-defined at this time in scientific literature and is inherently vague. For purposes of this document, the OBCE will forego its use.

Supportive Care:

Supportive care is ongoing treatment/care for patients who have reached MTB but who may fail to sustain these benefits and may progressively deteriorate without treatment. In addition, it is intended to minimize exacerbations and degenerative sequelae. Supportive care sometimes includes the return to curative care for the waxing and waning of chronic conditions. It follows appropriate application of active and passive treatments including rehabilitation and/or lifestyle modifications. It is appropriate when alternative care options, including home-based self-care or referral have been considered and/or attempted. Supportive care may be inappropriate when it interferes with other therapeutic protocols.

Wellness Care:

The purpose of chiropractic wellness care to enhance and optimize a patient's physical well-being and potentially prevent the future onset of symptoms. It is not limited to spinal manipulation but could include any element of the chiropractor's scope of practice.

Palliative Care:

Palliative care is treatment to temporarily improve a patient's quality of life without anticipation of overall improvement.