

CONSENSUS TERMINOLOGY FOR STAGES OF CARE: ACUTE, CHRONIC, RECURRENT, AND WELLNESS

Mark D. Dehen, DC,^{a,b} Wayne M. Whalen, DC,^{c,d} Ronald J. Farabaugh, DC,^{e,f} and Cheryl Hawk, DC, PhD^{g,h}

ABSTRACT

Objective: As the chiropractic profession delineates its role in the emerging health care marketplace, it will become increasingly important that the scope of appropriate chiropractic care is clearly defined relative to overall patient case management. Therefore, the Council on Chiropractic Guidelines and Practice Parameters engaged in a multidisciplinary consensus process addressing the terminology related to “levels of care.”

Methods: A formal consensus process was conducted in early 2009, following the RAND/UCLA method for rating appropriateness. Panelists were selected to provide a broad representation of the profession in terms of geographic location and organizational affiliation, and an attempt was made to include members of other professions, including representation from third-party payors. The Delphi process was conducted electronically in January-February 2009. A nominal group panel was conducted through an online meeting service using an experienced group facilitator. Twenty-seven panelists were selected; all but 3 were doctors of chiropractic. Six of the panelists had experience as consultants with third-party payors.

Results: Fifteen seed statements were circulated to the Delphi panel. Consensus was reached on all statements after 3 Delphi rounds, with further refinements made through the nominal group panel.

Conclusions: By using a recognized formal consensus process, the Council on Chiropractic Guidelines and Practice Parameters has endeavored to establish a set of terms that are acceptable to the chiropractic community in order to facilitate their use within the broader health care community. (*J Manipulative Physiol Ther* 2010;33:458-463)

Key Indexing Terms: *Chiropractic; Spinal Manipulative Therapy*

As the chiropractic profession pursues its role in the emerging health care marketplace, it will become increasingly important that the scope of appropriate chiropractic case management is clearly delineated. To

ensure equitable inclusion in the health care arena, it is imperative that the terms used in our interprofessional discussions are common to all health care providers. Therefore, the Council on Chiropractic Guidelines and Practice Parameters (CCGPP), at the behest of the American Chiropractic Association (ACA) Insurance Relations Committee, engaged in a multidisciplinary consensus process to address the terminology related to “levels of care.”

While the chiropractic profession is the third largest doctoral-level health care profession in the United States, behind medicine and dentistry, it is still not fully integrated into mainstream health care.¹ This is partly due to the ≥100-year history of stand-alone chiropractic education and practice. This isolation has tended to engender chiropractic with its own lexicon. As stated by Meeker and Haldeman¹ in 2002, “Perhaps one of the bigger challenges our profession faces centers on syntax. Clarity in how one uses words is an essential component of good communication. We chiropractors have several words that are unique and perhaps (forgive the pun) “‘out of alignment’ with another’s usage” (p 44).

However, those days of isolationism are fading away. Mainstream health care and governmental organizations such as the World Health Organization, US Department of

^a Immediate Past Chair, Council on Chiropractic Guidelines and Practice Parameters, Lexington, SC.

^b Clinic Director, Back to Wellness Clinic, North Mankato, Minn.

^c Past Chair, Council on Chiropractic Guidelines and Practice Parameters, Lexington, SC.

^d Clinical Director, Whalen Chiropractic, Santee, Calif.

^e Chair, Council on Chiropractic Guidelines and Practice Parameters, Lexington, SC.

^f Clinic Director, Farabaugh Chiropractic Clinic, Columbus, Ohio.

^g Chair, Scientific Commission of Council on Chiropractic Guidelines and Practice Parameters, Lexington, SC.

^h Vice President of Research and Scholarship, Cleveland Chiropractic Research Center, Kansas City, Mo, and Los Angeles, Calif.

Submit requests for reprints to: Cheryl Hawk, DC, PhD, Vice President of Research and Scholarship, Cleveland Chiropractic College, 10850 Lowell Av., Overland Park, KS 66210 (e-mail: cheryl.hawk@cleveland.edu).

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Health and Human Services and the National Center for Complementary and Alternative Medicine, a division of the National Institutes of Health, consider chiropractic to be complementary and alternative medicine (CAM). However, a 2008 study reported that 31% of surveyed chiropractors categorized chiropractic as CAM, 27% as integrated medicine, and 12% as mainstream medicine.² As one looks over the emerging health care landscape, there are more and more examples of integrated health care arising. New collaborative models are coming to the fore to comprehensively address patient care needs in novel and innovative ways. Pioneers in this area, such as the Texas Back Institute in the early 1990s, did so with an appreciation for the skill sets brought to the table by various practitioner types.^{3,4} Although Texas Back Institute has discontinued that experiment, that trend is now continuing with the integration of chiropractic care into the Veterans Administration hospital system, as well as many other private sector and educational environments, such as the partnership between Northwestern Health Sciences University and the Woodwinds Health Campus in Woodbury, Minn.

The common language spoken in these environments is the language of “best practices,” and it is a language in which practicing doctors of chiropractic (DCs) need to become fluent.⁵ Chiropractic colleges need to properly prepare students to thrive in the emerging evidenced-based practice environment. In this environment, DCs will regularly be faced with challenging diagnostic and treatment situations. As we become more fully integrated into mainstream health care, chiropractors will have to communicate effectively with other practitioners, using a common language of best practices.^{5,6} This will require enhanced critical thinking and research interpretation skills, an appreciation of the importance research has in improving clinical practice, and increased practical clinical experience and facility with common interdisciplinary terminology.⁷

These integrated exposures, along with the applicable literature syntheses of the CCGPP,⁸⁻¹³ are serving to further expose other health care stakeholders to the effectiveness of chiropractic case management in the continuum of patient presentations from acute to chronic neuromusculoskeletal conditions.⁶ This premise is endorsed in a 2007 article in the *Annals of Internal Medicine*, which recommends, “For patients who do not improve with self-care options, clinicians should consider the addition of nonpharmacologic therapy with proven benefits—for acute low back pain, spinal manipulation; for chronic or sub acute low back pain, intensive interdisciplinary rehabilitation, exercise, therapy, acupuncture, massage therapy, spinal manipulation, yoga, cognitive-behavioral therapy, or progressive relaxation.”¹⁴ This position is also reiterated by Bronfort et al who state, “For chronic low back pain, there is moderate evidence that spinal manipulative therapy (SMT) with strengthening exercise is similar to that of prescription nonsteroidal anti-

inflammatory drugs with exercise in both short and long-term...there is moderate evidence that SMT is superior to general practice medical care and similar to physical therapy in both the short and long term. There is limited evidence of short- and long-term superiority of SMT over hospital outpatient care for pain and disability.”¹⁵

The practice of chiropractic includes establishing a diagnosis, facilitating neurological and biomechanical integrity through appropriate chiropractic case management, and promoting health.¹⁶ Chiropractic practice includes examinations, diagnostic imaging, as well as extremity manipulation, physiotherapy modalities, therapeutic exercises, diet/nutritional counseling, and ergonomics consultation. Chiropractic case management is not solely spinal manipulative therapy, although that is the DC’s most commonly recognized mode of intervention.

To clarify how chiropractic care applies in the various stages of typical patient presentation, the ACA Insurance Relations Committee revised the terminology related to levels of care of appropriate chiropractic case management for all levels of care. Once internal consensus was obtained on these terms, the ACA Insurance Relations Committee then wanted to further refine this terminology among a broader, more diverse group of experts in order to facilitate its use in the external marketplace. Therefore, the ACA forwarded those terms to the CCGPP, and a formal consensus panel was convened. This panel consisted of a wide geographic representation of active chiropractic practitioners, other disciplines, and third-party payers. The process and results are described below.

METHODS

Background and Seed Documents

Background materials were recommended by the CCGPP Seed Development committee to assist the participants in orientation to the project. These were excerpts from the US and Canadian chiropractic guidelines,^{17,18} the ACA Wellness Model,^{19,20} and the Council on Chiropractic Education definition of wellness.¹⁶ This definition states that wellness is “a process of optimal functioning and creative adaptation involving all aspects of life. Health is a state of optimal well-being and functioning; wellness is an active process employing a set of values and behaviors that promotes health and enhances quality of life.”¹⁶ Seed statements were developed by the CCGPP Seed Development committee, based on the documents mentioned previously, in addition to documents provided by ACA, including the ACA Wellness Model document. This document states, “Since its inception, chiropractic has been based on an active care model that emphasizes wellness. Wellness requires active patient participation. It is a process of achieving the best health possible given one’s genetic makeup by pursuing an optimal level of function. The goal of wellness is to maintain the most favorable

balance between internal and external environments. Wellness care incorporates active lifestyle changes consistent with the goals of Healthy People 2010...As an active care model, the commitment of the DC to wellness emphasizes collaboration with patients on the development of a life-long path for health promotion and disease prevention. Wellness is a patient-centered process.”^{19,20}

Selection and Composition of the Panel

The CCGPP asked ACA and the Congress of Chiropractic State Associations for nominations to the panel. Efforts were made to include a broad representation of the profession in terms of geographic location and organizational affiliation, and an attempt was made to include members of other professions, including representation from consultants with third-party payors. The CCGPP Seed Development committee reviewed nominations to ensure that the panelists were highly experienced in clinical practice and represented a variety of stakeholders, in terms of location, affiliation, and profession.

Method for Conduct of Delphi Rounds

The Delphi process followed established methodology.²¹ It was conducted electronically in January to February 2009, using the RAND/UCLA method for rating appropriateness.²² There were 15 seed statements to be rated. We used an ordinal rating scale of 1-9 (highly inappropriate to highly appropriate). As per the RAND/UCLA methodology, “appropriateness” indicated that the expected health benefit to the patient exceeds the expected negative consequences by a sufficiently wide margin that it is worth doing, exclusive of cost.²¹ Ratings were scored as follows: 1 to 3, inappropriate; 4 to 6, undecided; 7 to 9, appropriate. Panelists were instructed that “inappropriate” ratings required provision of specific reasons, providing a citation from the peer-reviewed literature to support it, if possible. In the analysis, agreement on appropriateness was indicated by presence of both a median rating greater than 6 and at least 80% of panelists rating the statement higher than 6. Panelists were given unlimited space on the ratings form to enter comments on each statement. The CCGPP Seed Development committee then reviewed the ratings and all comments, and, for the statements on which consensus was not reached, revised the statements as per the panelists’ comments. These revised statements were then circulated in the next round, to be rated and commented on by the panelists. Panelists were given 10 to 14 days for each round. The project coordinator sent regular reminders until responses were received from all panelists in each round.

Method for Conducting the Nominal Group Panel

Nominal group panels (NGPs), such as Delphi panels, also facilitate problem solving and are frequently used to

reach consensus.²¹ Because the group meets face to face, the size of the panel is limited to 9 to 12 participants, and employing an experienced professional facilitator is necessary to protect the integrity of the consensus process.²¹ For this project, an innovative method of convening the group electronically was used, through an online meeting service. An experienced group facilitator led the meeting and the meeting was audio taped, as well as having a recorder take notes manually. Participants were selected from the Delphi panel, with 2 additional members with expertise in third party-payor issues. There were some technical difficulties in conducting the panel, in which 1 panelist did not have audio and so could not comment, but this was addressed by having a postsession conducted electronically so that the panelist was satisfied that his input had been incorporated into the results. Although a formal survey was not conducted as to participants’ satisfaction with the process, a number of participants, including the NGP facilitator, expressed positive reactions to the Delphi and NGP processes.

Consensus Panel

Twenty-seven panelists were selected; all but 3 were DCs; 2 non-DCs were among the 6 panelists who were consultants with third-party payors, and 1 NGP member was a registered nurse (RN). One panelist was a lawyer as well as a DC, and 1 was a DC/PhD who was also a licensed acupuncturist (LAc). They represented 14 states (CA, GA, IA, IL, IN, MA, MD, MO, NV, NY, PA, SD, TX, UT). Most (18) belonged to their state chiropractic associations; 18 were members of ACA, and 2 were members of International Chiropractors Association. The DCs’ average number of years in practice was 22 (range, 3-38 years).

RESULTS

A total of 15 seed statements were developed from the ACA materials by the executive committee and circulated to the Delphi panel. Consensus was reached on all statements after 3 Delphi rounds, but due to the panelists’ comments, the CCGPP Seed Development committee felt that additional “word-smithing” by means of a NGP was necessary in order to clarify 2 of the statements (see below).

A NGP was conducted with 11 panelists representing 11 states; all but 2 were also on the Delphi panel. The 2 additional members were an RN working in the insurance industry and a DC. Consensus on the 2 statements was reached in a 90 minute meeting. These were the 2 statements considered by the NGP:

- **Management of Chronic/Recurrent Conditions**

When functional improvement has remained stable and further improvement is not expected, further care may still be considered necessary for the goals of: minimizing/controlling pain, supporting function,

strengthening weakened areas, improving lifestyle, reducing reliance on medications, minimizing exacerbation frequency and duration, minimize further disability, keeping the patient employed/active, and maximizing patient's satisfaction.

● Management for Wellness

"Optimizing levels of function" includes the use of chiropractic manipulative therapy/adjustments or manual therapies, in combination with other health care strategies such as exercise, diet/nutrition counseling, and lifestyle coaching in order to maximize health.

The results were compiled into the following terminology and descriptions related to levels of care:

Terminology Related to Levels of Care

Care of Acute Conditions

- Medically necessary care of acute conditions is care that is reasonable and necessary for the diagnosis and treatment of a patient with a health concern and for which there is a therapeutic care plan and a goal of functional improvement and/or pain relief.
- The result of the care is expected to be an improvement, arrest, or retardation of the patient's condition.
- Initially, the care may be more frequent, but as levels of improvement are reached, a decrease in the frequency of care is to be expected.
- A patient may experience exacerbations of an acute injury/illness being treated that may clinically require an increased frequency of care for short periods of time.
- A patient may also experience a recurrence of the injury/illness after a quiescence of 30 days that may require a reinstatement of care.

Care of Chronic/Recurrent Conditions

- Medically necessary care of recurrent/chronic conditions is care that is provided when the injury/illness is not expected to completely resolve after a treatment regimen but where continued care can reasonably be expected to result in documentable improvement for the patient.
- When functional status has remained stable under care and further improvement is not expected or withdrawal of care results in documentable deterioration, additional care may be necessary for the goals of supporting the patient's highest achievable level of function, minimizing or controlling pain, stabilizing injured or weakened areas, improving activities of daily living, reducing reliance on medications, minimizing exacerbation frequency or duration, minimizing further disability, or keeping the patient employed and/or active.

- Chronic/recurrent care may be inappropriate when it interferes with other appropriate primary care or when its benefits are outweighed by its risks, for example, psychological dependence on the physician or treatment, illness behavior, or secondary gain.

Care for Wellness

- Achieving wellness requires active patient participation.
- Wellness is a process of achieving the best health possible, given one's genetic makeup, by pursuing an optimal level of function.
- "Optimizing levels of function" may include a combination of health care strategies such as chiropractic adjustments, manipulative therapy, manual therapies, exercise, diet/nutrition counseling, and lifestyle coaching.

DISCUSSION

This formal consensus process to clarify the terminology used by chiropractors related to common areas of patient care is important as such care becomes increasingly integrated into the mainstream. The chiropractic profession's history of developing outside mainstream medicine has fostered colloquialism and confusion, often to the detriment of our shared patients. Terms such as *preventative/maintenance care*,¹⁷ defined as care to reduce the incidence or prevalence of illness, impairment, and risk factors and to promote optimal function, and *supportive care*, defined as treatment/care for patients having reached maximum therapeutic benefit, in whom periodic trials of therapeutic withdrawal fail to sustain previous therapeutic gains that would otherwise progressively deteriorate,¹⁷ are chiropractic specific and not commonly used by other health care disciplines.

Therefore, for the purposes of this project, chiropractic care as it applies to the typical patient presentation was to be described using conventionally recognized terminology across the accepted continuum of care, from acute to chronic/recurrent on to wellness. Acute conditions were those having a relatively short but possibly severe course, for example, acute cervical torticollis. Chronic/recurrent conditions were those persisting over a long period, for example, lumbar degenerative disc disease with associated osteoarthritis and occasional sciatic leg referral. Wellness care was considered more related to enhancement of function and ability to perform daily activities. Our panelists were charged with identifying the common characteristics of each of these 3 primary levels of care. *Medically necessary care* refers to care that is generally reimbursable by third party carriers, for example, acute and/or chronic/recurrent care. Ongoing care in the chronic/recurrent population was discussed as potentially contraindicated, for example, if it delayed appropriate psychological care in the dependent personality patient.

In addition, providing context for chiropractic care in chronic/recurrent cases, as supported by contemporary research previously identified in the CCGPP's literature syntheses,⁸⁻¹³ is important in establishing a chiropractic alternative for this expanding patient population. Concomitantly, while the definition of *wellness care* remains fluid, the historical chiropractic health care model of improving function, good nutrition and exercise endorsement are consistent with basic wellness tenets. Refining these terms with a chiropractic lens was felt to be important in order to standardize the delivery of such care.

In the face of the evolving health care market, with its demands for effective collaborative outcome-oriented patient management, there is a role for chiropractic integration. However, this historic lack of standardized common language is a handicap that needs to be addressed. Therefore, this consensus project is an initial step to close that gap. Currently, the CCGPP is involved in a new multidisciplinary consensus project to better outline documentation and parameters for chronic/recurrent care. Future research will also be necessary in the area of wellness care as that area of patient focus matures.

Limitations

The chief limitation of this project was the lack of diversity in the consensus panel, which included only 3 non-DCs (one of whom was an RN) and only 2 International Chiropractors Association members. The CCGPP had hoped to attract a broader, more multidisciplinary panel. Our inability to do so may reflect the longstanding isolation of the profession, as well as the factionalism within it. Another limitation may be related to the number of source documents available to provide to the panel as background on terminology in use throughout the medical and research communities. Additional sources may have been useful for the panel to gain a broader understanding of common medical lexicon. We reviewed only a limited number of terms and perspectives centered on "levels of care." There may be other terminology, definitions, or perspectives which were not considered, although efforts were made to include those most commonly used in the health care arena. Limitations imposed by the Delphi process, as well as the limited diversity of the panel members, may also have contributed to a bias in consideration of other definitions or terminology.

CONCLUSION

Achieving consensus on this terminology related to the spectrum of patient presentations is expected to facilitate their use within the profession of chiropractic, which, in time, may facilitate better integration of chiropractic care within the health care mainstream.

Practical Application

- It will become increasingly important in the emerging health care system that the scope of appropriate chiropractic care is clearly defined relative to overall patient case management.

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