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Canadian
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Association

Professional Practice Recommendations

Joint Statement of Action Commitment

January 2018

Introduction

Opioids have quickly emerged as one of the primary means for managing acute and chronic non-cancer pain in primary care settings. Available evidence points to back pain and other musculoskeletal conditions as a leading reason for opioid prescribing. This over-reliance on opioids occurred despite limited evidence supporting their use or efficacy in treating acute and chronic musculoskeletal pain. The unforeseen consequences of opioids are increasingly evident and constitute a major health concern. The impact on vulnerable and marginalized populations is even graver, given the higher prevalence of both low back pain and incidence of opioid use within this group. Effective solutions must include reducing the pressure to prescribe by prioritizing alternative approaches to pain management.

As outlined in the Canadian Chiropractic Association's (CCA's) White Paper [A Better Approach to Pain Management](#), the CCA strongly believes that to actually change the current course and to reduce reliance on opioids we must take a broader approach to comprehensively manage pain. The most up-to-date evidence, including the recently released [2017 Canadian Guideline for Opioid Therapy and Chronic Non-Cancer Pain](#), clearly identifies that manual therapies, including chiropractic, should be first-line options for the management of musculoskeletal conditions within interprofessional healthcare teams.

As a signatory of the federal government's [Joint Statement of Action to Address the Opioid Crisis](#), the CCA has committed to developing evidence-based professional practice recommendations and resources to facilitate the appropriate triage and referral to Canadians suffering from chronic and acute musculoskeletal conditions and reduce their reliance on opioids. To complete this work, the CCA assembled several clinicians, educators, researchers, and policy-makers to form the National Advisory Committee, providing a balanced perspective on the recommendations. The National Advisory Committee was mandated to provide strategic guidance in the development of these key recommendations and resources. The committee was instrumental in the creation of a comprehensive strategy and the early development of tools and resources to help facilitate better triage of patients and referrals to providers.

The comprehensive process/methodology was followed to complete the work. Part of the process was to do a selective review of the literature and best practices, interview key informants and stakeholders, and critically appraise these to draft recommendations and



resources to help inform clinical decision making—which aims to facilitate better triage of patients and referrals to conservative care providers, consequently providing options beyond the prescription of opioids. The recommendations are meant to highlight best practices through various patient touch points in the management of back and neck pain.

PROFESSIONAL PRACTICE RECOMMENDATIONS

Overarching General Principles

Informational only

1. The use of evidence-informed multidisciplinary spine care pathways that are consistent with clinical practice guidelines and established clinical protocols should be considered in all primary care settings.^{1, 2, 3, 4, 5, 6}
2. To ensure optimal outcomes, healthcare providers are encouraged to use a systematic approach^{A, 7} to diagnose and manage back and neck pain. This approach should take into account patient preferences.

Diagnostic Triage

3. When a patient first presents symptoms, primary care providers should undertake the following:
 - A detailed history which may include Opioid Risk Tool if opioids are indicated^{B, 8}
 - Exclusion of serious underlying pathology (red flags^{C, 9, 10}) and identification of prognostic factors (yellow flags^{D, 11, 12}) likely to adversely impact the prognosis
 - A focused clinical physical examination
 - Determine if the spinal disorder is mechanical^E or due to a visceral or non-mechanical pathology (see Appendix 1)^{F 13}
 - Determine appropriate means of treatment based on suspected cause of pain or dysfunction (see Appendix 2)
4. If the diagnosis is of mechanical back or neck pain, patients with acute,^{G, 14} subacute,^{H, 14} and chronic^{I, 14} symptoms should initially be managed with non-opioid and nonpharmacological care such as chiropractic (see Appendix 2).^{15, 16, 17, 18}

^A Most efficient means to generate consistent, optimal results.

^B These risks include younger-aged patients with previous or current mental illness, patients with previous or current substance use disorder, and patients with high-dose prescriptions.

^C Red flag conditions indicating possible underlying pathology include onset <20 or >55 years, non-mechanical pain, previous history of carcinoma, steroids and HIV, feeling unwell, sudden weight loss, widespread neurological symptoms, and structural spinal deformity.

^D Yellow flag conditions indicating possible presence of psychosocial risk factors that can contribute to development of chronicity. These include belief that pain is harmful or potentially severely disabling, fear and avoidance of activity or movement, tendency to low mood and withdrawal from social interaction, expectation of passive treatment(s) rather than a belief that active participation will help, current substance dependence/intoxication, solicitous behaviours from others or highly punishing social responses from others, and poor job satisfaction.

^E Mechanical pain is the general term that refers to any type of back pain caused by placing abnormal stress and strain of structures of the vertebral column with multifactorial etiology.

^F Injuries of traumatic nature or when a suspected fracture is present should be managed differently than other mechanical causes of back pain and the present recommendations may not apply.

^G Acute: low back pain that lasts less than 4 weeks.

^H Subacute: low back pain that last 4 to 12 weeks.

^I Chronic: low back pain that lasts over 12 weeks.

5. Unless there are specific indications, radiographic imaging is not recommended for the diagnosis of mechanical back and neck pain.^{J, 19}
6. All healthcare providers should discuss the recommended treatment options with patients. They should work with the patient to determine the program of management most appropriate to their circumstances and level of financial and geographic access to care.

Referral to Nonpharmacological Therapies

Built for chiropractic (in anticipation of similar efforts for other key alternatives to opioids)

7. As part of the assessment and re-assessment, relevant evidence-informed outcome measures should be administered and scored (see Appendix 3).^K
8. Chiropractors must conduct a detailed but focused history and physical examination, and provide a diagnosis or clinical impression, and evidence-informed treatment plan. They should also discuss expectations of care as well as patient goals and gain informed consent in accordance with the Road Map to Care and standards of practice (see Appendix 4).^{20, 21}
9. Patients with mechanical back and neck pain should be advised to avoid bed rest and be encouraged to engage in early return to activity.²²
10. Chiropractors should take into consideration a patient's identified and recorded goals. Education and self-management strategies should be incorporated into the care plan.
11. If patients do not respond to conservative care or exceed the timeline for expected resolution based on the condition's natural history then co-management should be considered or a referral should be made back to the referring practitioner.
12. Patients should be discharged or referred once the maximal therapeutic benefits^L from conservative care are attained.

Interprofessional Care

13. Communication between healthcare providers and patients should be central to treating pain. Communication can be facilitated by using existing tools and resources such as electronic health records.
14. Upon receiving a referral, all healthcare providers should provide a report to the referring provider. This should include key assessment findings, a diagnosis, and/or clinical impressions and the proposed plan of management.
15. Where a patient fails to respond to care, or where there is deterioration in the patient's overall condition, referral and/or communication with the patient's primary care physician should be considered.

^J Imaging is only indicated if there are suspected red flags including suspected cancer, suspected infection, cauda equine syndrome, severe/progressive neurologic deficit, and suspected compression fracture.

^K Functional measures refer to measuring outcomes of care within the relevant components of function, including body functions and structures, activity, and participation.

^L A therapeutic effect results from a medical treatment which is deemed desirable and beneficial. A treatment has reached maximal therapeutic benefits when the results/outcomes have plateaued following relevant therapeutic treatment over therapeutically relevant treatment interval.

Appendix 1

Examples of Spinal Pain

Examples of mechanical, visceral and non-mechanical spinal pain*		
Mechanical	Visceral	Non-mechanical
<ul style="list-style-type: none"> • Lumbar sprain/strain • Degenerative disc/facet joints • Disc herniation • Spinal stenosis • Spondylolisthesis • Traumatic • Congenital disease 	<ul style="list-style-type: none"> • Aortic aneurysm • Pelvic (i.e., gynecological, prostatitis) • Renal (i.e., urinary tract infection) • Gastrointestinal 	<ul style="list-style-type: none"> • Neoplasia • Infection • Inflammatory arthritis • Paget's disease • Scheuermann's disease • Myofascial pain syndrome

*Jarvik JG, Deyo RA. Diagnostic evaluation of low back pain with emphasis on imaging. *Ann Intern Med.* 2002; 137: 586-97. PMID: [12353946](https://pubmed.ncbi.nlm.nih.gov/12353946/).

#Spinal instability and internal disc disruption were removed as examples from the original article due to expert opinion.

Appendix 2

Nonpharmacological Interventions

		Nonpharmacological Interventions Supported by Select Clinical Practice Guidelines								
		Spinal manipulative therapy or mobilization	Exercise	Rehabilitation	Massage	Acupuncture	Tai chi or yoga	Cognitive behavioural therapy	Relaxation	Superficial heat
Back pain	Acute and Subacute ^{23,24, 25}	X			X	X				X
	Chronic ^{26, 27, 28, 29}	X	X	X		X	X	X	X	
Neck pain	Acute and subacute ^{30, 31}	X	X							
	Chronic ³²	X	X	X	X		X	X		

(X) signifies that the intervention is supported by clinical practice guideline associated with a specific condition.

Appendix 3

Select List of Commonly-Used Outcome Tools

Outcome measures: The results of an objective and validated test used to determine/quantify pain and function of a patient at baseline and to determine progress throughout phases of treatment.

Prognostic measures: Any measures used to objectively evaluate or quantify factors/characteristics that predict response to a therapeutic intervention.

List of commonly-used and validated outcome tools:

Disability

Oswestry Disability Index (ODI)

ODI Instrument
ODI Instrument Review

Neck Disability Index (NDI)

NDI Instrument
NDI Instrument Review

Roland Morris Disability Questionnaire (RMDQ)

RDMQ Instrument
RMDQ Instrument Review

Headache Disability Index

Headache Disability Index Scoring

Functional and stratification

STarT Back Screening Tool

STarT Back Tool Instrument
STarT Back Tool Instrument Review

Health status

Patient Health Questionnaire-9 (PHQ)

PHQ-9 Instrument
Instrument Review

Opioid Risk Tool

Opioid Risk Tool Instrument
Opioid Risk Tool Instrument - Alternate Format

Psychosocial factors

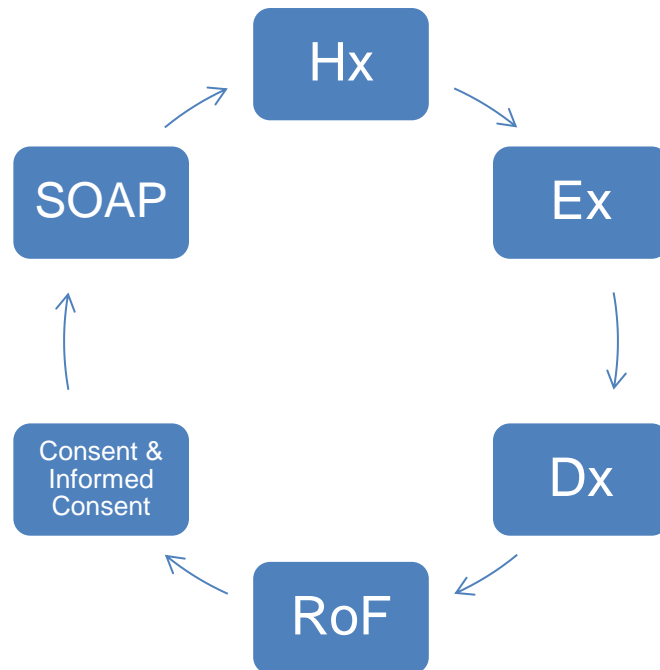
Fear Avoidance Beliefs Questionnaire (FABQ)

FABQ Instrument
FABQ Instrument Review

Assessing Psychosocial Yellow Flags in Acute Low Back Pain Instrument

Appendix 4

Road Map to Care



Hx: A careful and focused history including but not limited to current and past health problems, ongoing treatment, medication, and family health history.

Ex: An examination based on and congruent with the history provided by the patient.

Dx: A diagnosis and differential diagnosis based on and congruent with the history and examination findings.

RoF: The report of findings is an important part of the process where the patient is actively involved in a discussion about their care. This includes an opportunity to discuss the patient's preferences, allow them to ask questions about the proposed plan of management, and have them take an active role in their care plan.

Informed Consent: The informed consent is the discussion of the risks, benefits, and alternatives to the treatment you are offering the patient. This discussion is documented and signed.

SOAP: This is the documentation of your treatment of the patient and their response to care. The SOAP notes must justify that the care you are providing is accomplishing what you set out in the treatment plan.

Source: Canadian Chiropractic Protective Association



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