Low Back Pain (LBP) Clinical Care Standard

Submission by Osteopathy Australia to:

Australian Commission on Safety and Quality in Health Care (ACSQHC) on:

The draft LBP Clinical Care Standard

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Contact

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Summary

Osteopathy Australia thanks ACSQHC for the opportunity to lodge a submission on the draft *LBP Clinical Care Standard*.

The osteopathic profession is a first line clinical management option for LBP in both osteopathy specific and interdisciplinary community based allied health care practices. LPB and clinical conditions influencing LBP are managed by osteopaths daily and are highly prevalent in osteopathic practice presentations. As such, we value the opportunity to provide feedback for this important consultation. We recognise the individual, community and public health systems costs of LBP and hope to assist ACSQHC to manage these significant costs through our response.

Our recommendations aim to increase uptake of the standards by practitioners and bolster their public recognition; our recommendations also aim to assist the commission in mitigating systemic barriers to practitioner and patient uptake of the standard.

Our recommendations are as follows:

Recommendation 1: ACSQHC should minimise standard document length, wordiness, and repetition wherever possible. The commission should aim for the standard document to be no more than 20 pages longer than the in-brief summary of the standard.

Recommendation 2: ACSQHC should amend the standard to assure equal coverage of acute and persistent LBP care principles. The commission should include content on persistent LBP per **recommendations 4 and 5**.

Recommendation 3: ACSQHC should amend the draft standard to acknowledge the role of osteopaths in delivering skilled clinical exercise. This amendment would aid the commission in engaging the full range of appropriately qualified health professionals for standard implementation.

Recommendation 4: ACSQHC should amend the standard to incorporate principles of good management in persistence, in particular, the benefit of interdisciplinary

approaches, the need for valid and reliable outcome measures in gauging biopsychosocial risk, as well as need to avoid advocating rapid cessation of analgesics in patients for whom qualified Medical Practitioners have deemed them well indicated.

Recommendation 5: should the ACSQHC hold concerns about Medical Practitioners having inconsistent interpretations of 'when prescribed analgesics' are indicated, it should be explicit about the circumstances, symptoms, or presentations that would indicate need for analgesia within the standard.

Recommendation 6: ACSQHC should note the high likelihood of LBP knowledge variance among health professionals by graduation year, patient cohorts primarily attending and beyond. The commission should not for instance assume all health professionals in any profession have consistent knowledge of 'addressing patient concerns and beliefs', 'setting SMART goals, and 'prescribing self-management strategies', which the draft standard now does assume. E-learning modules and other learning resources on these crucial topics should be developed and made available either via the commission or housed on health professional association e-learning platforms and websites.

Recommendation 7: ACSQHC should train mentors for LBP clinical excellence across each musculoskeletal profession to provide ongoing advice, support and guidance in the practical management of LBP. These mentors should be located in major cities, rural, regional and remote communities wherever possible to assure equitable access for practitioners.

Recommendation 8: ACSQHC should advocate that the Commonwealth Department of Health explore innovative approaches to establishing specialty pain clinics in rural, regional, and remote areas of Australia offering allied health support. This could include advocating for innovative procurement approaches, or financial incentives for practice relocation/colocation.

Recommendation 9: ACSQHC should advocate that the Commonwealth Department of Health introduce an annual quota of 10 consultation items for LBP under Medicare's *Chronic Disease Management Program*. Our members commented that the current limit of five consultations per annum often does not facilitate the time needed to offer comprehensive health promotion strategies, exercise advice and address patient concerns and beliefs.

Osteopathy and LBP

Osteopaths in Australia are government regulated allied health professionals with inbound and outbound referral relationships to other health professionals.

Osteopaths complete a dual Bachelor or Bachelor/Masters qualification covering functional anatomy, biomechanics, human movement, the musculoskeletal and neurological systems as well as clinical intervention approaches. Significant commonalities exist between the health science units undertaken by osteopaths and those undertaken by peers of other allied health professions, including physiotherapy.

As a defining characteristic, the osteopathic profession emphasises the neuromusculoskeletal system as integral to daily function and uses client-centred biopsychosocial approaches in managing presenting issues, including LBP. The *Capabilities for Osteopathic Practice (2019)* [i] outline the professional skills, knowledge, and attributes osteopaths must possess; many of these skills are shared across allied health and health professions.

Osteopaths conduct comprehensive functional examinations. Evidence informed reasoning is fundamental to case management and clinical intervention. Osteopaths prescribe skilled clinical exercise, including general and specific exercise programming for functional improvement and pain management. [ii] Patients consult osteopaths for advice on physical activity, positioning, posture, and movement in managing a diverse range of neuromusculoskeletal functional impairments, LBP being among the most prevalent. A 2018 representative survey of the osteopathy profession reveals 99% of osteopaths manage LBP and conditions influencing LBP.[iii] Patients with LBP and related conditions present to osteopaths using both private income streams and government rebated programs, such as Medicare's *Chronic Disease Management Program* (CDM).

Most osteopaths are consulted within primary healthcare practices, being a key source of allied health advice for tens of thousands of patients per week. Osteopaths work within hundreds of primary health care practices, both osteopathy specific and interdisciplinary.

Osteopathy Australia is the peak body representing the interests of osteopaths, osteopathy as a profession, and consumer rights to access osteopathic services. We promote standards of professional behaviour over and above the requirements of AHPRA registration. A vast majority of registered osteopaths are members of Osteopathy Australia.

Our core work is liaising with state and federal government, and all other statutory agencies, professional bodies, and private industry regarding professional, educational, legislative, and regulatory issues. As such, we have close working relationships with the Osteopathy Board of Australia (the national registration board), the Australian Health Practitioner Regulation Agency (AHPRA), the Australasian

Osteopathic Accreditation Council (the university accreditor and assessor of overseas osteopaths), government schemes in each jurisdiction and nationally, and other professional health bodies through our collaborative work with Allied Health Professions Australia (AHPA).

In our capacity, we offer this submission on the draft standard and its appropriateness. In developing our submission, we issued a callout for members to review the standards and offer feedback. This submission consolidates overall feedback themes received.

Members based their views on the summary standard document

All members based their opinion on the in-brief summary document for the standard (9 pages), rather than the standard document (55 pages); this itself raised for us the issue of digestibility in a busy practice setting where allied health professionals can be time poor. For the standards to be widely recognised and cited, a desired outcome for the level of work obviously placed into their development, we strongly suggest the larger document be distilled and summarised in a more user-friendly format.

Recommendation 1: ACSQHC should seek to minimise standard document length, wordiness, and repetition wherever possible. The commission should aim for the standard document proper to be no more than 20 pages longer than the in-brief summary document.

The standards generally reflect a sound understanding of management principles in acute LBP

Overall, our members appreciated the standards, their currency and general pitch. They commented that the standards are broadly reflective of best or evidence-informed practice and the principles informing such practice--- particularly as it pertains to acute LBP management. Aspects of the standard that were highly valued are:

- Advice limiting x-rays and diagnostic imaging to appropriate pathologies, consistent with best practice
- Advice in general supporting limitations to the prescription of strong analgesic medications, except where expressly deemed necessary by a Medical Practitioner and as an option of next resort, consistent with peak bodies including Pain Australia
- Advice supporting active management, exercise therapy, and movement encouragement from an early stage
- Advice supporting the principle of early management of psychosocial factors in the pain management continuum.

However, members also commented that the standards could incorporate a greater emphasis on principles of clinical management in persistent LBP.

While we recognise important need to manage acute LBP to offset its transition to a persistent presentation, we also recognise there are now many Australians with persistent LBP needing appropriate management. Persistent LBP has an exceptionally high cost for individuals, local communities, and health care systems. For all these reasons, we would suggest including broader principles of sound management in persistence. More is said on this specific issue in the submission section below *Improvements on the current emphasis*.

Recommendation 2: the ACSQHC should amend the standards to assure equal coverage of acute and persistent LBP care principles. The commission should include content on persistent LBP consistent with submission **recommendations 4 and 5**.

Improvements to current content emphases

Acknowledge the interface between modern osteopathy and exercise prescription

Both our members and we noted that the current standards omit the role of osteopathy in exercise prescription, instead couching physiotherapy and exercise physiology as professions of choice. This is counterintuitive to comprehensive uptake of the standards and the implementation of the standards using all appropriate health professional and system resources.

The ACSQHC must be mindful to avoid outdated notions of osteopathy as a 'purely manual profession' and instead recognise the multimodal nature of modern osteopathy in the same manner as physiotherapy. At least 74% of the osteopathy profession regularly prescribes skilled clinical exercise in managing musculoskeletal complaints, pain and movement impairments; additionally, each osteopathy registrant must possess exercise prescription capabilities in order to become registered with AHPRA after an approved course of university study. [iv] [v]

Recommendation 3: ACSQHC should amend the standard, acknowledging the role of osteopaths in delivering skilled clinical exercise. This amendment would aid the commission in implementing the standards using the full range of appropriately qualified health professionals.

Include more content on best management principles in persistent LBP

As specified prior, our members noted that the standard applies primarily to acute LBP, although they did acknowledge overlap between principles of sound management in acuity to offset the transition to persistence. Nevertheless, if the commission were to include content on principles of management in persistence, key suggestions made were that:

- The standard should note the merit of interdisciplinary approaches to biopsychosocial management and the role of specialty pain clinics in persistent LBP

- The standard should list valid and reliable outcome measures for biopsychosocial risk assessment, including TSK-11, DASS, the Pain Catastrophising Scale, the Tampa Scale of Kinesiophobia, for some examples

- The standard should recognise that in persistent LBP, while limiting strong analgesic prescriptions for extended periods is to be stressed, the commission should be cautious in ensuring it is not advocating rapid cessation for all patients for whom a qualified Medical Practitioner has deemed such analgesics indicated. Our members noted some case examples where patient outcomes regressed on rapid cessation.

Recommendation 4: ACSQHC should amend the standard to incorporate principles of good management in persistence, in particular, the benefit of interdisciplinary approaches, the need for valid and reliable outcome measures in gauging biopsychosocial risk, and the need to avoid advocating rapid cessation of analgesics for all patients for whom qualified Medical Practitioners have deemed these well indicated.

Recommendation 5: should the ACSQHC hold concerns about Medical Practitioners possessing inconsistent interpretations of 'when prescribed analgesics are indicated', it should be explicit about the circumstances, symptoms, or presentations that would indicate need for analgesia.

Need for ACSQHC action to aid standard implementation

For the standard to be adhered to and not simply comprise another written document in a long succession about LPB, several preconditions would apply. These include:

- Adequate practitioner consultation time

- Adequate and consistent knowledge as well as competence among managing health professionals

- Sole practitioners and small practices having access to adequate finances or learning options for clinical knowledge growth

- Adequate referral pathways and consultation options in rural, regional and remote areas of the country.

To assure each of these preconditions are met, several barriers need to be addressed through ACSQHC's policy operations, Commonwealth and other governmental liaison initiatives, and via ACSQHC educational projects.

Recommendation 6: the ACSQHC should recognise difference in LBP knowledge among health professionals depending on period of graduation, patient cohorts primarily attending and beyond. The commission should not for instance assume all health professionals in any profession have consistent knowledge of 'addressing patient concerns and beliefs', 'setting SMART goals', and 'prescribing self-

management strategies'. E-learning modules and learning resources on these crucial topics should be developed and made available either via the commission or for housing on health professional association e-learning platforms.

Recommendation 7: the ACSQHC should train mentors for LBP clinical excellence across medical and allied health professions to provide ongoing advice, support and guidance in the practical management of LBP. These mentors should be located in major cities, rural, regional and remote communities to assure equitable access for practitioners.

Recommendation 8: the ACSQHC should actively advocate that the Commonwealth Department of Health explore innovative approaches to establishing specialty pain clinics in rural, regional and remote areas of Australia offering allied health support. This could include advocating for innovative procurement approaches or financial incentives for practice relocation/colocation.

Recommendation 9: the ACSQHC should advocate that the Commonwealth Department of Health introduce an annual quota of 10 consultation items for LBP under Medicare's *Chronic Disease Management Program*. Our members commented that the current limit of five consultations per annum often does not facilitate the time needed to offer comprehensive health promotion strategies, exercise advice and address patient concerns or beliefs.

References

[i] Osteopathy Board of Australia (2019), Capabilities for osteopathic practice [online] https://www.osteopathyboard.gov.au/Codes-Guidelines/Capabilities-for-osteopathic-practice.aspx

[ii] Adams et al (2018), A workforce survey of Australian osteopathy: analysis of a nationally-representative sample of osteopaths from the Osteopathy Research and Innovation Network (ORION) project, BMC Health Services Research December 2018, 18:352

[iii] *Ibid,* page 4

[iv] *Ibid,* page 5

[v] Osteopathy Board of Australia (2019), Capabilities for osteopathic practice [online] https://www.osteopathyboard.gov.au/Codes-Guidelines/Capabilities-for-osteopathic-practice.aspx