Enhancing Musculoskeletal Care for Ontarians

Ontario Chiropractic Association

Introduction

Three of the four leading causes of disability in North America are musculoskeletal (MSK) in nature, with low back pain (LBP) ranking first[1]. MSK conditions (conditions affecting muscles, bones and joints, such as LBP) in Ontario cost over $2 billion dollars annually in medical expenditures, in addition to costs to society such as loss in worker productivity and associated disability payments.[2] MSK-related pain is also a primary reason for opioid prescriptions[3], yet recent national clinical guidelines recommend non-pharmacological approaches, such as manual therapies performed by chiropractors and other MSK practitioners before prescribing opioids[4].

The Challenge

Despite MSK-related pain being a primary reason for opioid prescriptions and new national clinical guidelines recommending non-pharmacological approaches such as manual therapies before prescribing opioids, primary care physicians have limited options in terms of referral of patients with MSK conditions, such as LBP, to funded, MSK primary care services.

The current approach to improving MSK care is focused on initiatives for surgical assessment, triage and self-care. However, approximately 93% of patients with low back pain and 40% of patients with hip and knee pain do not require surgery[5]. For these patients, self-care can sometimes not be enough and access to comprehensive MSK programming in primary care is limited or non-existent in Ontario.

The Solution

The Primary Care Low Back Pain (PCLBP) Pilots, launched by the Ministry of Health and Long-Term Care in 2015, provide MSK care in interprofessional primary care settings, such as family health teams, community health centres, and nurse practitioner-led clinics that include MSK experts, like chiropractors. The pilots exemplify new MSK clinical practice guidelines calling for manual therapies such as spinal manipulation as the first line treatment for acute, subacute and chronic low back pain. They provide an excellent model for comprehensive MSK programming in primary care which includes chiropractors and other providers.

Primary Care Low Back Pain Programs:

- ✓ Increase equity of access to services for a vulnerable patient cohort with numerous comorbidities
- ✓ Provide alternative evidence based care pathways for LBP patients
- ✓ Reduce unnecessary Emergency Department Visits and Diagnostic Imaging
- ✓ Support the ISAECs and CIACs for non-surgical patients who need manual therapy
- ✓ Leverage existing primary care programing and resources
- ✓ Enhance MSK service access in the sub-LHINs
- ✓ Provide MDs/NPs with alternatives to prescribing opioids

Our Recommendation

To provide accessible primary MSK care, we recommend transitioning the PCLBPs to base funding and a provincial roll out of the PCLBP Pilots (see Appendix A for budget calculations and Appendix B for details on Pilot outcomes). This approach will reduce unnecessary visits to physicians, nurse practitioners and emergency departments; reduce use/abuse of pain medications including opioids; and improve patients' function, mobility, and quality of life.

Establish base funding for the Primary Care Low Back Pain Pilots and expand with a sub-LHIN strategy - $7.6m in the 2018 Ontario Budget, $15 m in the 2019 Budget. This will enhance access by supporting the implementation of comprehensive inter-professional primary care MSK programs and patient services.

Chiropractors can be a significant part of the solution to reducing and preventing opioid use so patients can manage or eliminate medication, and get back to work and their activities of daily living.

Ontarians would benefit from greater integration of chiropractors into the health care system.

References

[1] Vos, T., Flaxman, A., Naghavi, M., et al. (2012). Years lived with disability (ylds) for 1160 sequelae of 289 diseases and injuries 1990—2010: A systematic analysis for the global burden of disease study 2010. The Lancet, 380(9859), 2163 – 2196.

[2] Public Health Agency of Canada. (2014). Economic burden of illness in Canada, 2005-2008. Retrievable from: ebic-femc.phac-aspc.gc.ca/index.php.

[3] Deyo, R.A., Von K.M., & Duhrkoop, D. (2015). Opioids for Low Back Pain. BMJ, 350:g6380.

[4] Busse, J. (2017). The 2017 Canadian guideline for opioids for chronic non-cancer pain. Retrieved from: http://nationalpaincentre.mcmaster.ca/documents/Opioid%20GL%20for%20CMAJ_01may2017.pdf

[5] Ministry of Health and Long-Term Care. (2017). Personal communication, November 1, 2017.

Appendix A

Primary Care Low Back Pain Program

- ✓ Increases equity of access to services for a vulnerable patient cohort with numerous comorbidities
- ✓ Provides alternative evidence based care pathways for LBP patients
- ✓ Reduces unnecessary emergency department visits and diagnostic imaging
- ✓ Supports the ISAECs and CIACs for non-surgical patients who need manual therapy
- ✓ Leverages existing primary care programing and resources
- ✓ Enhances MSK service access in the sub-LHINs
- ✓ Provides MDs/NPs with alternatives to prescribing opioids

Features

- The program will model the PCLBP pilots and be situated in primary care interprofessional teams (i.e., CHC, FHT, NPLC or AHAC). Given the high prevalence of co-morbidities amongst MSK patients, this will provide the opportunity to leverage the programs already offered by these teams such as diabetes, COPD and mental health services.
- The Low Back Pain program would be placed in each of the 76 sub-LHIN regions.
- The program would be considered a sub-LHIN resource - physicians/NPs from across the sub-LHIN would be able to refer into the LBP program to create equal access for patients of sole practitioners. This approach builds on the underlying principle that LHIN sub-regions are local planning regions that will serve as the focal point for improved health system planning, performance improvement and service integration.
- The median population size of LHIN sub-regions is about 140,000 and there are approximately 150 primary care practices in each sub-region. This provides more than sufficient volume of patients to support the requirement for programming at the sub-LHIN level.
- The programs will support and enhance the government's current initiatives by serving as an "off-boarding route" for non-surgical patients who have undergone assessments at Interdisciplinary Spine Assessment and Education (ISAEC) and the Central In-Take for Hip and Knee and don't require surgery but do need manual therapy to address their MSK pain and improve functioning and mobility.
- Teams that provide care to specific populations (e.g., Francophone) may service multiple sub-LHINs.
- The programs would have capacity to address (in the future) other MSK conditions such as shoulder, neck pain, etc. as the government moves beyond low back pain

PCLBP Pilot Outcomes

1) Patient Outcomes

- Less reliance on pain medication;
- Improved function and decreased pain; and
- Improved quality of life

2) System Outcomes

- Better use of health human resources;
- Reduced unnecessary diagnostic imaging;
- Reduced specialist referrals and unnecessary physician visits; and
- Enhanced patient self-reported health status

3) Provider Outcomes

- Improved satisfaction, collaboration and knowledge

See appendix B for more details

Budget Assumptions

A two year implementation with the program rolling out in 38 (50%) of the 76 sub-LHINs in year one (2018-19) and the balance in year two (2019-20). The seven existing PCLBP sites would be renewed with permanent funding as part of the first year. The first year budget would be maximum of $7.5M growing to $15.2M at full implementation.

	2018-2019	2019-2020	On-going
# sites	**38** (7 existing, 31 new)	**76** (38 new & 38 existing)	**76**
Minimum ($150,000 per sub- LHIN)	**$5,700,000**	**$11,400,000**	**$11,400,000**
Maximum ($200,000 per sub-LHIN)	**$7,600,000**	**$15,200,000**	**$15,200,000**

APPENDIX B

Primary Care Low Back Pain Pilots Highlights

Background

Recognizing the need to enhance the management of low back pain (LBP) care, the Ontario Ministry of Health and Long-Term Care (MOHLTC) announced the Primary Care Low Back Pain Pilots (PCLBP) in October 2013. There are currently seven PCLBP Pilot Sites in Ontario situated in primary care interprofessional teams (family health teams, nurse practitioner-led clinics, community health centres, and an Aboriginal health access centre) that include MSK experts, such as chiropractors.

The pilots began in the winter and spring of 2015, and were scheduled to end in March 31/2016. The Ministry has extended the pilots until March 31/2018. Most MSK patients do not require surgery, yet current MSK strategies predominately focus on surgical patients. The pilots provide a cost-effective approach to delivering primary care MSK services to patients who do not require surgery.

The PCLBP program pilot sites have primarily served uninsured and/or vulnerable patient populations who would otherwise not have access to care for low back pain due to their financial and employment situation.

- 'Typical' pilot patients suffer from significant co-morbidities including diabetes and other chronic disease, mental health and addictions issues, and co-occurrence of other types of MSK pain.
- The archetypal PCLBP patient depicts a profile similar to those characteristics identified of high-cost users of the health system.

Evaluation Findings

The Centre for Effective Practice (CEP) in Toronto conducted an evaluation of the PCLBP pilots that builds on the data collected by the Ministry through quarterly reports submitted by the pilot sites. The evaluation demonstrates there is both a need and an opportunity to enhance LBP and MSK strategies and pathways in Ontario. Below is a summary of the findings presented in CEP's final reports.[1]

Findings on Patient Population, Experience and Outcomes

Patients experienced:

- Improved function and decreased pain;
- Less reliance on pain medication;
- Increased access to LBP programs that patients otherwise would not have received;
- Better ability for clients to understand and self-manage their LBP; and
- High level of satisfaction with assessment and treatment received.

Patient Self-Reported Data (n=146):

94% satisfied or extremely satisfied with assessment and treatment received

87% agreed or strongly agreed the pilot gave them access to LBP care that they otherwise wouldn't be able to access

83% agreed or strongly agreed they now rely less on medication to help manage LBP

93% agreed or strongly agreed that their quality of life has improved

Findings on System Impacts and Outcomes

Based on the anecdotal evidence and available narratives, the PCLBP pilot sites have, to varying degrees, had a positive impact on a range of system and patient outcomes, including:

- Reducing unnecessary diagnostic imaging;
- Reducing specialist referrals;
- Improving medication management by reducing opioids and NSAIDs use; and
- Improvements in patient experience, enhanced knowledge and practice of LBP self-management techniques, and enhanced patient self-reported health status.

Findings on Provider Integration & Clinical Care

- The low rules nature of the pilot allowed teams to hire and integrate MSK providers based on community needs and provider competency.
- Providers work collaboratively and have been able to comprehensively address a patient's condition rather than relying on symptom management, and address other co-morbid conditions, such as opioid dependency and diabetes.
- All sites have leveraged services or formed linkages with community resources to enhance the value of the program for patients enrolled into the pilot
- Improved satisfaction, knowledge, and application of LBP techniques for providers

Summary

The evaluation findings demonstrate the PCLBP pilots are improving access to the right care; delivering better coordinated, interprofessional, integrated care in the community; and through patient education, assisting individuals in making decisions about how to live healthier. The results are showing significant impact on the patient population in primary care that is complex with co-morbidities including opioid use and mental health conditions.

Primary Care Low Back Pain Pilots Locations

The PCLBP pilots are currently operating at the following seven areas:

1. Belleville: Belleville Nurse Practitioner-Led Clinic (South East LHIN)
2. Estrie: Centre du santé communautaire de (Champlain LHIN)
3. Mount Forest/Wellington/Maple: Mount Forest, East Wellington and Minto-Mapleton Family Health Teams (Waterloo Wellington LHIN)
4. Orillia/North Simcoe: Couchiching Family Health Team (Muskoka LHIN)
5. Scarborough: Taibu Community Health Centre (Central East LHIN)
6. Sudbury: Shkagamik-Kwe Aboriginal Health Access Centre (North East LHIN)
7. Windsor/Essex: City Centre Health Care & Essex Court Nurse Practitioner Led Clinic (Erie St. Clair LHIN)

[1] Centre for Effective Practice (March 31, 2017). Primary Care Low Back Pain Pilot Evaluation: Final Report. Toronto: ON.