Public Comments Summary
Spine/Low Back Pain Report and Recommendations

Thank you to all those who submitted comments during our public comment period. Specific changes made to the Spine/Low Back Pain Report and Recommendations as a result of public comments include:

- Add page numbers for each recommendation in the Executive Summary table
- Make the health plan recommendation about screening tools more general; individual plans can decide what strategies work best for them (e.g. prior authorization process)
- Add a sentence to Section V that surgery may be appropriate in selected red flag cases
- Change area of focus to include disability (i.e. preventing the transition of acute pain to chronic pain *and disability*)
- Change "time-limited intensive care" to "rehabilitative services"
- Add a recommendation for health plans to design benefits in a way that supports multidisciplinary care
- Add "osteopathic medicine" wherever chiropractic methods are referenced
- Add detailed description of treatments used in the RCT for the STarT Back tool
- Change "While activity may hurt, it will not harm" to "While exercise like walking may hurt, it will **not usually** cause harm"

Public Comment Survey for Spine Report

1. What sector do you represent? (Choose the option that is the best fit.)

	Response Percent	Response Count
Primary Care Provider	**28.6%**	**4**
Physical Medicine and Rehabilitation (PM&R) Physician	7.1%	1
Chiropractor	0.0%	0
Physical Therapist	7.1%	1
Spine Surgeon	7.1%	1
Hospital/Clinic	7.1%	1
Government/Public Purchasers	7.1%	1
Employers	0.0%	0
Health Plans	14.3%	2
Consumers/Patients	0.0%	0
Self	0.0%	0
Other (please specify)	21.4%	3
	answered question	**14**
	skipped question	**0**

2. Do you agree with the Areas of Focus and Goals (Section III)?

	Response Percent	Response Count
Yes	**92.9%**	**13**
No	7.1%	1
Neutral/No Opinion	0.0%	0
	answered question	**14**
	skipped question	**0**

3. Any comments about the Areas of Focus and Goals?

	Response Count
	5
answered question	**5**
skipped question	**9**

4. Do you agree with the Problem Statement (Section II) and description of the problem (Sections IV and V)?

	Response Percent	Response Count
Yes	**85.7%**	**12**
No	0.0%	0
Neutral/No Opinion	14.3%	2
	answered question	**14**
	skipped question	**0**

5. Any comments about the Problem Statement and description of the problem?

	Response Count
	4
answered question	**4**
skipped question	**10**

6. Are you familiar with the Oswestry Disability Index (ODI)?

	Response Percent	Response Count
Yes	**64.3%**	**9**
No	35.7%	5
answered question		**14**
skipped question		**0**

7. Are you familiar with the STarT Back Screening Tool (SBST)?

	Response Percent	Response Count
Yes	**64.3%**	**9**
No	35.7%	5
answered question		**14**
skipped question		**0**

8. Are you familiar with the Functional Recovery Questionnaire (FRQ)?

	Response Percent	Response Count
Yes	50.0%	7
No	50.0%	7
	answered question	14
	skipped question	0

9. Any comments about the selected tools (ODI, SBST, or FRQ)?

	Response Count
	10
answered question	10
skipped question	4

10. Do you agree with the recommendations related to guidelines (Section VI-A)?

	Response Percent	Response Count
Yes	64.3%	9
No	28.6%	4
Neutral/No Opinion	7.1%	1
	answered question	14
	skipped question	0

11. Any comments about the recommendations in this section?

	Response Count
	7
answered question	7
skipped question	7

12. Do you agree with the recommendations related to screening (Section VI-B)?

	Response Percent	Response Count
Yes	**64.3%**	**9**
No	14.3%	2
Neutral/No Opinion	21.4%	3
answered question		**14**
skipped question		**0**

13. Any comments about the recommendations in this section?

	Response Count
	6
answered question	6
skipped question	8

14. Do you agree with the recommendations related to patient education (Section VI-C)?

	Response Percent	Response Count
Yes	**92.9%**	**13**
No	0.0%	0
Neutral/No Opinion	7.1%	1
	answered question	**14**
	skipped question	**0**

15. Any comments about the recommendations in this section?

	Response Count
	4
answered question	**4**
skipped question	**10**

16. Do the proposed recommendations provide sufficient flexibility for the treating physician to effectively manage patient care?

	Response Percent	Response Count
Yes	**50.0%**	**7**
No	28.6%	4
Neutral/No Opinion	21.4%	3
	answered question	**14**
	skipped question	**0**

17. Please provide any general comments here:

	Response Count
	9
answered question	9
skipped question	5

18. Name:

	Response Count
	11
answered question	11
skipped question	3

19. Email address:

	Response Count
	11
answered question	11
skipped question	3

20. Organization:

	Response Count
	11
answered question	11
skipped question	3

Page 2, Q1. What sector do you represent? (Choose the option that is the best fit.)		
1	Medical Specialty Society	Oct 30, 2013 1:09 PM
2	Medical Device/Orthopedic Company	Oct 30, 2013 10:30 AM
3	DO Using OSteopathic Manipulation	Oct 19, 2013 8:41 AM

Page 2, Q3. Any comments about the Areas of Focus and Goals?		
1	The American Academy of Orthopaedic Surgeons (AAOS) applauds the efforts of stakeholders in Washington State through the Bree Collaborative to meet together towards the mission of improving health care. Washington State, along with the rest of the country, is working to identify and promote strategies that improve patient outcomes and the quality of health care services while reducing costs. Achieving these goals requires collaboration, and the Bree Collaborative helps fill this need by providing a forum in which this collaboration can be successful. The Bree Collaborative identifies three broad goal areas in its report on the management of low back pain (LBP). The AAOS is largely supportive of these goals, and we hope that careful attention is paid to goal one's call for "reducing the use of non-value-added modalities in the diagnosis and treatment of LBP." The AAOS is absolutely supportive of the pursuit of high-value healthcare, and we hope that any effort to define high- or low-value services include the input of physician stakeholders.	Oct 30, 2013 1:09 PM
2	No additional comment	Oct 30, 2013 10:30 AM
3	Back pain and chronic pain in general is a very common problem however we rarely do a good job in diagnosis and treatment.	Oct 23, 2013 10:08 AM
4	who is paying for this?	Oct 22, 2013 1:13 PM
5	Professional non-surgical treatment emphasizes Chiropractic., including the Oswestry Index, but completely ignores Osteopathic Manipulation.	Oct 19, 2013 8:41 AM

Page 2, Q5. Any comments about the Problem Statement and description of the problem?		
1	The AAOS recognizes that variation exists in the diagnosis and treatment of LBP and that early identification and care management of patients with LBP is critical. We also believe it is important to recognize the role of surgical care for patients with appropriate indications and who are experiencing LBP.	Oct 30, 2013 1:09 PM
2	DJO believes that sections II, IV and V are very accurate. The cost drivers that DJO has studied for low back patients are in allignment with this draft report.	Oct 30, 2013 10:30 AM
3	there isn't much focus on back pain and management of it in medical school or residency. THe problem is prevelent and difficult to treat.	Oct 22, 2013 1:13 PM
4	STarT is too elementary/narrow and ignores many additional areas of concern.	Oct 19, 2013 8:41 AM

Page 2, Q9. Any comments about the selected tools (ODI, SBST, or FRQ)?		
1	Have you considered the FABQ? http://www.drmikesdidactics.com/files/fabq.pdf	Oct 30, 2013 4:30 PM
2	The AAOS is supportive of the use of these tools. However, we hope that any use of outcomes or screening tools be considered alongside the already substantial reporting burden that physicians of all specialties and in all states experience. We hope that the implementation of any additional measure reporting requirements be done in collaboration with input from physicians.	Oct 30, 2013 1:09 PM
3	No additional comment	Oct 30, 2013 10:30 AM
4	We use the Oswestry in our facility, but after reviewing and reading the other 2 I am now familiar with them.	Oct 25, 2013 12:53 PM
5	Requiring use priior to authorizing interventions is difficult for heatlh plans.	Oct 23, 2013 10:35 AM
6	I was not familiar with these specific questionnaires however they certainly look good. I am not sure we need all three - could they somehow be combined?	Oct 23, 2013 10:08 AM
7	I read the ODI and SBST and think they look good	Oct 22, 2013 4:09 PM
8	I'm very successful in treating LBP without imaging, surgery , and medication. These tools are too elementary for my requirements.	Oct 19, 2013 8:41 AM
9	providers need education about them	Oct 18, 2013 9:56 AM
10	Only became familiar as result of reading the draft report. If permitted, including copies of these tools in the appendix of the report would be valuable.	Oct 17, 2013 1:12 PM

Page 2, Q11. Any comments about the recommendations in this section?		
1	The 2002 Article in the Annals of Internal Medicine regarding the suggested algorithm for initial screening for low back pain is well within the scope of physical therapy practice. Please see JOSPT May 2012, Boissonnault WG review of published case reports citing examples of physical therapists using effective multifactorial screening strategies for referred and direct-access patients leading to timely referral to physicians when indicated. Consider physical therapy as a lower cost primary care provider for low back pain. In the event a patient sees a PCP for diagnosis of low back pain, once red flags are cleared, consider the next referral to physical therapy vs. physiatry. See Spine. Fritz JM et al, 2012 for data regarding early intervention by physical therapy and cost savings per episode of care. Early intervention by a physical therapist can lead to reduced costs related to unnecessary imaging or lab studies, and reducing need for expensive interventions such as medications, injections, and surgery. According to Health Affairs Sept. 2011, providing services of an orthopedic surgeon or other procedural specialist costs approximately $4 per minute. A PCP whose practice consistes primarily of patient evaluation and management, rather than procedures, cost $2 per minute. A PT, whose practice consists of the same patient evaluation process in addition to biomechanical evaluation of underlying causal factors and treatment including education and focus on function is $1 per minute or less.	Oct 30, 2013 4:30 PM
2	Our main objection would be that in the presence of any red flags the recommendations are not appropriate and further work-up is as deemed appropriate by the treating physician.	Oct 30, 2013 1:09 PM
3	Please review the attached studies from Bertalanffy and Friedrich on TENS for acute back pain.	Oct 30, 2013 10:30 AM
4	the problem is that guidelines become policy. this then leads to mismanagement. erodes the doctor patient relationship and interferes with providing care. If all patients were the same, everyone could go thru a simple algorithm. I do think this is a good starting point for those who don't know how to manage these patients. again, who is going to pay for administering these surveys, storing them and implementing the program. I don't think it should be the providers. it should be the payors. I would be happy to have them in my office asking the questions.	Oct 22, 2013 1:13 PM
5	I disagree with emphasizing Chiropractic methods over more appropriate Osteopathic ones. Guidelines should not be requirements.	Oct 19, 2013 8:41 AM
6	I mostly agree. This gives documentable evidence for items that were somewhat known.	Oct 18, 2013 9:56 AM
7	Epidural steriods should be a first consideration for acute radiculopathy significantly decreasing time down and away from work and more relief of pain than any medicine or modality can give. I believe this is part of the new North American Spine Society guidlines.	Oct 17, 2013 1:27 PM

Page 2, Q13. Any comments about the recommendations in this section?		
1	Of patients seeking referral for low back pain symptoms, 93% have back pain only. Of those with age < 50, no symptoms of systemic disease, no history of cancer, no neurologic deficit; >0.99 have a likelihood of musculoskeletal cause.* No further diagnostic tests are necessary and referral to a physical therapist for further musculoskeletal evaluation and intervention should proceed. There does not appear to be a need to refer to physiatry at this juncture. Physical therapists provide additional evaluation of the movement system leading to a diagnosis of underlying biomechanical causes of low back pain and the related physiologic impairments. Comprehensive treatment and education focused on function can proceed immediately. *Annals of Internal Medicine, October 2002.	Oct 30, 2013 4:30 PM
2	While the AAOS agrees in principle with the recommendations, we recommend that in the presence of any red flags that a complete work-up is performed.	Oct 30, 2013 1:09 PM
3	No additional comment	Oct 30, 2013 10:30 AM
4	Requiring use priior to authorizing interventions is difficult for heatlh plans.	Oct 23, 2013 10:35 AM
5	I think this would label lots of people as pain seeking, chronic pain patients when they really aren't. Pain doctors don't really know much about the spine. they know pain and chronic pain very well, but don't know much about how to manage people for the long run.	Oct 22, 2013 1:13 PM
6	Osteopathic structural diagnosis is much more robust and effective in discovering specific problems related to LBP.	Oct 19, 2013 8:41 AM

Page 2, Q15. Any comments about the recommendations in this section?		
1	Yes, I think the message from the campaign regarding early activity is excellent. However, I feel that a patient should be sent to a physical therapist for evaluation of the musculoskeletal system to determine the best course of exercise based on numerous factors related to back symptoms, general health and fitness level, and physiologic function such as muscle performance, motor control, joint mobility, myofascial extensibility, etc. Though exercise may hurt, it will not do harm is not always true. A physical therapist has the expertise to determine what is safe and effective for the patient. Patient and public awareness that includes physical therapy as a care provider that can provide the best advice on a case by case basis should be included in the recommendations.	Oct 30, 2013 4:30 PM
2	Please see the attached Abstract submitted to the American Acadany of Orthopefic Surgeons (AAOS) titled, The Clinical and Economic Impact of TENS in Patients with CLBP: A Long-Term Retrospective Database Study.	Oct 30, 2013 10:30 AM
3	Overall effectiveness of public campaigns is questionable and likely to cost far more than justifies the results.	Oct 19, 2013 8:41 AM
4	before they are put in place providers must be educated on them	Oct 18, 2013 9:56 AM

Page 2, Q17. Please provide any general comments here:		
1	I would include early referral to physical therapy for evaluation and treatment. I would also ask you to consider physical therapy as primary care provider for low back pain, providing medical screening and effective treatment at low cost to the health care system.	Oct 30, 2013 4:30 PM
2	We are supportive of the efforts of the Bree Collaborative to enhance care for patients suffering with LBP. We hope that future efforts of the Bree Collaborative will continue to involve input from physicians of all specialties. It is the opinion of the AAOS that the treating physician is the final arbiter of all treatment of the patient due to the fact that the treating physician has both history and physical exam that may not be readily apparent to the insurer and reviewing physician.	Oct 30, 2013 1:09 PM
3	DJO feels that use of medical devices are underutilized in your recommendations, specifically the use of TENS for low-back pain.	Oct 30, 2013 10:30 AM
4	Each provider should have some flexibility in their treamtent however going completly out of a protocol should be discouraged. i.e. - the provider that always uses high doses and long term narcotics may in many cases be doing a dis-service to the patient. In military situations nearly every injured soldier gets anti-inflammatory meds and physical therapy for two weeks - then MRI IF no improvement.	Oct 23, 2013 10:08 AM
5	Important to include patient incentives along with the education of patients and providers.	Oct 22, 2013 4:09 PM
6	I see this as making it more difficult, from an administrative perspective, but it will help the community as a whole	Oct 22, 2013 1:13 PM
7	Osteopathic concepts and treatments have been completely ignored in favor of better known methods. OMT is more successful overall.	Oct 19, 2013 8:41 AM
8	It needs to be very clear that radiculopathy (pain going down the leg) needs to be approached differently form back pain and not be lumped together. It also needs to be easy to order an MRI after a back fails to get better. I have a cousin and a friend that both were diagnosed over a year late with life threating cancer that started with back pain because everyone was trying to "avoid an MRI". The message cannot be "avoid MRI's for back pain" it needs to be don't do the MRI for back pain only in the first month unless it is necessary. Doctors are just people and tend to take guidelines as Black or White. Ceretainly the insurance companies make this worse. I have to justify completly legitimate MRI's to insurances all the time that should not even raise a red flag much less require me talking to their physicians. I'm afraid guidlines could really begin interfering with good patient care.	Oct 17, 2013 1:27 PM
9	This looks like an excellent guideline.	Oct 17, 2013 1:12 PM

Pages 14-16 include the names and contact information for respondents and have therefore been removed from the publicly posted version.