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The advantages to being seen and evaluated by a surgeon who has been recognized by the National Committee for Quality Assurances are as follows:

1. On the initial visit, there is a tremendous focus on pain assessment, functional status, looking for red flags, developing an assessment of all prior treatment and response and employment status. Part of the pain assessment includes psychological evaluation, including a short form 36, which also helps with the functional status. The red flags rule out history of cancer, infection, the possibility of a fracture or cauda equina syndrome and I evaluate the employment status, prior injuries that would affect that and whether or not it is safe for them to return into that job.
2. The second area is regarding the physical exam where there is a documented physical exam with neurological focus. NCQA watches this carefully. This includes completion of a neurovascular exam in the presence or absence of neurologic signs and symptoms.
3. Next is a mental health assessment, which is very important for people with back pain or chronic pain issues. The intent here is to look for potential barriers to recovery and it helps to inform treatment decisions and provides a baseline for assessing improvement in symptoms. Again, this is very frequently done as a short form 36 in my office or if I pick up other issues, I send the patient for a neuropsychological evaluation. This has to be done for the NCQA certification.
4. Next is using appropriate imaging for acute back pain. This assesses whether or not the physician orders appropriate imaging in the first six weeks after the beginning of pain in the absences of the red flags. This looks for over-use ordering of plain films or MRI scans, CAT scan or myelography. The cost of these are skyrocketing and the NCQA seeks to provide ultimate patient care but with an eye toward economy also. I follow these guidelines very carefully and it is a major portion of success of these guidelines.
5. Next is dealing with repeat imaging studies. Like #4, inappropriately ordering repeat imaging in the absence of red flags or progressive symptoms is a massive over-use and extraordinarily expensive to society with a very low performance and low evidence for improving patient outcome. This particular criteria is changing rapidly but is being carefully monitored by the NCQA to determine best practices. I do not repeat the films unless there are progressive symptoms, especially functional loss, or if there has been a significant change in the signs or symptoms.
6. Medical assistance with smoking cessation. The reason for this is that a percentage of patients with documentation that the physician has assessed their smoking status and for smokers that the physician provide medical assistance with cessation, is important. I 100% of the time ask if they smoke and 100% of that time tell them to quit smoking if they do. If they need medical management with that, I ask them to have that achieved through their family practice doctor and we discuss nicotine patch, gum, nasal sprays, inhalers and prescription medications. There are smoking cessation programs to which I can refer the patient also.

7. Advice for normal activities. Specifically, the percentage of patients with medical record documentation that the physician has advised them to maintain or resume normal activities. The old practice of keeping people at bedrest four to six weeks is no longer appropriate and it is very important to encourage patients to resume normal activities as soon as possible. This is something that I always do and it is monitored by the NCQA.

8. Similar to #7, advice against bedrest. I specifically tell patients not to be put in bed rest and to be as active as they can.

9. Recommendation for exercise. NCQA follows a percentage of patients who have back pain that is lasting more than twelve weeks with documentation by me, advising for supervised exercise. Now, this can be at a local gym with supervision or a physical therapist and I follow their guidelines.

10. Appropriate use of epidural steroid injections. NCQA monitors the percentage of patients with back pain who receive an epidural steroid injection in the absence of radicular pain and those patients with radicular pain receive an epidural steroid injection without imaging guidance. The issue is that the doctor to whom I refer for an epidural steroid injection has to use image guidance, otherwise I won't pass this criteria. I also have to be careful that only the patients with radicular signs and pain be referred for the epidural steroid injection. It is not meant for chronic pain management and this is watched very carefully.

11. Surgical timing. NCQA carefully monitors the percentage of patients without documentation of red flags who have surgery within the first six weeks of back pain onset. The issue is that patients being operated on for back pain only should be rarely, if ever, done and this should be reserved more exclusively for those with progressive pain, numbness, tingling or weakness in an extremity. There are times when with back pain alone it can be done, but that should be a very small percentage. Especially in the first six weeks, surgery for back pain only should virtually never be done assuming there are no red flags or cancer, infection, fracture or cauda equina syndrome.

12. Patient reassessment. I must document that I have conducted a reassessment of the pain and functional status with the patient within four to six weeks of the initial visit. I commonly will repeat the SF 36 at that time and reassess their history and physical.

13. Shared decision making. This is where I document that I have reviewed a range of treatment options including alternatives to surgery prior to the surgery and demonstrate a shared decision making with the patient. This must be documented in the patient record that includes treatment choices, alternatives to surgery, risks and benefits and evidence of effectiveness.

14. Patient education. NCQA has monitored and evaluated the educational material that I give to the patients, both through my website and here in the clinic with handouts and in direct teaching. They review the natural history of the disease, treatment options including alternatives to surgery, the risks and benefits and the evidence. I ask for and receive feedback from the patients as to whether or not they understood what I taught.

15. Postsurgical outcomes. I have demonstrated that I have a system to examine postsurgical outcomes that include tracking specific complications of back surgery like infection or cerebrospinal fluid leak or nerve injury, and that I analyze these periodically and I have a plan for improving my outcomes. Because of this, I know that I have an extremely low risk of complications, infection, wound dehiscence, hematoma or CSF leak, however I am constantly trying to improve my system and I am analyzing it.

16. Evaluation of the patient experience. The goal here is to demonstrate that the physician has mechanisms to evaluate the patient experience and that I am assessing 1) an ongoing system of obtaining feedback about the patient experience with care and 2) a process for analyzing the data and a plan for improving patient experience. I get information back on my website and we send out fliers to the patients and we analyze these to look for holes in the system and make it better.

In order to become recognized by the NCQA, I am following all these guidelines and I have to show a proficiency percentage of each.