



CLINICAL OUTCOMES IN A LARGE COHORT OF MUSCULOSKELETAL PATIENTS UNDERGOING CHIROPRACTIC CARE IN THE UNITED KINGDOM: A COMPARISON OF SELF- AND NATIONAL HEALTH SERVICE-REFERRED ROUTES

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ABSTRACT

Objective: An innovative commissioning pathway has recently been introduced in the United Kingdom allowing chiropractic organizations to provide state-funded chiropractic care to patients through referral from National Health Service (NHS) primary care physicians. The purpose of this study was to examine the outcomes of NHS and private patient groups presenting with musculoskeletal conditions to chiropractors under the Any Qualified Provider scheme and compare the clinical outcomes of these patients with those presenting privately.

Methods: A prospective cohort design monitoring patient outcomes comparing self-referring and NHS-referred patients undergoing chiropractic care was used. The primary outcome was the change in Bournemouth Questionnaire scores. Within- and between-group analyses were performed to explore differences between outcomes with additional analysis of subgroups as categorized by the STarT back tool.

Results: A total of 8222 patients filled in baseline questionnaires. Of these, NHS patients (41%) had more adverse health measures at baseline and went on to receive more treatment. Using percent change in Bournemouth Questionnaire scores categorized at minimal clinical change cutoffs and adjusting for baseline differences, patients with low back and neck pain presenting privately are more likely to report improvement within 2 weeks and to have slightly better outcomes at 90 days. However, these patients were more likely to be attending consultations beyond 30 days.

Conclusions: This study supports the contention that chiropractic services as provided in United Kingdom are appropriate for both private and NHS-referred patient groups and should be considered when general medical physicians make decisions concerning referral routes and pain pathways for patients with musculoskeletal conditions. (*J Manipulative Physiol Ther* 2016;39:54-62)

Key Indexing Terms: *Patient Outcome Assessment; Musculoskeletal Pain; Chiropractic; Health Services Evaluation*

Musculoskeletal conditions are common in all countries and cultures and are a major burden on health system.¹ In the next 50 years, this burden is predicted to increase as the population ages and public health issues such as obesity and lack of activity take their toll.²

In the United Kingdom (UK), back pain accounts for 4.8% of all social benefit claims³ with the overall cost of musculoskeletal (MSK) conditions estimated at £5 to 7 billion per year and the number of general medical physician (GP) visits estimated at more than 30% of all consultations.⁴ As national health systems strive to accommodate increasing demands and resources are stretched, the direct and indirect costs of shouldering the MSK burden are increasingly considered a national priority in the UK and in other developed economies.

Historically, in the UK, MSK conditions have been managed predominantly within the state health care system, although successive governments have attempted to bolster the contribution of the private (ie, independent) sector by providing funded access for patients to care normally considered to be outside the state system. Traditionally, outpatient MSK services have been provided by single large

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organizations covering 1 or more National Health Service (NHS) region. In the “new” NHS England, MSK care is envisaged to focus more on outcomes rather than targets and to be more patient focused, with greater empowerment, individualized plans, and evidence-based pathways in care choice as well as extending the freedom of payers to commission new services.⁵

An example of recent changes in such service provision was the development of contracts whereby independent or state sector organizations able to demonstrate achieving a priori excellence and clinical governance criteria as set by the UK government were able to apply to provide care funded by the NHS. These were termed *Any Qualified Provider (AQP) contracts*, and for the first time, they enabled organizations providing chiropractic services to accept and be remunerated for patient care as referred from primary care physicians (ie, general medical practitioners [GPs]) within particular NHS regions. These patients' health care treatments are paid for by the NHS through a set tariff not related to the number of treatments.

Previous research suggests that demographic and condition-based differences exist between private and state-funded patients with MSK conditions, with state-funded patients being somewhat less healthy (eg, greater severity, duration, and comorbidity) than private patients.⁶ However, it is not known if these differences affect response to chiropractic care.

In addition, pretreatment screening of patients with nonspecific low back pain (LBP) using the STarT Back Tool (SBT) has been developed and is intended to help GPs, and others direct such patients to targeted treatment.⁷ Given that its use has increasingly been included in NHS back pain pathways, the authors have described the prognostic utility of this tool in patients presenting privately for chiropractic care.⁸ However, little is known about the utility of SBT for patients seeking chiropractic care through state-funded services

The purpose of this study was to examine the outcomes of NHS and private patient groups presenting with MSK conditions to chiropractors under the AQP scheme and compare the clinical outcomes of these patients with those who presented privately. A second purpose was to examine the differential outcomes of patients with LBP who were classified as low, medium, and high risk of not improving by the STarT Back stratification tool in both patient groups.

METHODS

Participants

The design of the study was observational using routinely collected data from patients over the age of 16 years at a consortium of UK-based practices located in the south of the UK. These clinics, in addition to providing care for private self-referring patients, also provided services to

the NHS through an AQP contract with NHS patients being referred by local GPs.

Data Collection

Patient characteristics and outcomes were collected via a Web-based patient-reported outcome measure collection system (Care Response, <https://www.care-response.com/CareResponse/home.aspx>). This methodology has been developed to provide validated measures to patients by e-mail links sent automatically at set follow-up time points throughout and beyond the provision of face-to-face care. Using this system, baseline data that included patient- and condition-related characteristics, SBT, and the Bournemouth Questionnaire (BQ) were collected before the first visit using either the patients' e-mail collected by consent during the initial booking or at the clinic before the first appointment. Patients could designate areas of pain according to a pain manikin diagram and were able to indicate more than one area. Care Response enables exporting of anonymized information from participating practices to a secure encrypted server, thus facilitating collation and analysis of large sets of data collected as part of normal practice activity.

Patient-Reported Outcomes

The BQ is a condition-specific outcome measure and has been extensively validated and characterized.⁹⁻¹² It consists of seven 11-point numerical rating scales (0-10) each covering a different aspect of the back pain experience. These were (i) pain, (ii) disability in activities of daily living, (iii) disability in social activity, (iv) anxiety, (v) depression, (vi) fear avoidance behavior, and (vii) locus of control. Subscales are summed to produce a total BQ score (maximum of 70).

Using the Patients' Global Impression of Change (PGIC), patients were asked “How would you describe your pain/complaint now, compared to how you were when you completed the questionnaire before your first visit to this clinic?” The scale ranges from 1 (worse than ever) to 7 (very much improved). This outcome was dichotomized for each of the follow-up points with improvement being defined by a PGIC response of better or much better (score of ≥ 6).¹³

The BQ and a PGIC were collected at 14, 30, and 90 days after the initial visit. In addition, participants also completed a 7-point Likert scale measuring satisfaction at the 30-day follow-up. The satisfaction scale consisted of 7 items and was preceded by a question asking “Overall, how have you found the service and care you received? This would include the way you have been treated by our reception, practitioners or any other contact from us. Please select one of the following”: (1) unacceptably poor; (2) not as good as I was expecting, I would be concerned if a friend

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