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# The use of PROMIS and the RAND VSQ9 in chiropractic patients receiving care with the Webster Technique



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## ABSTRACT

**Introduction:** Our ongoing efforts to demonstrate effectiveness of care examined the quality of life (QoL) and patient satisfaction of chiropractic patients presenting for care in a PBRN.

**Methods:** In addition to socio-demographic and clinical care information, we examined visit-specific satisfaction and QoL using the RAND VSQ9 and PROMIS-29, respectively.

**Results:** Our study population was comprised of 126 subjects (average age = 39.68; 97 females). The majority of respondents presented with musculoskeletal complaints with an average mean duration of 7.188 years. The mean PROMIS-25 mean T Scores were: depression (47.80); pain interference (53.49); fatigue (51.02); physical function (49.02); satisfaction with social role (52.10); anxiety (50.14); and sleep disturbance (49.88). The VSQ9 mean score was 93.4% indicating high satisfaction.

**Conclusions:** Adults attending care in a chiropractic PBRN were able to successfully complete the PROMIS29 and VSQ9 instruments. Future longitudinal studies should quantify the minimal clinically important difference in mean T score changes.

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## 1. Introduction

Globally, the interest and use of complementary and alternative medicine (CAM) has increased dramatically in the last 2 decades [1,2]. In a systematic review of the literature, Harris and colleague [3] found substantial CAM use in 15 countries with the 12-month prevalence of use of any CAM ranging from 9.8 % to 76% while visits to CAM practitioners ranged from 1.8% to 48.7%. Frass et al. [4] found that of the various CAM therapies, chiropractic was cited 9 times more in terms of utilization compared to 2 other commonly used therapies – homeopathy and acupuncture. A systematic review of surveys examining the 12-month prevalence of visits to CAM practitioners found chiropractic to be the most utilized [5].

Chiropractic is the 3rd largest healthcare profession following medicine and dentistry. Of the alternative therapies, chiropractic has made the largest inroads into private and public healthcare financing systems and is increasingly viewed as an effective specialty by many in the medical profession, particularly for spinal pain

syndromes [6]. The size and scope of this profession may be unique to the United States given the popularity of religious practices other than prayer, named therapies not commonly regarded as CAM such as “dietary supplements”; and the use of indigenous, traditional medicine in other countries [3]. Nonetheless in this era of evidence-informed practice, there is a need for all healthcare providers to demonstrate safety and effectiveness of care. Towards these efforts, there has been an increasing focus on the use of patient reported outcomes (PROs) as a necessary component in clinical care and research. Traditional outcome measures such as radiographic imaging and laboratory tests have been argued to have minimal immediate relevance to the day-to-day functioning of patients while PROs add to capturing the impact (i.e., personal and social context) of a disease or condition on the lives of individuals suffering from various morbidities [7,8]. A recent review by Parkinson et al. [9] found that despite chiropractic's advocacy for a holistic and wellness approach to patient care, the quality of life, lifestyle, health and economic impacts of chiropractic intervention for back pain have rarely been investigated. We would hazard to guess that this problem is not unique to chiropractic. Given the international readership of this Journal by both allopathic and alternative practitioners, the relevance of this study is the demonstrability of the

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use of a valid and reliable PRO that is standardized with common domains and metrics for comparability across different clinical scenarios (i.e., different conditions, providers and healthcare settings). Towards initial efforts to address deficits raised by Parkinson et al. [9] and in the interest of evidence-informed practice, we examined the quality of life and patient satisfaction of chiropractic patients presenting for care in a practice-based research network (PBRN).

## 2. Methods

This study was approved by the Institutional Review Board of Life University (Marietta, GA, USA). An e-mail invitation was sent out to Doctors of Chiropractic previously or currently enrolled in a post-graduate course offered by the International Chiropractic Pediatric Association to participate in a PBRN study to examine the chiropractic care of patients utilizing, in part, a specific chiropractic technique called the Webster Technique [10]. As in previous studies implementing this PBRN [11,12], inclusion criteria for participation include the following: (a) the chiropractor must be in good standing with their licensing authority; (b) complete the National Institute of Health online course on the protection of human subjects for research [13]; (c) agree to the terms of participation as an ICPA PBRN participant (i.e., PBRN participation must not be used for practice-building or marketing) and (d) the Webster Technique is implemented as part of the care in the presenting patient. The participating Doctors of Chiropractic were encouraged to invite their patients as respondents for this study. Patient participation requirements involve the following: (a) they are  $\geq 18$  years of age and (b) provide consent for study participation and (c) attended chiropractic care for  $\leq 10$  visits.

### 2.1. Survey instruments

In addition to sociodemographic information (age, gender and level of education) and aspects of their clinical care (i.e., primary presenting complaints and duration), the primary outcome measures for this study examined the patient's visit-specific satisfaction and health-related quality of life. The RAND VSQ9 questionnaire [14] was utilized to examine the patient visit-specific satisfaction while the patient-reported health status for physical, mental, and social well-being was measured using the Patient Reported Outcome Measurement Information System (PROMIS) [15]. The PROMIS-29 instrument measured the quality of life domains of emotional distress (i.e., anxiety and depression), fatigue, pain interference and intensity, physical functioning, sleep disturbance and satisfaction with participation in social roles. The survey instruments were pilot tested with 10 patients and implemented as a paper-and-pencil questionnaire without difficulty.

### 2.2. Statistical analysis

The socio-demographic, VSQ9 and PROMIS data were entered into an online data processing center created for the purpose of this study and exported to a spreadsheet (Excel, Microsoft Corp) for analysis. The PROMIS29 data was analyzed using the PROMIS Assessment Center [16], a free, online data collection tool that enables researchers to create study-specific websites for capturing participant data securely and provide real-time scoring. For each PROMIS domain (i.e., anxiety, physical functioning, pain interference), a scoring table was developed to associate short form scores onto a T score metric, which is referenced to (and centered upon) the US General population [17]. The RAND VSQ9 questionnaire examined the patient's visit-specific satisfaction utilizing a Likert scale (i.e., poor; fair; good; very good; excellent). The response from

each responder was transformed linearly from 0% to 100% scale with 100% corresponding to "excellent" and 0% corresponding to "poor." Responses to the 9 VSQ-9 items were then averaged to create a VSQ-9 score for the responders. Descriptive summary statistics are provided as frequencies and percentages, means and standard deviations for demographic and clinical characteristics. Mean T scores and standard deviations were calculated for each of the 7 domains assessed. To assess the associations, Pearson's  $r$  was calculated when applicable and unpaired  $t$ -tests for variables with 2 levels and ANOVA for variables with more than 2 levels, when appropriate.

## 3. Results

A total of 126 subjects (97 females; 29 males) comprised our study population. Their average age was 39.68 years (range = 18–74 years; SD = 12.56). This cohort was highly educated with the vast majority (i.e., 81%) attaining some college education (N = 29) or higher (i.e., associate degree N = 13); baccalaureate (N = 28); master (N = 26); PhD (N = 6) while 21 graduated from high school with 3 having some high school education.

The respondents' presenting complaints or motivation for chiropractic care are presented in Table 1. Over half of the respondents (i.e., 57%) presented with low back pain, either as the single primary complaint (N = 37; 29%) or in combination with other pain complaints involving other parts of the spine, the extremities or headaches (N = 35; 28%). Twelve respondents had complaints involving the cervical spine, either as the single primary complaint of neck pain (N = 3; 2.4%) or in combination with another pain complaint of the spine, the extremities (N = 9; 7%) and headaches (N = 6; 5%). Some 12% (N = 15) presented for "wellness care" while the remainder (N = 13; 10%) presented with combinatory pain complaints involving the spine and upper/lower extremities and "other" (N = 6; 5%).

In terms of duration of presenting complaints, 20% (N = 25) of the responders did not provide timelines given the nature of their care (i.e., wellness care) (N = 15; 12%) or provided no response to the query (N = 10; 8%). The remainder (N = 103; 82%) provided mean duration of complaint of 7.188 years (range = 0.01–67 years; SD = 10.65). Pearson's  $r$  with respect to duration of complaint and mean T score for each domain revealed only a weak relationship between the variables (see Table 2). Given the chronicity of the presenting complaints, over half of the responders (N = 76; 60%) indicated seeking care elsewhere prior to attending care with their present chiropractor. Thirty-six percent (N = 41) of these responders sought medical care while 42 (i.e., 33%) attended the care of another alternative practitioner. Of those seeking previous care, only 7 (i.e., 6%) indicated seeking care from both medical and a CAM practitioner.

The mean T Scores for each domain are provided in Table 3. Mean T scores based on gender are provided in Table 4. Unpaired

**Table 1**  
Frequencies of presenting complaints or motivation for chiropractic care.

Presenting complaint	Count	%
Low back pain (LBP)	37	29
Low back pain + Other pain complaint(s)	35	28
Neck pain + Other complaints (except LBP)	9	7
Neck pain	3	2.4
Wellness care	15	12
Other spinal and/or Extremity pain	13	10
Other	6	5
Headaches	6	5
No indicated	2	1.6
Total	126	100

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