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Describing the Primary Care Journey for People with Musculoskeletal Pain

Hamish Beal – Advanced Physiotherapist
Sunshine Coast Hospital and Health Service
Queensland Health
E: hamish.beal@health.qld.gov.au

Katherine Howard - Advanced Physiotherapist
Sunshine Coast Hospital and Health
Queensland Health

Luke Goldston – Advanced Physiotherapy
Metro North Hospital and Health Service
Queensland Health

David Thompson – Director of Physiotherapy
Caboolture Hospital, Metro North Hospital and Health Service

Jennifer Finch – Director of Allied Health
Office of the Chief Allied Health Officer
Clinical Excellence Queensland

Katelyn Clarke – Principal Workforce Officer
Office of the Chief Allied Health Officer
Clinical Excellence Queensland

Belinda Gavaghan – Director of Allied Health
Office of the Chief Allied Health Officer
Clinical Excellence Queensland, Queensland Health

Easing the burden: Insights from the primary care journey for people with musculoskeletal pain

Introduction

This brief describes findings from a review of patient care journeys and experiences within a musculoskeletal physiotherapy screening clinic (MPSC) and highlights the dissonance between patient experiences and care pathways, best practice guidelines and the delivery of value-based, holistic, and person-centred primary health care.

In exploring patient journeys in primary care, it was hypothesised that this cohort will have accessed a variety of services prior to referral

Background

Musculoskeletal (MSK) disorders, characterised by “pain and limitations in mobility, dexterity and overall level of functioning, reducing people’s ability to work” (WHO, 2022), represent a significant burden to individuals across the life course, the health system and society as a whole (Briggs et al. 2015; Vos et al. 2020; Cieza et al. 2021; WHO, 2022; AIHW, 2023). In Australia, it is estimated that one in three people have some form of MSK condition (DoHAC, 2020), and three in ten people report experiencing a chronic MSK condition, of which back problems are the most common (3.9 million people) (AIHW, 2023).

Globally, 1.71 billion people live with MSK conditions, and they are the leading contributor to global disability (years lived with disability; YLD) and the need for rehabilitation,

to the public health service for specialist opinion. However, the detail and variation of each patient journey, including length of time before referral, the extent of allied health and associated care received, and the patient views of their care were largely unknown.

A research study was undertaken to explore patient experiences and outcomes prior to first attendance and management within the MPSC.

accounting for approximately 17% of all YLDs (Cieza et al. 2021; WHO, 2022).

The impact of MSK pain and disorders on health systems is expected to be compounded by an aging population and increasing rates of overweight and obesity (Margham T, 2011; Briggs et al. 2015; AIHW, 2023; Chen et al. 2023), necessitating appropriate consideration by health system managers and policy makers.

In many health systems, including Australia, general practitioners (GPs) are the first point of contact for people with MSK pain and disorders (Foster et al. 2012); with MSK conditions accounting for almost 20% of all GP consultations (Haas et al. 2021).

In Australia, the Medicare system supports GPs to provide the vast majority of MSK care in primary care utilising Medicare Benefits Schedule (MBS) payments.

In some circumstances, a limited number of community-based and private allied health services may be provided and partially subsidised by the MBS if the person is formally referred by a GP under a Chronic Disease Management MBS item. This effectively places GPs in the role of 'gate keeper' to subsidised allied health services in the community, in addition to hospital-based care.

While there is limited data on the rates of GP referrals to physiotherapists in Australia, a study published in 2017 found that only 6.8% of MSK problems managed by GPs were referred to physiotherapists (Dennis et al. 2017). Data from the Bettering the Evaluation and Care of Health (BEACH study) indicated

that the rate of GP referrals to physiotherapy increased by over 1.2 million referrals in 2015-2016, when compared to 2006-2007, most likely due to MBS changes for chronic disease management (Briggs et al. 2016), although there are recognised limitations of data on referrals to allied health services (Haas et al. 2021).

GPs traditionally refer patients for a specialist medical opinion when the patient cannot be adequately managed in primary care (NICE, 2014). BEACH data found rates of referral to orthopaedic specialists remained stable between 2006-2007 and 2015-2016 at 0.5 per 100 referrals (Briggs et al. 2016).

What consumers told us?

Twenty-three people with MSK pain who had been referred for specialist orthopaedic opinion and subsequently triaged to the MPSC were interviewed to explore their care journey and to understand what interventions and therapy had been recommended and received in primary care. The average time from GP referral to initial assessment in the MPSC was eight months, and the interviews occurred between one and 19 weeks (average of seven weeks) after the initial physiotherapy screening appointment.

The key findings were:

- Most patients were managed by their GP for several years in the community prior to referral for a specialist opinion (average of seven years), with multiple GP consultations (average of seven appointments).
- At the first appointment imaging referrals were made for over half of those interviewed, and a small number of people were referred for medical specialist opinion.
- None of the people interviewed recalled being referred to allied health services at their first appointment, however by the time the person was first seen at the MPSC, over half had accessed allied health services privately in the community.
- Few respondents recalled receiving information or being directed to educational resources regarding their condition to assist with self-management.
- Those interviewed did not recall, or were not aware of, any specific indicators or prompts regarding the GP decision to refer for a specialist opinion.

Our findings from the 23 interviews indicate a discrepancy between patients' experiences and care journeys in primary health care and current evidence-based guidelines for MSK pain and disorders, including the Australian Commission on Safety and Quality in Health Care Low Back Pain Clinical Care Standard

Implications for clinical practice

Despite the volume of research and evidence to inform the management of MSK pain and disorders, or perhaps because of the plethora of information, some of which is conflicting, some patients who participated in this research study did not receive evidence-based, cost effective and value-based health care (VBHC) (Lin et al. 2020).

MSK pain and disorders are not homogenous, there are however similarities in the mechanisms, prognostic factors and clinical course, and broad consensus in how this patient group should be managed.

Recommendations in contemporary guidelines for the management of MSK pain and disorder consistently include:

- a patient-centred, holistic, and individualised biopsychosocial approach that also considers co-morbid conditions as best-practice (Bannuru et al. 2019; Lin et al. 2020; Cohen et al. 2021),
- a focus on non-surgical management and self-management strategies, including the provision of information and education, to develop and improve patient self-efficacy and health literacy, moderating dependency on health care providers alongside the goal of symptom resolution

(Foster et al. 2018; ACSQHC, 2022). However, it may be the case that people managed in accordance with best practice guidelines did not require referral for specialist opinion and were therefore not part of the study population.

(Lewis, O'Sullivan, 2018; Lin et al. 2020; Kongsted et al. 2021);

- only performing diagnostic imaging for non-traumatic MSK pain in primary care when clinically indicated (Cuff et al. 2020; Lin et al. 2020), and
- management that includes/addresses physical activity and/or exercise (Lin et al. 2020).

Common issues in MSK care include the overuse of medical imaging, surgery and opioids, in addition to the inadequate provision of patient resources, education and advice (16), and high rates of referral for specialist/surgical opinion, despite limited evidence for many elective orthopaedic interventions and surgical intervention recommended for only a small proportion of individuals (NICE, 2014; Briggs et al. 2016; NICE, 2016; Babatunde et al. 2017; RACGP, 2018; Bannuru et al. 2019; Lin et al. 2020; Blom et al. 2021).

Reported barriers to adoption of evidence-based guidelines and care for MSK pain and disorders have been synthesised by relevant findings to our study include (Hall et al. 2009):

- a lack of time for GPs to complete recommended assessments, adequately

communicate the complex nature of MSK pain and provide comprehensive advice and education within short primary care consultations,

- patient expectations and social pressure to provide a 'precise diagnosis' using medical imaging and provide a specialist referral,
- a lack of knowledge of, and familiarity with, conservative interventions (provided by allied health professionals such as physiotherapists, exercise physiologists and psychologists) and a belief that physiotherapy and other conservative interventions were not necessary, not effective, or too difficult for patients to access,

Implications for Policy

While it is easy to make broad proclamations that something needs to change, what specifically needs to change is a vexed question. Is it simply a matter of more education, training, and support to improve the confidence of GPs and other members of the multidisciplinary primary care team to manage MSK pain? Or is it that a VBHC approach is required, with changes required at a system and policy level?

By using a patient-focussed lens, it is possible to take a more comprehensive and solutions-orientated view to consider and address the challenges to the provision of guideline-concordant management of MSK pain and disorders, such as a lack of integration of allied health services into primary care and poorly defined patient pathways (Schwarz et al. 2022), and inequitable access to primary health and allied health care across the patient's entire health care journey,

a lack of knowledge and understanding of the benefits of exercise and skills to provide advice to patients regarding appropriate types of exercise (Hall et al. 2015).

To optimise patient outcomes and lower healthcare costs, primary health care for MSK pain and disorders should be provided by a holistic and multidisciplinary team. Care should be concordant with best-practice guidelines, including taking a biopsychosocial approach and being tailored to individual patient needs, and with shared ongoing responsibility (along with the patient) for setting and working towards care goals (Bair et al. 2009; Briggs et al. 2016; Cohen et al. 2021,).

perpetuated by activity-based funding and limited access to subsidised allied health services through the MBS (PHCAG, 2016).

In the long term, this will require a comprehensively restructured payment system to support flexible team-based primary health care and embedded and adequately funded referral pathways from primary care to MPSC and other primary contact models in the public hospital system (PHCAG, 2016; MOVE & PWC, 2017).

In the short term, better access and integration of allied health services may be achieved through more equitable subsidisation of care within the MBS for allied health care in the community and MBS items that enable physiotherapists to adequately contribute to comprehensive MSK care, including coordination of MSK care where appropriate.'

Conclusion

This study highlights variation in patient care pathways and experiences in primary care for the management of MSK pain and disorders, including discordance with best-practice guidelines and the contribution of a health system that does not currently support the provision of multidisciplinary, VBHC. But more importantly, this review provides a new and unique patient perspective of MSK pain management and care pathways, which is essential for the delivery of VBHC that more efficiently and effectively meets the needs of patients and communities.

To address the growing demand for MSK services, provide optimal care for those with MSK pain and ensure the most efficient use of limited healthcare resources, this study suggests that a multimodal approach involving individual health care providers, health system managers and policy makers is required to address the multiple factors contributing to inconsistent assessment and management of MSK conditions and pain.

Perhaps the hypothesis should be reframed to 'if people with MSK pain and disorders received timely care that met their needs and was in line with best practice guidelines, they would not have required specialist opinion'?

We conclude by posing the following - what does VBHC look like for people with MSK disorders and how can we ensure that patients have equitable access and receive evidence-based, integrated, and comprehensive MSK health care that improves the health outcomes and experience of care across the full care pathway, for the cost of resourcing that care?

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Contact:

Adj AProf Rebecca Haddock
Executive Director Knowledge Exchange
Australian Healthcare and Hospitals Association.
Email: rhaddock@ahha.asn.au

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