OSTEOARTHRITIS (OA) is the most common chronic joint disease globally: one in five Australians over the age of 45 years has OA. The National Osteoarthritis Strategy (the Strategy) aims to outline Australia’s national response to OA, covering three areas: ‘prevention’, ‘living well with OA’ and ‘advanced care’. Development of the Strategy is detailed in part one of the Strategy series. This article, part two, focuses on ‘living well with OA’.

The 2018 Royal Australian College of General Practitioners (RACGP) guideline for the management of knee and hip OA recommends self-management, exercise and weight control (lifestyle interventions) for first-line care. Unfortunately, many Australians with OA do not receive ‘high-value care’ defined as treatment that is supported by evidence of benefit to patients, associated with a higher probability of benefit than harm, and costs that provide proportionally greater benefits than other treatments.

Identified evidence–practice gaps
Underuse of lifestyle interventions and overuse of medications and imaging
Although general practitioners (GPs) describe favourable attitudes towards clinical practice guidelines, their familiarity with, and application of, OA management guidelines reveals an important implementation gap. The CareTrack study reported a median of 43% (95% confidence interval: 35.8, 50.5) of primary care–based healthcare encounters provided appropriate OA care. The Bettering the Evaluation and Care of Health (BEACH) study reported that only 17% of patients who consulted their GP for hip/knee OA were referred for lifestyle interventions. Previous research into barriers to the use of lifestyle interventions found that primary care practitioners (GPs, nurses, pharmacists, physiotherapists) feel underprepared to deliver these. Previous studies have identified a lack of confidence and knowledge of primary care practitioners to effectively deliver lifestyle interventions. Some practitioners continue to prescribe pharmacological agents with small therapeutic effects (e.g., paracetamol) and/or with unsatisfactory risks of side effects (e.g., opioids, nonsteroidal anti-inflammatory medication and corticosteroid injections). Also, despite recommendations for a limited role in the diagnosis of OA, there remains an overuse of unnecessary imaging. These evidence–practice gaps should be addressed by supporting practitioners with training and resources to enhance their knowledge, skills and confidence in the provision of high-value OA care. The RACGP offers continuing professional development courses on OA management for GPs and has published several OA entries in the Handbook of Non-Drug Interventions (HANDI) project.

Important system- and service-level barriers to high-value OA care include inadequate consultation times; limited allied health networks for onward
referral, particularly in regional areas; and inflexible funding models that inadequately support community-based care.1 The Medicare Benefits Schedule (MBS) provides a maximum of five face-to-face consultations per person with allied health per year, with no provision for addressing care disparities attributable to geography or case complexity. Improved access to effective lifestyle interventions would substantially improve outcomes.

OA guidelines recommend lifestyle interventions as a first-line treatment for OA.3 MBS Chronic Disease Management items and private health insurance should be accessed where appropriate. Hospital-based OA management programs available in some states, such as the Osteoarthritis Chronic Care Program18 in NSW and the Osteoarthritis Hip and Knee Service19 in Victoria, and the GLA:D Australia program is available through selected private physiotherapy clinics and some hospitals.20

Inadequate, inequitable uptake of high-value osteoarthritis care

Some Australians are dissatisfied with the care they receive for their arthritis, reporting poor access to health practitioners and information about possible treatments.1,2 These issues are amplified in rural/remote areas23 and among Aboriginal and Torres Strait Islander peoples.24,25 A potential strategy to address poor access to health services is the provision of remotely delivered healthcare. Although patients and practitioners are willing to embrace remotely delivered models for managing OA26–29 and there is evidence that telehealth is effective for managing musculoskeletal conditions,30,31 the opportunities for subsidised multidisciplinary telehealth services are limited. Establishing new, outcomes-based funding models involving Primary Health Networks in partnerships with private health insurers, local hospital networks and private providers for delivery of high-value face-to-face and digitally enabled OA care is vital to improving access. For example, Healthy Weight for Life is an existing remotely-delivered OA management program funded by some health insurers.32

Where high-value care is accessible, there is often a lack of uptake of lifestyle interventions by people with OA.35 Common misconceptions of people with OA include: OA is caused by ‘wear and tear’, their affected joint is ‘bone on bone’ and will inevitably deteriorate, activity may cause further joint ‘damage’ and lifestyle interventions have limited effectiveness.34 It is important for primary care practitioners to address misconceptions of patients as part of the overarching strategy to improve the uptake of high-value care by Australians with OA.

**Priorities and strategic responses**

The evidence–practice gaps identified in the literature informed the determination of two national priorities for the ‘living well with OA’ working group. Actionable strategic responses to tackle these priorities are proposed (Figures 1 and 2). The Consolidated Framework for Implementation Research (CFIR)35 was adapted to generate these figures. The full National Osteoarthritis Strategy provides detailed implementation plans for each strategy (https://ibjr.sydney.edu.au/wp-content/uploads/2019/05/National-Osteoarthritis-Strategy.pdf). By following the relevant recommendations proposed in the Strategy, healthcare providers can ensure the provision of appropriate care for people with OA.

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**Figure 1.** Strategic responses proposed to address priority 1

OA, osteoarthritis

Figure adapted from Wolk et al36 and based on the Consolidated Framework for Implementation Research37
**Strategies**

**Empower consumers with knowledge and confidence to seek and request high-value care from primary care practitioners**

**Actions**
1. Deliver public health messages about high-value OA care including nationally accepted minimum standards for OA care.
2. Produce an online web platform for consumer educational resources, decision aids and service directories.
3. Produce consumer resources in multiple languages and modalities (e.g. hard copy leaflets).
4. Enhance the delivery of education and support for self-management in primary care settings (e.g. increase capacity for shared medical appointments, practice nurses).

**Improve access of consumers to lifestyle interventions and coordinated, interdisciplinary OA care when needed**

**Actions**
1. Deliver educational resources and training programs for primary practitioners concerned with high-value OA care and referral for lifestyle interventions.
2. Partner with community groups to deliver lifestyle interventions for OA.
3. Implement models that deliver coordinated, interdisciplinary OA care.
4. Advocate for new funding models (public and private) that support group-based exercise and/or weight loss and coordinated care programs.

**Implement programs of OA care tailored for populations with specific needs including culturally and linguistically diverse groups and outreach for rural/remote areas**

**Actions**
1. Evaluate, identify and report on geographic areas and culturally and linguistically diverse groups with specific needs.
2. Build partnerships with opinion leaders and stakeholders to establish strategies and pathways to implement high-value care with these groups.
3. Evaluate consumer resources and programs of care to ensure they meet the needs of specific groups.

**Support existing or implement new models of remotely delivered OA person-centred care**

**Actions**
1. Promote existing and implement new models of remote OA care delivery.
2. Develop and implement training programs and core capabilities for practitioners to roll-out remotely delivered OA care.
3. Advocate for new funding models (public and private) that support remotely delivered OA care.

**Advocate for musculoskeletal health to be prominent in health planning and policy**

**Actions**
1. At all government levels, inform and support existing or emerging health policy frameworks and funding agreements to include an explicit focus on musculoskeletal health.
2. Advocate for expanding funding models for chronic disease management.

**Priority**

**Enhance the uptake of high-value care by Australians with OA**

**Figure 2.** Strategic responses proposed to address priority 2

OA, osteoarthritis

Figure adapted from Wolk et al. and based on the Consolidated Framework for Implementation Research. 

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LIVING WELL WITH OSTEOARTHRITIS

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