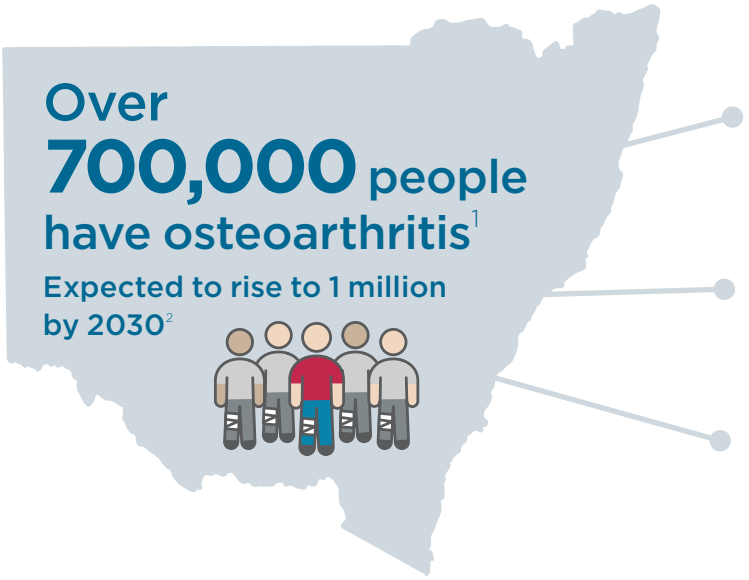
NSW Health

Leading Better Value Care

Osteoarthritis Chronic Care Program

Clinical priorities

Osteoarthritis (OA) is a degenerative joint disease that commonly affects the knees and hips. It is a leading cause of chronic pain, disability, early retirement and lost productivity.



Over 700,000 people have osteoarthritis[1]

Expected to rise to 1 million by 2030[2]

7 out of 10

people on the surgery waitlist do not access conservative care[3]

Over 50%

increase in joint surgery (2005 to 2015)[4]

$3.75 billion

annual cost to the Australian health system[5]

This clinical overview summarises four key areas that ensure effective management of hip and knee OA. It is based on the *NSW Model of Care for Osteoarthritis Chronic Care Program.*[6]

WHOLE-OF-PERSON ASSESSMENT

A dedicated coordinator provides care coordination, case management and comprehensive assessments.

REGULAR REVIEW

Reviews are used to assess progress, provide ongoing self-management support and review treatment plans.

COORDINATION OF CONSERVATIVE CARE

The program team offers conservative care as the first line of treatment for those with osteoarthritis of the hip or knee.

SHARED DECISION-MAKING ABOUT SURGERY

Patients should partner in all planning and decisions about surgery.

CLINICAL OUTCOMES[3]

- ✓ Improved pain and comorbidity management
- ✓ Better function, mobility and quality of life
- ✓ Improved readiness for surgery
- ✓ More appropriate surgical waitlists

NSW GOVERNMENT

AGENCY FOR CLINICAL INNOVATION

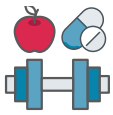
The Osteoarthritis Chronic Care Program (OACCP) is a comprehensive, multidisciplinary conservative management program for people in NSW with OA of the hip and/or knee. The objective is to reduce pain, and improve function and quality of life. Leading Better Value Care in OACCP focuses on people with OA who have elected for conservative management or elective joint replacement surgery. Refer to OACCP site manual for a implementation guide against the model of care, including key features and supplementary tools and resources.

Whole-of-person assessment

The OACCP coordinator is central to the model of care. Their role is to conduct a whole-of-person assessment and to provide overall care coordination.

The assessment will take into account factors that impact the person's quality of life, participation in usual activities and ability to self-manage. This includes:

- clinical assessment including symptoms and pain
- assessment of comorbidities, social and psychological aspects of health
- medication, including use of analgesia and identification of polypharmacy
- physical assessment of function.



Coordination of conservative care

Conservative, non-surgical care should be offered as the first line of treatment for people with OA. The program coordinator is responsible for organising access to multidisciplinary conservative care interventions, including:

- health education and self-management strategies
- general and specific exercise (land or water-based, aerobic and strength training)
- weight management support, particularly for those who are overweight and obese
- pharmacological pain management using simple analgesics and topical or oral non-steroidal anti-inflammatory drugs (NSAIDs)
- use of mobility aids and devices to improve function and activities of daily living
- coordination of comorbidity management.

These interventions support individuals to manage symptoms, promote self-management and optimise health for surgery.

Regular review

Regular reviews should be scheduled at 3, 6, 9 and 12 months to monitor the person's progress, make adjustments to treatment based on any changing needs and promote ongoing self-management.

This includes review of:

- symptoms, function and progression of self-management goals
- psychosocial, comorbidity and other health needs
- reassessment of patient reported and clinical measures
- the response to conservative care interventions (assessing the clinical need to delay or escalate to surgery)
- the personalised management plan, which is adjusted as required at every 3/12 review.

Shared decision-making about surgery

Patients should partner in all planning and decisions about surgery during the program ensuring appropriate and timely access to surgery.

- Ensure the patient is aware of the treatment options and realistic outcomes.
- Support patients pre and post-surgery by:
  - providing education about the surgical and post-operative process, including the risks of surgery and anaesthesia
  - helping them manage their comorbidities
  - ensuring home modifications are in place prior to surgery (as required).
- Escalate to surgery when a patient is not responding to conservative management, or if his/her condition is deteriorating.
- Transition to primary care those patients who choose to delay surgery or remove themselves from the waitlist, ensuring ongoing management of their condition.

Evidence

1. Deloitte Access Economics, Osteoarthritis Chronic Care Program Evaluation. Chatswood; Agency for Clinical Innovation: Sydney
2. Australian Institute of Health and Welfare. Arthritis Snapshot [Internet]. July 2018 [cited March 2019]. Available from: *https://www.aihw.gov.au/reports/arthritis-musculoskeletal-conditions/arthritis-snapshot/data*
3. Schofield D, Shrestha R, Cunich M. Counting the cost part 2 economic costs; the current and future burden of arthritis. In: Counting the cost. 2016, Arthritis Australia.
4. Arthritis Australia. Time to Move: Osteoarthritis: A National Strategy to Reduce a Costly Burden. 2014.
5. Australian Institute of Health and Welfare. Osteoarthritis Snapshot [Internet]. 2018 01/08/2018]; Available from: *https://www.aihw.gov.au/reports/chronic-musculoskeletal-conditions/osteoarthritis/contents/impact-of-osteoarthritis*

NSW Agency of Clinical Innovation. *Model of Care Osteoarthritis Chronic Care Program*. 2nd ed. Chatswood, ACI: 2017.

ACI_0218 (02/20; ACI/D19/3874)