NSW Health

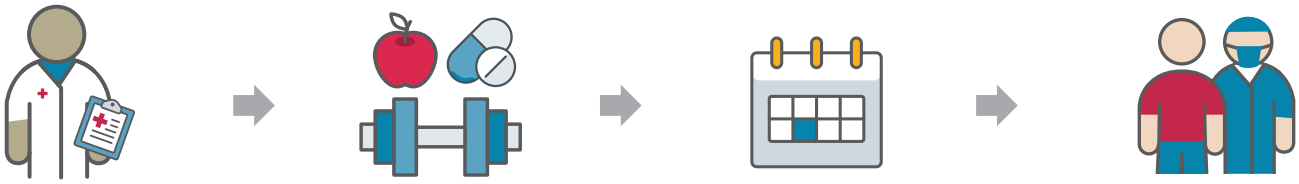
Leading Better Value Care

Osteoarthritis Chronic Care Program

Organisational models

This document provides decision-makers with options to improve care in different service delivery settings. Building on *Osteoarthritis Chronic Care Program (OACCP): Clinical priorities (2020)* which describes *what* to improve, the focus here is on *how* to improve care. These documents are informed by research evidence about best clinical care, frameworks around chronic care delivery, empirical evidence from the OACCP pilot study, current service delivery levels, and experiential evidence from clinicians and patients.

IMPROVING KEY PRIORITY AREAS



Whole-of-person assessment

- Define eligible patients, including those on the surgical waitlist and specialist or GP referrals
- Provide comprehensive patient assessment including validated tools and function tests
- Proactively identify risk factors and potential complications from surgery

Coordination of conservative care

- Arrange access to multidisciplinary care
- Offer conservative interventions through consultations, clinics, groups or classes
- Deliver effective multidisciplinary team communication
- Establish referral pathways spanning primary and community care

Regular review

- Proactively set review appointments for 3, 6, 9 and 12 months following initial assessment
- Assess symptoms and quality of life at each review; consider escalation or delay
- Reinforce behaviour change
- Use telehealth where suitable

Shared decision-making about surgery

- Take a shared decision-making approach when discussing treatment options
- Develop local pathways for surgical escalation and support patients who are removed from the surgical waitlist
- Discharge patients post-program and post-surgery, transfer care to GPs for those who have completed the program and/or have had surgery

IMPROVING THE OVERALL PATIENT JOURNEY

- Partner with members of the healthcare team to ensure the patient's care is shared (e.g. primary care, hospital and community services, Aboriginal health services and consumer organisations)
- Have dedicated members of the multidisciplinary team deliver OA-specific and streamlined care
- Support self-management through education, behaviour change approaches and shared decision-making
- Build efficiencies with administrative support, electronic reminders and streamlined processes
- Use outreach services and telehealth capacity to improve patient access to services
- Measure and act upon patient reported experience and outcome measures (PROMIS-29 and KOOS/HOOS or OHS/OKS)

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OPTIONS FOR ORGANISATIONAL CONFIGURATIONS

There are core elements for implementing the Osteoarthritis Chronic Care Program. However, the methods for implementing these elements may vary due to local decision-making about goals and priorities, and available resources. There are two main organisational configuations. The main point of difference is access to an internal multidisciplinary team.

Regardless of which option is selected, there are common elements of care:

- Whole-of-person assessment for all program participants
- Coordination of access to multidisciplinary services
- Development of a conservative (non-surgical) personalised management plan
- Provision of osteoarthritis education and ongoing support to self-manage condition
- Program participants are optimised for surgery and are placed at the centre of all surgical decision making

Option 1: Coordinated multidisciplinary model

This multidisciplinary model is centred around a coordinator and an 'in-house' multidisciplinary team. The coordinator conducts whole-of-person assessment and arranges access to interdisciplinary and specialised care.

This model is well suited to services with ready access to multidisciplinary care and facilities to support shared care.

Why choose this model?

- provides care in a central location (a one-stop-shop)
- ensures specialised care is available
- maximises the benefits of interdisciplinary care
- supports collaborative multidisciplinary care

If you choose this, then...

- prioritise recruitment of a coordinator
- tailor team configurations
- ensure sufficient clinic time and space is available for multidisciplinary assessment
- establish communication processes within the team with case conferences and documentation

Option 2: Coordinator model

A coordinator independently assesses each patient and coordinates access to multidisciplinary services outside the OACCP team.

This model utilises existing resources in the local health district and primary health setting. It is well suited to services in rural settings or where there is limited access to multidisciplinary care.

Why choose this model?

- access to a multidisciplinary on-site team is limited or not available
- limited availability of physical clinical space
- provides patients access to services close to home, despite living in rural areas services close to home
- simple to set up

If you choose this, then...

- recruit and appoint a coordinator
- plan and set up referral pathways to multidisciplinary and community services
- establish strong relationships with the primary health network and GPs
- set up processes for effective communication using standardised documentation
- maximise the use of digital platforms such as telehealth and applications

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