



Victorian Model of Care for Osteoarthritis of the Hip and Knee

VICTORIAN MUSCULOSKELETAL
CLINICAL LEADERSHIP GROUP

February 2018

Publication details

The project to develop the Victorian Model of Care for Osteoarthritis of the Hip and Knee was supported by the Victorian Government, co-funded by St. Vincent's Hospital Melbourne and auspiced by the Victorian Musculoskeletal Clinical Leadership Group. The document is published by MOVE muscle, bone & joint health, with support from the Medibank Better Health Foundation.



ISBN: 978-0-9925452-5-3

Suggested citation:

Victorian Musculoskeletal Clinical Leadership Group (2018): Victorian Model of Care for Osteoarthritis of the Hip and Knee. Melbourne: MOVE muscle, bone & joint health.

Executive Summary

Background to the Model of Care

Osteoarthritis (OA) places a major burden on Victorians who live with the condition and their communities. Often health services for people who live with OA are not consistently aligned to their needs or with best evidence for effective care. As a strategy to address the burden of disease of OA in Victoria and optimally align health services to consumers' needs and evidence, the Department of Health and Human Services commissioned the development of a Model of Care (MoC). A MoC is an evidence- and consultation-informed framework that describes what and how health services and other resources should be delivered locally to people who live with specific health conditions.

The MoC was informed by an External Expert Advisory Committee and aligns with MoCs in other Australian jurisdictions, Victorian health policy, and current care standards and guidelines for OA care. The MoC focuses on diagnosed hip and knee OA only, and considers the continuum from diagnosed early OA management to advanced OA management, which for some people may include surgery. The MoC does not consider prevention of OA or OA at sites other than the hip and knee.

The MoC is intended as a best-practice guide and resource for individuals or organisations tasked with the planning or delivery of care to Victorians with hip and/or knee OA. It is relevant to policy makers, health administrators, health funders, service delivery organisations, clinicians, consumers and carers across all care settings (public, private and compensable systems). It is recommended that the MoC be considered along with emerging state and federal health policies, funding agreements and service contracts.

Diagnosis and assessment

OA can be diagnosed clinically by a qualified health professional without the need for imaging. In particular, magnetic resonance imaging (MRI) is not required unless a specific differential diagnosis is needed for an atypical presentation. Assessment in people with OA should be holistic, considering social factors and social supports; beliefs, concerns and knowledge about pain and OA; the occupational impact of OA; mood; sleep; pain features; attitudes to exercise; and comorbidities. The MoC recommends specific patient-reported and physical assessments be undertaken in people with hip or knee OA.

Components of care

All people with hip or knee OA should be provided with appropriate non-pharmacological and non-surgical care. This includes education about pain, their condition and effective strategies for self-care; support for physical activity and exercise; weight loss (where indicated); and strategies for effective management of persistent pain that are underpinned by a contemporary understanding of pain science. Pharmacological care is an important adjunct for some people with OA and may include simple analgesics, non-steroidal anti-inflammatory agents, intra-articular agents, and for a minority, a short-term trial of opioids with a discontinuation plan in place. It is imperative that pharmacological therapy is integrated with non-pharmacological management options to ensure that pain and function are addressed holistically, based on contemporary pain science. For a sub-group of people with advanced disease, total joint replacement (TJR) may be indicated. Importantly, TJR surgery should be reserved for people who have exhausted all other non-surgical care options and where there is good probability

of successful surgical and patient satisfaction outcomes. Health services should endeavour to provide surgery, to those who need it, within a time frame consistent with current Victorian policy on urgency categorisation, informed by clinical assessment, pain and disability. That is, patients classified as Category 1 receive surgery with 30 days, Category 2 within 90 days and Category 3 within 365 days. For most patients who are appropriately selected for TJR surgery, a Category 2 classification would be expected. Patients who have been assessed and deemed to not require TJR surgery should not be placed on a surgical waitlist. The [Western Australian Model of Care for Elective Joint Replacement Surgery](#) provides a comprehensive framework concerning peri-operative care, peri-operative processes of care and post-operative care that could be adapted to Victoria.

Inappropriate care

Arthroscopic debridement and/or lavage for knee OA are not recommended as a primary treatment.

Delivery of care

The MoC supports access to effective OA care through:

- community health education
- delivery of accurate pain and OA care information in multiple formats and culturally-sensitive modes
- promoting availability of local services to support effective self-care.

Innovative models of service delivery are necessary to more effectively meet consumers' needs, ensure evidence-based care is delivered more systematically, and to ensure health services meet the projected increase service requirements in coming decades. Such models should include:

- Funding mechanisms that support components of care for OA that are known to be effective and move towards supporting care packages, rather than care episodes.
- Improved access to allied health providers and strategies that support effective self-care (e.g. exercise facilities).
- Models that support effective use of the workforce through widespread implementation of advanced practice roles for allied health and nursing staff.
- Building workforce capacity in best-practice OA and pain care, particularly among primary care providers, through a range of flexible professional development options.
- Supporting care delivery in local settings, rather than tertiary hospital settings. This might include establishment of community-based musculoskeletal clinical centres for people with advanced OA or complex presentations; establishment of community-based, multidisciplinary OA programs; and multidisciplinary outreach services for rural areas.
- Establishment of systems to manage and triage orthopaedic surgery referrals to public hospitals to facilitate provision of surgery, to those who need it, within a time frame consistent with current Victorian policy.

Information and communication technologies (ICT) are also an important enabler to delivery of care. ICT strategies that could be supported, implemented and disseminated at scale to improve access to effective OA care include:

- Telehealth/telecare services to improve access to specialist and allied health clinics in public and private settings.
- Web platforms that provide accurate, contemporary information to support effective care and education for consumers and clinicians.

Implementation of the Model of Care

Improving the delivery of care for OA in Victoria by actualising the MoC is the responsibility of the whole health sector, with consumers, clinicians, peak bodies and service providers, as well as the system managers, being major actors in achieving positive change.

Suggested system level approaches to improve care delivery and strategies to achieve such improvements, are presented across four key domains, and outlined in Section 2; Table 2.

1. Building people's capacity to more effectively participate in care
2. Models of Health Service Delivery
3. Information and communication technologies
4. Health policy and planning.

Importantly, while these suggestions are targeted at the whole health sector, clinicians and peak bodies are well placed to champion improvements and drive best practice. It is urged that partners from across the sector support the dissemination and implementation of this MoC across Victoria.

Priority areas for action have been identified to inform future planning, and include a number of focused initiatives under each of the following categories:

1. Information delivery
2. Service delivery for OA care
3. Funding models
4. Workforce capacity building in OA care
5. Information and communication technologies
6. Health policy and governance
7. Research and evaluation.