AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

Clinical Care Standards

April 2017

Consultation Report

Draft Osteoarthritis of the Knee Clinical Care Standard

Published by the Australian Commission on Safety and Quality in Health Care
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ISBN: 978-1-925224-38-2

The Commission's preference is that you attribute this publication (and any material sourced from it) using the following citation:

> Australian Commission on Safety and Quality in Health Care. Consultation Report: Draft Osteoarthritis of the Knee Clinical Care Standard. Sydney: ACSQHC; 2017

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Introduction

The Australian Commission on Safety and Quality in Health Care (the Commission) was created by Health Ministers in 2006 to lead and coordinate health care safety and quality improvements in Australia. *The National Health Reform Act 2011* established the Commission as an independent statutory authority. It specifies that the Commission will formulate and monitor safety and quality standards and work with clinicians to identify best practice clinical care.

The *National Health Reform Agreement 2011* identifies that the Commission will work with clinicians to develop clinical standards for ensuring the appropriateness of care for people with specific clinical conditions, and that the Commission will recommend to Health Ministers the clinical standards suitable for implementation as national clinical standards.

The Commission has been working with consumers, clinicians, health managers and researchers to develop the Osteoarthritis of the Knee Clinical Care Standard.

This report provides a summary of consultation findings regarding the draft Osteoarthritis of the Knee Clinical Care Standard.

Note that the terms ‘osteoarthritis of the knee’ and ‘knee osteoarthritis’ are interchangeable. The term ‘knee osteoarthritis’ is used in the quality statements and has frequently been used in this report for brevity and readability.

About the consultation

The public consultation period ran from 7 July 2016 to 31 July 2016, with a number of extensions granted through to 18 August 2016. A total of 57 responses were received by the Commission.

Consultation documents for this clinical care standard are described below:

Draft Osteoarthritis of the Knee Clinical Care Standard – This document outlines key components of care that a person aged 45 years and over should receive when they have knee pain and are suspected of having knee osteoarthritis. It covers care from initial clinical assessment through to ongoing review and management over the course of the condition. This clinical care standard applies to all healthcare settings where care is provided to patients with knee osteoarthritis, including primary care, specialised care, hospitals and community care settings.

Draft consumer and clinician fact sheets – These documents provide a summary of the quality statements for consumers and clinicians.

Draft indicator specification – This document outlines a set of suggested indicators that have been developed to assist with local implementation of this clinical care standard. These indicators can be used by health services to monitor the implementation of the quality statements and support improvement as needed.

Summary of evidence sources – This document contains the evidence sources used to support the clinical care standard, according to each quality statement.

The purpose of the consultation was to determine if the draft clinical care standard is appropriately targeted to make the most difference to routine patient care and outcomes, to assess the relevance of suggested indicators and fact sheets, and to identify strategies that could support the sharing and local implementation of the clinical care standard.

Stakeholders across Australia were contacted by post and asked to submit feedback on the draft clinical care standard and Indicator Specification using an online survey tool available on the Commission's website. The Commission also accepted feedback in writing via mail or email.

Those contacted included medical colleges, organisations with a specific interest in the management of osteoarthritis, state health departments, Local Hospital Networks, Primary Health Networks, consumer groups and private sector organisations. The Commission also promoted the consultation on its website, Twitter account, *On the Radar* weekly publication and email bulletin. Members of the Osteoarthritis Clinical Care Standard Topic Working Group (TWG) publicised the consultation among their networks.

The following sections of the report provide a summary of the consultation process and responses.

Consultation process

Consultation questions

The Commission asked stakeholders to respond to the following six consultation questions:

1. Which two or three quality statements would make the most difference to routine care and outcomes for patients if implemented nationally? Why?

2. Which two or three quality statements would make the least difference to routine care and outcomes for patients if implemented nationally? Why?

3. Is there a component of patient care for this condition that is not covered by the quality statements and should be included? What evidence is there to support your response?

4. In consultation with key experts, a set of draft indicators has been prepared. Are you aware of any existing alternatives to any of the indicators that would have advantages over the drafted material?

    a. If yes, describe the alternative indicator and its evidence source (e.g. name of registry, citation of research paper/reference).

    b. Describe its advantages over the drafted material.

    c. Specify the indicator it would replace.

5. How should the clinical care standard be shared?

6. What current or planned activities are you aware of that may provide opportunities for the implementation of this clinical care standard?

For Question 5, respondents were provided with a list of options to rank in order of importance from one (most important) to eight (least important). Respondents could also provide additional ideas for dissemination of the resources.

Submissions received

A total of 57 responses were received by the Commission during the consultation period. There were 28 by online survey and 29 by email, letter or at meetings.

A breakdown of the responses is provided below:

Respondent type	Number of responses
Individual	27
Organisations:	30
- Health professional education providers (including Colleges)	9
- Jurisdiction[a] (state or territory response)	3
- Local Hospital Network[b]	8
- Private Hospitals	2
Other organisation:	
- Commonwealth agency	2
- Primary care network	1
- Other	4
Committee	1
Total responses	57

[a] State and territory health departments and/or agencies
[b] Including public hospitals and other public health services

Assessment of submissions

Following the close of consultation, the Commission logged and summarised all responses, noting submission method (online survey or written).

Comments via online survey were analysed by consultation question and by quality statement. For written submissions, comments were classified according to subject matter; this included feedback on the scope or context of the clinical care standard; individual quality statements; language; consumer information; and general comments.

Action categories were determined for each comment:

1. No change
2. Change by the Commission (editorial suggestions)
3. For consideration by the Topic Working Group (substantive comments about content).

Themes in each action category mainly related to:

1. No change: Suggestions that were not relevant to the Osteoarthritis of the Knee Clinical Care Standard or did not align with previous discussions of the Topic Working Group.
2. Change by the Commission: Clarity of language, terminology, emphasis on the multidisciplinary nature of management of osteoarthritis of the knee, alignment of indicators to quality statements, and supporting evidence.
3. For consideration by the Topic Working Group: Scope of the Osteoarthritis of the Knee Clinical Care Standard and the focus of each quality statement; additional information regarding assessment tools and options for the management of osteoarthritis; imaging in the assessment of osteoarthritis; medications for treatment of osteoarthritis; and use of arthroscopy.

Factors considered in the qualitative analysis included whether the comment was:

- Within the scope of the CCS
- Supported by evidence
- Raised an important point
- Previously considered by the Topic Working Group.

Following the assessment, the information was provided to the Osteoarthritis of the Knee Clinical Care Standard Topic Working Group for further refinement of the clinical care standard.

Consultation feedback

Overall, there was strong support for the development of a clinical care standard for Osteoarthritis of the Knee due to concerns about the current care of patients and the growing burden on the health system relating to this condition. Many respondents noted the role of the proposed standard to address unwarranted clinical variation; to provide a clear pathway of quality care for patients; and to emphasise the importance of non-pharmacological and non-surgical interventions for initial management of the condition.

The clinical care standard appears to address the main elements of care effectively, with strong support for Quality Statements 1, 3 and 4 as potentially making the most difference to routine care and patient outcomes. Fewer respondents nominated quality statements that would make the least difference to care; however, the most frequently chosen statements were Quality Statements 5, 6 and 7. Of the respondents who chose these, most indicated that because the clinical care standard emphasises conservative management of osteoarthritis of the knee, Quality Statements 5, 6 and 7 should make less difference to care.

Below is a summary of the responses received. It is not exhaustive.

Structure and language

Feedback was generally positive about the presentation, layout and structure of the information. Overall, the clinical care standard was commended as being clear and well written. However, there was mixed opinion about the level of detail in the clinical care standard, with comments ranging from ‘clear and concise’ through to ‘waffly’.

The main concerns about language were around some potentially unclear terminology in parts, such as the way to define certain clinicians and the precise definition of words or phrases such as ‘regular’, ‘standard’ and ‘fitness for surgery’.

Feedback on the consumer fact sheet was positive, suggesting the level of detail and the language is appropriate for a consumer audience.

Scope and context

Some suggestions were received to expand the scope of the standard by not including a specified age of the patient (45 years and over) and by including information on rehabilitation following surgery for osteoarthritis. Feedback also highlighted the need to ensure the information regarding the scope of the standard was consistent with the information in the Indicator Specification document.

Quality statements

Draft Quality Statement 1: Comprehensive assessment

A patient with knee pain and other symptoms suggestive of osteoarthritis receives a comprehensive assessment that includes a detailed history of the presenting signs and symptoms and other health conditions, a physical examination, and a psychosocial evaluation that identifies factors that may affect their quality of life and participation in usual activities.

Feedback was generally positive. The majority of comments focused on the importance of a comprehensive assessment to not only achieve an accurate and timely diagnosis of knee osteoarthritis, but also to provide a strong basis for its management by optimising clinician understanding of patient needs and psychosocial factors that may affect their care.

Some comments suggested that examples of validated tools for functional assessment be included in the text to assist clinicians in providing a full assessment.

Concern was raised that typical consultation times did not provide sufficient time for GPs to undertake a comprehensive assessment. In addition, comments noted that a comprehensive assessment was multidisciplinary, and that Quality Statement 1 should emphasise that in undertaking a comprehensive assessment, clinicians would be assisted by a team of other health professionals.

Draft Quality Statement 2: Diagnosis

A patient presenting with knee pain and other symptoms suggestive of osteoarthritis is diagnosed as having knee osteoarthritis based upon clinical assessment alone. The use of plain X-rays or magnetic resonance imaging (MRI) is considered only if the diagnosis is uncertain or to inform management.

The quality statement was generally supported, with a number of comments highlighting the need to reduce the number of unnecessary investigations, and their associated costs, in diagnosing osteoarthritis of the knee. Comments also suggested that the quality statement would support improved quality and accuracy in clinical assessment.

Comments received also expressed a range of views on the appropriate role of imaging in the diagnosis of knee osteoarthritis. A number of responses suggested that greater clarity was needed on the circumstances where use of X-ray or MRI would be appropriate. It was suggested that X-ray played an important role in confirming alternate diagnoses in circumstances where there was clinical suspicion that a patient may have a different pathology.

Including diagnostic criteria or a diagnostic tool for clinicians to use was also suggested.

Draft Quality Statement 3: Education and self-management

A patient with knee osteoarthritis receives education about the condition and treatments for it, and participates in the development of an individualised self-management plan.

There was strong support for the quality statement in feedback, with a number of respondents suggesting that the quality statement would support patients taking an active role in their care and encourage communication and engagement. It was suggested that improved education and self-management could reduce reliance on medicines and delay the need for surgery for a number of patients. There was a belief among some respondents that effective education and self-management could support patients in managing their condition and enable them to participate in their usual activities of life.

It was suggested that there should be a greater emphasis on the multidisciplinary approach to care planning, and that self-management plans should set specific goals so the patient and clinician can monitor progress. An increased focus on addressing psychosocial health needs was also identified as part of the development of a patient's self-management plan.

Regarding the role of health services in education and self-management, it was suggested that there was a need for health services to provide the supports for clinical teams to work across a number of sites.

Draft Quality Statement 4: Weight loss, exercise and joint protection

A patient with knee osteoarthritis receives advice and support on weight loss, exercise and joint protection, throughout the course of their care.

There was agreement that weight loss and exercise were particularly effective strategies for reducing pain, increasing mobility and improving the quality of life for patients with osteoarthritis of the knee. It was also identified as an area where there was a known gap in care.
In particular, respondents highlighted the link between weight loss and a range of positive outcomes for patients, including:

- Managing the cause of osteoarthritis in many people
- Symptom control: reducing pain, increasing mobility and improving quality of life
- Slowing disease progression, and delaying or avoiding the need for surgery
- Better post-operative success.

Feedback also noted the need for patients to get adequate education and support, and to set goals in order to maximise their results. A number of respondents highlighted both the importance of ensuring that any weight loss and/or exercise program was tailored to the needs of individual patients, and that the role of multidisciplinary care should be emphasised in conservative management, including allied health such as a physiotherapist, a dietitian and, in certain cases, a podiatrist.

Draft Quality Statement 5: Medicines used to manage symptoms

A patient with knee osteoarthritis is offered medicines to manage their symptoms according to the current version of *Therapeutic Guidelines: Rheumatology* (or local concordant guidelines). This includes consideration of the patient's clinical condition and their preferences.

Feedback regarding the use of medicines was divided. A number of respondents commented that medicines were over-prescribed or prescribed inappropriately. Of particular concern was the overuse of opioids and their related risks. However, respondents also noted the important role of safe medicine use in managing pain and improving a patient's quality of life and ability to exercise.

A few respondents raised concerns that medicine use was less effective for managing osteoarthritis of the knee than weight loss, exercise or surgery. Respondents also queried the use of paracetamol as a first-line treatment to manage osteoarthritis. Several respondents suggested that greater clarity of the role of non-steroidal anti-inflammatory drugs (NSAIDs) for managing osteoarthritis was required, given the most recent evidence on their potential adverse effects and interaction with antihypertensive medications.

Draft Quality Statement 6: Appropriate review and referral

A patient with knee osteoarthritis receives a planned clinical review at an interval mutually agreed by the patient and their clinician. If the patient is not progressing to their satisfaction, they are referred, in a timely manner, for specialist care.

Respondents acknowledged regular clinical review and referral as important components of the management of knee osteoarthritis. Clinical review was seen by a number of respondents as an important opportunity to measure change in the patient and their disease, and to escalate care appropriately. Several respondents noted that often patients were referred for surgery without exploring medical or other non-surgical (conservative) strategies for managing their osteoarthritis.

Some respondents suggested that the quality statement could be better focused on particular types of review and referral (for example, GP referral to physiotherapists or the need for an adequate trial of non-surgical management before surgical referral). Concern was raised with the phrase 'not progressing to their satisfaction', as it was felt that this could encourage patients to be referred to specialist care and surgery before an adequate period of using non-surgical options.

Other feedback was that:

- A physiotherapist or other clinician might be the first point of contact for a patient with osteoarthritis of the knee, rather than a GP
- The decision to refer to surgeons usually occurred when a patient's symptoms were unmanageable, not at a fixed review.

Draft Quality Statement 7: Surgical management

A patient with knee osteoarthritis who is not responding to non-surgical management is offered timely joint conserving or joint replacement surgery, depending on their fitness for surgery and preferences. The patient receives information about the procedure to inform their treatment decision. Arthroscopic procedures are not effective treatments for osteoarthritis of the knee, and therefore should not be offered in uncomplicated osteoarthritis.

Respondents put forward a range of views concerning surgical management of osteoarthritis of the knee. Several responses highlighted the importance of ensuring patients received timely access to joint replacement surgery to improve patient outcomes. Other respondents emphasised the need to reinforce that non-surgical treatments should be tried before joint replacement for osteoarthritis of the knee be considered, and that surgical treatment (joint replacement) should be seen as a 'last resort'.

A number of respondents agreed that there was no role for arthroscopic procedures in the treatment of osteoarthritis of the knee, and that communicating this position to clinicians and patients was important. Other respondents suggested the role of arthroscopic procedures be clarified, noting that the term 'uncomplicated osteoarthritis' was not well defined, and suggesting that the indications for the use of arthroscopy in the presence of osteoarthritis also be described within the quality statement.

A small number of responses suggested greater clarity was needed in the definition of some terms, such as 'fitness for surgery', the role of surgeons and what 'timely' surgery meant.

Feedback on Indicators

The Commission received 29 comments on the indicators from a number of organisations and individuals. Respondents were asked to comment on the following question:

- In consultation with key experts, a set of draft indicators has been prepared. Are you aware of any existing alternatives to any of the indicators that would have advantages over the drafted material?

    a. If yes, describe the alternative indicator and its evidence source (e.g. name of registry, citation of research paper/reference).

    b. Describe its advantages over the drafted material.

    c. Specify the indicator it would replace.

Feedback on the indicator specification was generally supportive, with the majority of respondents suggesting no indicator changes. It was also found that a significant proportion of the feedback provided on the indicators was more relevant to the content of the associated quality statement.

The main feedback on indicators is below:

Indicator 6b: Proportion of patients with knee osteoarthritis with evidence of pain and function assessment within the previous 12 months

Indicator 6c: Proportion of patients with knee osteoarthritis who have documented pain level reduction by 20%, 12 months after initiation/change of pharmacological/non-pharmacological treatment

Indicator 6d: Proportion of patients with knee osteoarthritis with a functional limitation who have a 10% improvement in function 12 months after initiation/change of pharmacological/non-pharmacological treatment

A few respondents indicated that it might be difficult to consistently measure the degree of improvement in patient-reported symptoms. It was suggested that validated assessment tools be specified to support system-wide comparison. One respondent noted that the indicators were not designed to measure whether patients were being referred for specialist care in a timely manner.

Indicator 7a: Number of patients undergoing arthroscopic procedures for uncomplicated knee osteoarthritis

Respondents queried the specification of a 50-year and older population group for this indicator, noting that this was inconsistent with the scope of the draft clinical care standard. Other respondents raised concerns that limiting the scope of the indicator to a particular age group was not supported by evidence. Respondents also raised the appropriateness of including all the Medicare Benefits Schedule (MBS) codes listed in the indicator.

Indicator 7b: Proportion of patients with knee osteoarthritis referred for consideration of surgery who were supported with non-surgical core treatments for at least 3 months

Public consultation feedback suggested that this indicator could detract from clinician autonomy, and did not address the needs of individual patients. It was noted that in some circumstances, appropriate clinical management might include the referral of a patient for consideration of surgery within three months of providing them support with non-surgical treatment.

Other indicator feedback

Other feedback about the indicators related to the difficulty of implementing indicators and the complexity of data collection, particularly in the allied health and primary care sectors and within small practices. Other feedback suggested that the indicator specification focus more on patient tracking and outcome measurement.

Improvements to support data collection

One respondent suggested that the Commission could support improved data collection by developing a complete list of data items that would be required for reporting against the indicators.

Feedback on sharing the clinical care standard

Respondents were asked how the clinical care standard should be disseminated. A number of options were provided for respondents to rank in order of usefulness. Respondents were also able to provide their own ideas.

Familiar electronic strategies, such as sharing electronic documents via web page links and email, were the most popular methods for disseminating the clinical care standard. Feedback also highlighted the need to share clinical care standard resources in hard copy printed form.

The options given the least emphasis by respondents were sharing the clinical care standard via social media, printed posters, and at workshops and conferences.

Additional strategies put forward by respondents for publicising the clinical care standard included linking with:

- Education and training programs run by professional associations and colleges for healthcare professionals
- Member networks within professional associations and colleges
- Integration of the clinical care standard into daily practice workflows, for example, by integration with software applications.

Feedback on opportunities for implementing the clinical care standard

Respondents were asked to provide information about any current or planned activities or initiatives that could support the implementation of the clinical care standard. A number of suggestions were provided, which included opportunities such as:

- The Health Care Homes comprehensive care coordination program
- The Health Pathways web-based information portal for referral pathways
- Conferences and orthopaedic physiotherapy screening clinics.

Barriers and enablers to care identified in the clinical care standard

Based on analysing the feedback across all questions in the survey, the barriers to implementing the care described in the clinical care standard can be summarised as follows:
Systems/operational

- Lack of coordination of the primary care services that may be needed to deliver effective conservative care

- Premature referral of patients for surgery prior to a trial of conservative management beyond the prescription of pain-relieving medication
- Limited availability of surgery time to undertake surgical treatment of osteoarthritis of the knee
- Standardised elective surgery booking practices mean that in most cases patients may wait for surgery for up to one year
- A lack of support within health services for clinical teams to work across service sites.

Staffing

- Limited availability of specialist rheumatologists, orthopaedic surgeons and in some areas, physiotherapists, particularly in rural/regional areas.

Resources/Environment

- Typical GP consultation times are not long enough, and GPs cannot afford to take the time to do comprehensive assessments
- Lack of access to surgery and allied health services, particularly in rural/regional areas
- Care delivery in some health settings is focused on acute care only, rather than treating early stages of the disease
- Measuring subjective patient-reported symptoms and outcomes with consistency may be difficult
- Measuring outcomes in this area is resource intensive, and appropriate data sources may not be available.

Communication

- A lack of coordination and integration between primary and secondary care means that reporting or measuring of outcomes that occur across these two areas of care may not be possible.

Staff education and training

- General practitioners have been deskilled
- There is a lack of training in general practice and primary care on appropriate diagnosis and management of osteoarthritis of the knee, particularly:
    - the importance of weight loss, exercise and appropriate medicine use
    - the role of imaging in diagnosing osteoarthritis of the knee
    - promoting the use of language that is inclusive of the patient
    - the use of treatment alternatives to surgery and pain-relieving medication.

Patient and carer engagement and education

- Lack of education for patients on conservative management, including weight loss and exercise
- Lack of support for patients seeking to achieve weight loss and undertake exercise, particularly for patients with co-morbidities
- Lack of education for the patient on the nature of osteoarthritis and disease progression
- Lack of education about non-surgical and non-medical options for management, which means that often patients diagnosed with osteoarthritis of the knee have an expectation of treatment that involves medication and surgery
- Lack of patient information about which type of clinicians may be involved in their care
- Lack of engagement with patients and carers, which increases the risk of reduced patient compliance

- Lack of opportunity for patients to express their perspectives on treatment goals and how these will be achieved.

Identified enablers to implementing care can be summarised as follows:

Protocols and policies:

- Applying a model of care that provides intensive physiotherapy; support with pre-operative weight loss, exercise and analgesia; and engagement with patients on exercises to preserve and/or improve function before surgery
- Improving the management of surgical waiting lists to enable the treatment of patients within clinically appropriate timeframes
- Greater client focus in policies and activities within health services, such as patient education, promotion of health literacy, and tailored information for patients.
- Increasing the role for allied health in the pre-surgical management of osteoarthritis.

Resources/Environment

- Incorporation of decision-making aids
- Use of diagnostic tools
- Development of a data dictionary to support the collection of indicator data.

Transition of care and general practitioner involvement

- Increasing the early use of conservative management
- Increasing early referral to allied health, where appropriate, to better support conservative management
- Improved referral between general practice and allied health.

Staff education and training

- Improving knowledge in general practice of non-surgical management of osteoarthritis of the knee.

Engagement and education of patients, carers and families

- Better engagement with patients and shared decision making
- Improving engagement with, and encouragement of, patients who are undertaking weight loss and exercise
- Increased use of goal setting within self-management plans.

Audits

- Collecting data on inappropriate referrals and arthroscopic procedures locally as part of a quality improvement strategy.

Next steps

Feedback from the consultation process was collated and analysed, and a summary of key findings was presented to the Osteoarthritis of the Knee Clinical Care Standard Topic Working Group. Following this, the clinical care standard was revised and finalised for submission to the Commission's various committees.

The endorsement process for clinical care standards involves passage through the Commission's governance committees, and then endorsement from the Australian Health Ministers' Advisory Council, a national committee that is instrumental in leading the coordination of health services across Australia.

It is envisaged that the Commission will provide high-level implementation support for this clinical care standard, with activities and resources to be identified and organised in the coming months. This clinical care standard will be launched in May 2017.

Further information about the Osteoarthritis of the Knee Clinical Care Standard can be found at www.safetyandquality.gov.au/ccs.

If you would like to be kept informed about the work of the Commission, sign up to the Commission's newsletter online, or follow the Commission on Twitter @ACSQHC.