National Osteoarthritis Strategy

DRAFT for Consultation – Online survey responses submitted by DAA, October 2018

1. Which state or territory are you in?

National – a member association that represents Accredited Practising Dietitians (APDs) nationally.

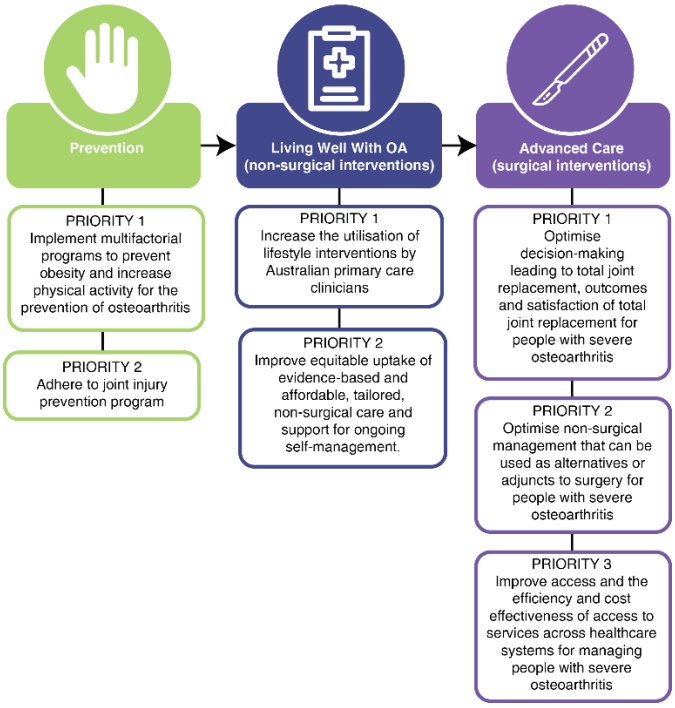
2. Are you completing this survey as a: Consumer, carer, health practitioner, researcher, other

Other: Member Association

3. Are you completing this survey: as an individual, on behalf of an organisation

On behalf of an organisation: the Dietitians Association of Australia (DAA)

Priority areas in the draft national osteoarthritis strategy:



4. Please rank the following areas identified in the draft strategy in order from 1 (the most important) to and 7 (the least important). You can only match one row to one column:
    1. **Implement multifaceted programs to prevent obesity and increase physical activity for the prevention of osteoarthritis**

1 (Rationale: prevention is of key importance to reduce the burden of osteoarthritis on the health system.

2. **Adhere to joint injury prevention programs**

6 (Rationale: though this is important as a preventative measure, strategies relating to sport injuries are not directly relevant to Accredited Practising Dietitians (APDs).

3. **Support primary care practitioners to deliver best-practice, evidence-based, appropriate care to people with osteoarthritis, including increased prescription of lifestyle interventions**

2 (Rationale: this relates to improving knowledge, skills and the provision of training to practitioners. It also relates to advocacy to increase government funding for OA programs and the MBS. Clients/patients with OA would benefit from this through improved service delivery from APDs).

4. **Improve the uptake of evidence-based and affordable, tailored, non-surgical care and support for ongoing self-management by all Australians with osteoarthritis**

3 (Rationale: this relates to improving self-management of disease, which DAA supports to reduce burden of health system. It also includes providing greater access to EB-lifestyle strategies, supports multi-disciplinary teams and equal access across demographics).

5. **Optimise decision-making processes leading to total joint replacement surgery and maximise outcomes and satisfaction following total joint replacement surgery for people with severe osteoarthritis**

5 (Rationale: decision process is important, but for APDs we want to encourage prevention and non-surgical management in the first instance).

6. **Optimise non-surgical management as an alternative, where indicated, or as an adjunct to total joint replacement for people with severe osteoarthritis**

7 (Rationale: DAA supports the promotion of appropriate non-surgical care for people with osteoarthritis as a precursor to surgery, including funding models (public and private) to support packages of care inclusive of weight loss, exercise, pain management and psychological health interventions, that align with peoples' needs, preferences and places of residence).

7. **Improve access to, the efficiency and cost effectiveness of services across healthcare systems for managing people with severe osteoarthritis**

4 (Rationale: whilst this is important, DAA encourages prevention and non-surgical management in the first instance).

a. **Are there any outstanding priorities not identified in the draft Strategy that you feel should be included? Yes/No**
    i. **If so, please outline outstanding priorities (text box)**

DAA are unsure of the rationale behind ranking the priorities 1-7, given they are not ranked like this in the strategy document. DAA highlight that prevention is of key importance to reduce the burden of disease on the health system, however managing patients/clients with Osteoarthritis (OA) is equally important. DAA have ranked priorities 1-7 as relevant to our members, Accredited Practising Dietitians (APDs) in Australia and around the world. DAA recognise that priorities may differ for other organisations and individuals. For example, DAA acknowledge that adhering to joint injury prevention programs is an important preventative priority, but is not directly relevant to the role of APDs in OA management, therefore we have not prioritised it.

b. **Are there any barriers to implementing the strategies recommended? Yes/ No**
    i. **If so, please specify the relevant priority areas**
        - Prevention Priority 1
        - Prevention Priority 2
        - Living Well with Osteoarthritis Priority 1
        - Living Well with Osteoarthritis Priority 2
        - Advanced Care Priority 1
        - Advanced Care Priority 2
        - Advanced Care Priority 3
    ii. **What are the barriers? (text box)**
    DAA highlight that one barrier to implementing all strategies is a lack of Government recognition & support for the important role that allied health practitioners play in the prevention and management of chronic diseases, including OA.
    iii. **What would you suggest to facilitate the implementation? (text box)**
    Greater lobbying of Government on behalf of allied health professions to achieve better health outcomes for people with Osteoarthritis, this includes supporting new MBS items for allied health (e.g. longer consultations for Accredited Practising Dietitians (APDs) where needed, greater financial reimbursement to APDs to better align with the level of skill, knowledge and care required to achieve agreed outcomes, reimbursement for communication

between practitioners to facilitate inter-disciplinary communication etc.)

8. **Do you have any additional strategies you feel should be included, especially for the area(s) that you have ranked as the most important? Yes/No**

If so, for which priority areas (tick box):

- Prevention Priority 1
- Prevention Priority 2
- Living Well with Osteoarthritis Priority 1
- Living Well with Osteoarthritis Priority 2
- Advanced Care Priority 1
- Advanced Care Priority 2
- Advanced Care Priority 3

What suggestions would you like to make?

DAA supports long-term, comprehensive public health messages and education programs for the management of Osteoarthritis, including to assist in managing risk factors such as obesity [1]. DAA highlight that strategy 4 '*utilise mass media for a better access to knowledge and information*' is a positive strategy that should be implemented across all priorities, not just priority 2 '*adhere to joint injury prevention programs*'.

Reference:

1. Obesity Policy Coalition [internet]. Melbourne, Australia: Obesity Policy Coalition Tipping the Scales: Australian obesity prevention consensus; 2017 [cited 2018 Sept 18]. Available from: http://www.opc.org.au/downloads/tipping-the-scales/tipping-the-scales.pdf.

9. **Do you have any further comments about the draft National Osteoarthritis Strategy? Yes/No**
    a. **Please provide your comments**

- *3.1 - Prevention, Priority 1, Objective a), Strategy 1 (p8).*
  As well as working with national obesity groups, DAA considers it important to work with relevant allied health organisations (e.g. Dietitians Association of Australia (DAA) and Exercise & Sports Science Australia (ESSA)) as part of Strategy 1, to help drive obesity prevention policies & program at all levels of government, community & business, and drive greater access to effective weight loss therapies in community settings. As such, DAA recommends rewording Strategy 1 and the implementation plans that follow to include 'relevant allied health organisations (e.g. DAA & ESSA)'.

- *3.2 – Living well with Osteoarthritis, Priority 1, Strategy 1, implementation plan 7 (p12).* DAA has concerns regarding Implementation plan 7 to '*tailor upskilling strategies to support other potential workforce practitioners such as fitness professionals to provide education, exercise and weight loss support in community settings…'*. DAA highlight that considering scope of practice in relation to level of qualification is important here. DAA supports the training of these workforce practitioners in:
    - (1) providing dietary advice for weight loss support that is limited to Australian Dietary Guideline only; and
    - (2) information on appropriate referral pathways (e.g. how to refer a client needing individualised dietary advice specific to disease states, such as Osteoarthritis (OA), to an Accredited Practising Dietitian (APD)).
- *3.2 – Living well with Osteoarthritis, Priority 2, Objective a), Strategy 1, implementation plan 5 (p13).* DAA recommends, in order to support self-management in primary care, extending this to include '*… and encouraging referrals to self-management group education classes run by arthritis organisations and allied health professionals (e.g. weight loss programs run by Accredited Practising Dietitians)'*.
- *3.2 – Living well with Osteoarthritis, Priority 2, Objective a), Strategy 2, implementation plan 6 (p13).* DAA supports the strategy to '*encourage the Government to expand access to Medicare items for approved allied health practitioners to provide support for osteoarthritis chronic disease management programs beyond the current maximum of five sessions per year per patient'*. The current limit of five services per annum in total for allied health is inadequate to achieve satisfactory health outcomes and follow-up appointments.
- *3.2 – Living well with Osteoarthritis, Priority 2, Objective a), Strategy 3, implementation plan 1 (p13-14).* DAA supports reforms to Medicare and private health insurance schemes to increase the number of services and rebates for people with OA to better support high-value care and improved outcomes. DAA also supports reforms to cover care delivery and interdisciplinary care planning using strategies remotely delivered, such as telehealth for allied health professionals. DAA recommends extending the examples provided in Implementation Plan 1 (iii) to include '*Accredited Practising Dietitians (APDs)'*, in addition to physios, given the integral role that APDs play in providing individualised evidence-based weight loss assistance to people with OA. APD services should be available to all clients/patients with OA, regardless of location.
- *3.2 – Living well with Osteoarthritis, Priority 2, Objective a), Strategy 4, implementation plan 3 (p14).* DAA supports the development and implementation of models of care for OA in Australian States and Territories. It is important that models of care for OA include access to APDs for individualised evidence-based weight loss assistance.
- *3.3- Advanced Care, Priority 1, stage 3 strategy, implementation plan 4 (p16).* DAA supports the inclusion of a directory of existing physical activity, weight-loss, and other specialist services in the decision aid. Given the instrumental role that APDs

play in providing individualised, evidence-based weight management support for clients/patients with OA, it will be important to include APD services as key diet and nutrition advisors in this directory.

- *3.3- Advanced Care, Priority 2, stage 1 strategy, implementation plan 2 (p17).* DAA supports promoting programs tailored for OA management for healthcare practitioners. It is vital that programs for weight management are evidence-based and do not involve additional costs for clients/patient with OA. The 'Healthy Weight for Life' program includes KicStart™ VLCD meal replacements, which may not be suited to (or afforded by) everyone. DAA recommends promoting a range of evidence-based weight loss programs that are suited to and afforded by the majority of OA clients/patients, including individualised dietary support from an APD for those who require it.
- *3.3- Advanced Care, Priority 2, stage 2 strategy, implementation plan 2 & 4 (p18).* DAA strongly supports new MBS items for allied health (e.g. longer consultations for APDs where needed, greater financial reimbursement to APDs better align with the level of skill, knowledge and care required to achieve agreed outcomes, reimbursement for communication between practitioners to facilitate inter-disciplinary communication etc.). DAA further supports expanded funding for telehealth services and training to include allied health practitioners in public and private settings (e.g. revision of Medicare item numbers for allied health services to accommodate telehealth consultations for APDs).
- *3.3- Advanced Care, Priority 3, Objective a), implementation plan 2 (p19).* DAA supports the '*implementation of a consistent, national and state-wide post-operative pathway of care, with an emphasis on discharge to the home environment where access to appropriate post-operative care services, such as allied health care, is available*'. It is vital to include APDs in the post-op pathway of care, especially for patients who are overweight post-op [1].
- *3.3- Advanced Care, Priority 3, Objective b), implementation plan 1 (p19).* DAA highlight that APDs play an important role in multidisciplinary pre-surgery assessments (especially for clients/patients who are overweight or obese), to identify possible surgical risk factors and inform discharge planning.
- *3.3- Advanced Care, Priority 3, Objective b), implementation plan 3 (p19).* DAA supports the establishment of private and public musculoskeletal health centres, incorporating allied health practitioners, especially APDs. DAA highlight that APDs play a pivotal role in the management of people with OA who are overweight/obese [1].

References:

1. The Royal Australian College of General Practitioners. Guideline for the management of knee and hip osteoarthritis [internet]. 2nd edition. Melbourne (VIC): 2018 [cited 2018 Sep 18]. Available from: https://www.racgp.org.au/clinical-resources/clinical-guidelines/guidelines-by-topic/view-all-guidelines-by-topic/musculoskeletal-health/hip-and-knee-osteoarthritis