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Research Article

Providing Consumers, Physicians, And Health Services With A Resource That Is Appropriate For Their Needs: The Revised Osteoarthritis Of The Knee Clinical Care Standard.

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Abstract

A common and incapacitating ailment, knee osteoarthritis affects daily living activities, involvement in job and family responsibilities, and general quality of life. An increasing proportion of Australians—more than 1.9 million in 2019—have knee osteoarthritis as a result of population expansion and aging; this represents a 126% increase from 1990 estimates. One According to national estimates, the disability burden from knee osteoarthritis surpasses that from dementia, stroke, or ischemic heart disease, accounting for roughly 59,000 years lived with disability per year.With over $3.5 billion spent on hospital admissions related to osteoarthritis each year and an estimated $424 billion in lost productivity, knee osteoarthritis also has a significant economic impact in Australia. 3. According to international clinical guidelines, non-surgical techniques should be the primary treatment for osteoarthritis in the knee, with referrals for joint replacement surgery saved for patients with advanced disease. 4–6 It is concerning if low value care—that is, care that is damaging, inefficient, and/or wasteful—continues throughout the course of osteoarthritis in the knee. This is frequently fueled by myths regarding osteoarthritis, such as false assumptions about diagnosis and treatment, which can be dispelled with knowledge and clear communication.standard for osteoarthritis in the knee. The Osteoarthritis of the Knee Clinical Care Standard was introduced in 2017 after a thorough development process that included consumers and subject matter experts, as well as wider stakeholder input and national peak body endorsement. We present the revised Osteoarthritis of the Knee Clinical Care Standard and indicator set, which can be found at www.safetyandquality.gov.au/oak-ccs, after seven years. These have been meticulously updated to guarantee that they are in line with new research, current international guidelines, and developments in person-centered care. The updates also focus on current targets for lowering low-value treatment and improving osteoarthritis care. These priorities include cutting back on inappropriate arthroscopy as well as unneeded imaging, narcotic prescriptions, and unnecessary knee replacements in cases when the best non-surgical treatment has not been tried.

INTRODUCTION

A number of Clinical Care Standards have been created by the Australian Commission on Safety and Quality in Health Care. These seek to lessen clinical care disparities throughout Australia, encourage shared decision-making between consumers and health professionals, and facilitate the provision of evidence-based clinical care for a medical condition or procedure. Clinical Care Standards do not cover every aspect of care, in contrast to clinical guidelines. Rather, they cover a small number of quality statements that outline priorities for quality improvement and explain the expected care for a procedure or medical condition.

The necessity for the first clinical care was indicated by evidence of low-value osteoarthritis therapy, particularly the high rates of knee arthroscopy among older Australians, with significant geographic variation.standard for osteoarthritis in the knee. The Osteoarthritis of the Knee Clinical Care Standard was introduced in 2017 after a thorough development process that included consumers and subject matter experts, as well as wider stakeholder input and national peak body endorsement. We present the revised Osteoarthritis of the Knee Clinical Care Standard and indicator set, which can be found at www.safetyandquality.gov.au/oak-ccs, after seven years. These have been meticulously updated to guarantee that they are in line with new research, current international

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guidelines, and developments in person-centered care. The updates also focus on current targets for lowering low-value treatment and improving osteoarthritis care. These priorities include cutting back on inappropriate arthroscopy as well as unneeded imaging, narcotic prescriptions, and unnecessary knee replacements in cases when the best non-surgical treatment has not been tried.

Why is a Clinical Care Standard for osteoarthritis in the knee necessary?

A number of Clinical Care Standards have been created by the Australian Commission on Safety and Quality in Health Care. These seek to lessen clinical care disparities throughout Australia, encourage shared decision-making between consumers and health professionals, and facilitate the provision of evidence-based clinical care for a medical condition or procedure. Clinical Care Standards do not cover every aspect of care, in contrast to clinical guidelines. Rather, they cover a small number of quality statements that outline priorities for quality improvement and explain the expected care for a procedure or medical condition.

What is different now?

Clinical diagnosis and avoiding needless imaging, particularly computed tomography, magnetic resonance imaging, and ultrasound, are increasingly given more attention. There is a firm belief that erect x-rays are the best choice in the few situations where imaging is necessary (limited to the presence of unusual features, the suspicion of alternative diagnosis, the rapid worsening of symptoms, or when surgery is being considered). Patients are given advice to assist them comprehend why imaging might not be helpful in their particular situation. The quality statement on exercise now contains physical activity recommendations, emphasizing the value of self-management support. Additionally, a new quality statement on weight management (as opposed to "weight loss") and appropriate nutrition has been added.

Box 1 provides a summary of the most recent version of the Osteoarthritis of the Knee Clinical Care Standard. There are a few significant adjustments and new features, but the objectives and scope are still the same. Crucially, the quality standards aim to encourage uniformity in assessment, management, and communication for all medical practitioners, allied health specialists, and nurses who treat knee osteoarthritis. With broad applicability to all venues where osteoarthritis care is provided, the settings to which the Clinical Care Standard apply are now clearly defined. These include of hospital settings, private medical clinics, Aboriginal and Torres Strait Islander Community Controlled Health Organizations, and community and primary healthcare services.

New elements to promote equity, cultural safety, and efficient communication

The new Clinical Care Standard now includes cultural safety and equality concerns to enhance the treatment of osteoarthritis in Aboriginal and Torres Strait Islander people. It is acknowledged that compared to non-Indigenous Australians, Aboriginal and Torres Strait Islander peoples have a higher burden of osteoarthritis and less access to care. 10. Broad guidelines for integrating cultural safety into healthcare are offered, together with connections to pertinent frameworks and resources, in order to enhance fair access to care. Individual quality statements are also connected to specific cultural safety and equity guidelines. Collaborating with Aboriginal and Torres Strait Islander health workers, medical professionals, and community services in a multidisciplinary care approach is one of these. Another is optimizing care delivery by building solid, trustworthy relationships and having good communication with patients and their families.

Low-value treatment is a result of poor communication between the patient and the practitioner. For instance, according to ChoosingWisely polls of general practitioners, specialists, and other medical professionals in Australia, up to 73% of respondents were willing to suggest an unneeded test, treatment, or surgery if it would meet the expectations of the patient. 11 There are still a number of common patient misunderstandings regarding osteoarthritis, including the belief that a scan is required to diagnose and treat knee osteoarthritis and that physical activity will exacerbate joint degeneration in patients with the condition. Despite initiatives to shift away from terminology that emphasizes structural deterioration and is joint-centric,13 According to a recent survey of patients in Australia, their healthcare providers frequently used antiquated, derogatory phrases (such "wear and tear" and "bone on bone") to characterize osteoarthritis. 14This kind of language can lower participation in effective care, such fitness therapy. 12Recommendations for successfully discussing knee osteoarthritis with patients are connected to each quality statement in the revised Clinical Care Standard to support the provision of evidence-based care. Examples of favorably phrased language that practitioners might use to encourage constructive thoughts and behaviors are included in these recommendations.

Resources to assist patients, physicians, and healthcare providers

Access to high-quality information on osteoarthritis can encourage treatment adherence and active self-management, enhance health outcomes, and empower consumers and their families to take a more active role in healthcare decisions. 15. Links to evidence-based consumer resources in a variety of formats are included for each quality statement to accommodate different needs and preferences. These consist of community events and information resources

for Aboriginal and Torres Strait Islander peoples, as well as participatory online programs and activities. Online materials are also available to support the Clinical Care Standard, such as fact sheets and a consumer guide for healthcare providers.

SET OF INDICATORS

The Revised Clinical Care Standard is accompanied by a redesigned set of practical indicators to support local quality improvement initiatives. Nine indicators are offered, including: thorough evaluation and diagnosis; suitable imaging, education, and self-management; medications for pain and mobility management; patient reviews; and surgery. For instance, certain metrics take into account the percentage of patients with osteoarthritis whose individualized self-management plan includes written recommendations on physical activity and the percentage of patients with osteoarthritis who are identified without the need of imaging.

CONFLICTING INTERESTS

The authors disclose the following: compensation for attending the Osteoarthritis of the Knee Clinical Care Standard meetings (Dooley, Favorito); research funding unrelated to editorial preparation (Ackerman, Buchbinder, Bunzli, Hunter); employment with the Australian Commission on Safety and Quality in Health Care (Doukas, Bhasale, Holdenson Kimura); royalties for authorship of UpToDate on an unrelated topic (Buchbinder); consulting fees for pharmaceutical Scientific Advisory Boards (Hunter; Pfizer, Lilly, TLCBio, Novartis); compensation for co-editor-in-Chief, Osteoarthritis and Cartilage journal (Hunter); compensation for serving as editor of the Osteoarthritis section for UpToDate (Hunter); travel assistance as an invited speaker at scientific conferences (Buchbinder) or for attending international conferences or research meetings (Bunzli);

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CONCLUSION

For those who present with suspected knee osteoarthritis, the revised Osteoarthritis of the Knee Clinical therapy Standard is a valuable resource that can promote best practice therapy. The Clinical treatment Standard encompasses the entire range of treatment that should be tested before considering surgery, with a particular emphasis on the importance of clinical diagnosis and an increased emphasis on exercise, physical activity, weight control, and nutrition. A modern resource with usefulness is ensured by the inclusion of cultural safety and equality issues, clinician communication advice, and new guidelines for healthcare services, clinicians, and consumers.

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