Mapping Integrated Care Cases in Australia

“The Joint Approach” Project – Tweed Specialised Osteoarthritis Screening Clinic (SOS Clinic)

The Tweed Hospital – Physiotherapy Department

Tweed Heads

Services the Tweed-Byron region of the Northern NSW Local Health District (NNSW LHD)

Partners
NNSW LHD – Integrated Care
North Coast Primary Health Network (NCPHN)
Agency for Clinical Innovation (ACI)
1. SUMMARY

Knee and hip osteoarthritis (OA) are linked to hip and knee pain; which is exacerbated by excess weight, weakness, stress and environmental factors.

The SOS Clinic was established to provide holistic care for patients with OA though a person-centred model which engages all members of the health care team. GPs are integral as they oversee all their patients’ needs; the OA team and orthopaedic surgeons can focus on their area of specialty.

The SOS Clinic undertakes a comprehensive assessment including physical fitness and function, quality of life, weight and self-management. Holistic assessment, education, simple exercise and coaching improves joint pain and physical function in 3 out of 4 patients.

**Project Lead:**

Luke Schultz  
Project Lead | Musculoskeletal Services | Leading Better Value Care

T: 0418 974467  
E: Luke.Schultz@ncahs.health.nsw.gov.au
2. BACKGROUND

What are the aims and objectives of the project?

The SOS approach empowers patients to take control of their joint pain through education, development of patient-centred goals, and health coaching to work toward goal achievement. SOS patients are referred from the “pre-waitlist space” and can be referred by GPs and/or orthopaedic surgeons.

The Joint approach was developed in partnership with NCPHN and NNSWLHD – Integrated Care, supported by the Agency for Clinical Innovation (ACI). It provides seamless, person-centred care across primary and public health in the Tweed-Byron area for patients suffering from osteoarthritis (OA) related hip and knee joint pain. By providing timely and evidence-based assessment and intervention, it aims to reverse functional decline, and where appropriate, avoid joint surgery. The SOS clinic provides holistic hip and knee joint assessment to assist GPs and surgeons better manage their clients joint pain in partnership with Tweed community and allied health clinicians. The service aims to utilise suitable public, private and NGO services to assist clients achieve their goals.

How did the project come to being and what are the significant milestones?

In October 2016 a 12-month Project Lead was appointed to develop the ACI Osteoarthritis Chronic Care Program (OACCP) for The Tweed Hospital. Using a Clinical Redesign methodology, the Tweed Specialised Osteoarthritis Screening Clinic (SOS Clinic) was designed and implemented in June 2017.

The Primary Health Network assisted in project development through provision advertising and event funding for service ‘launch’, plus human resources for promotion and engagement with GPs.

Milestones:

- To date the SOS Clinic has received over 230 referrals from local GPs and Orthopaedic Specialists.

- It is the first NSW Health service to use electronic secure messaging (Medical Objects) to receive referrals and send reports. More than 50% of GP referrals to the program were made via Medical Objects and 100% of communications from the SOS Clinic were sent via Medical Objects.

- Funding for the project was originally for a 12-month period however due to its success in patient outcomes funding was extended for a further 12 months.

How is the project funded, managed and governed?

The project is currently funded and managed by the NNSWLHD. The project receives ongoing support from NCPHN. The service is listed and linked in with the ACI – Musculoskeletal Network – OACCP services.

How is care organized and delivered to users and patients in local communities?

The services follow the OACCP model of care which promotes a health coaching approach to the development of patient centred goals and a management plan.
2. BACKGROUND

Patients are empowered through a ‘hands off’ approach, education, and management plans based on patient reported measures (PREMs and PROMs).

Patients are encouraged to manage their health and lifestyle changes through publicly available support services including Get-Healthy, CHEGs (Community Health Education Groups), social hubs, local clubs and health groups in the local area.

The SOS Clinic Physiotherapist role is to assess the patient and provide them and their GP with a roadmap for better joint health.

**How is the project being taken forward in the future?**

The project is funded until end of June 2019. Development of the service is being considered by the NCPHN as a ‘template’ for Joint Pain management.
3. Evidence

What is the evidence related to improvements in the experience of service users?

More effective channels of communication have been established. GPs report better feedback from LHD clinicians facilitated by the use of Medical Objects.

The model aims to empower patients to take control of their joint pain and manage their pain in partnership with their general practitioner and specialised OA clinicians.

What is the evidence related to positive influences on care and health outcomes to individuals and/or communities?

The points below are some early observations for 80 patients completing 3 sessions over 4 months at the SOS Clinic:

• Improved patient reported measures of function (Oxford hip and knee) and pain as key indicators for surgery. That is, pain trending down and function trending up.

**OXFORD**: (functional assessment score - function score 0 to 48, <20 is severe)
77% improved, average improvement of 7 points from moderate-severe to mild-moderate impairment

<table>
<thead>
<tr>
<th>Initial</th>
<th>1st Review (1 month)</th>
<th>2nd Review (3 months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>27</td>
<td>29</td>
</tr>
</tbody>
</table>

**PAIN SCORE**: patient asked to rate pain out of 10, 10 being the worst pain imaginable.
75% improved, average pain change 1.9 from high-moderate to low-moderate range.

<table>
<thead>
<tr>
<th>Initial</th>
<th>1st Review (1 month)</th>
<th>2nd Review (3 months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.8</td>
<td>4.6</td>
<td>3.9</td>
</tr>
</tbody>
</table>

3 out of 5 patients said their walking (in general) and their hip or knee (in general) had improved.

1 in 2 of patient who were willing for surgery on their initial assessment changed to being unwilling or unsure about wanting surgery.

What is the evidence related to impact on reducing the unnecessary utilisation of care facilities (e.g. of hospitals and long-term residential homes), or the growth in use of alternatives (e.g. domiciliary care; care in the home; self-care)?

The SOS approach provides patients diagnosed with OA an earlier intervention model as opposed to offering conservative management once patients are already on a surgical waitlist.

Early indications are that the majority of patients feel able to better manage their joint pain and do not feel the need for surgery. The impact on waiting lists has not been measured. It is too early to do so.
What is the evidence that suggests the project has been able to secure a more cost-effective or sustainable care solution when caring for vulnerable people and communities through integrated community care?

The SOS approach provides patients diagnosed with OA an earlier intervention model as opposed to offering conservative management once patients are already on a surgical waitlist.

Early indications are that the majority of patients feel able to better manage their joint pain and do not feel the need for surgery. The impact on waiting lists has not been measured. It is too early to do so.

What is the evidence that suggests the project has been able to secure a more cost-effective or sustainable care solution when caring for vulnerable people and communities through integrated community care?

The NSW Health Osteoarthritis Chronic Care Program (OACCP) is being implemented state-wide as a Value Base Healthcare initiative. The SOS clinic was developed and implemented prior to the state-wide OACCP model and provides solid groundwork to improve OA management in Northern NSW.

Has the project ever been, or is it currently subject to a research and evaluation study?

No evaluation has taken place as of yet.
About IFIC Australia

The core mission of IFIC Australia is to develop capacity and capabilities in Australia and the Asia Pacific Region in the design and delivery of integrated care. IFIC Australia seeks to achieve this by providing a platform to develop and exchange ideas and promote activities in the region in keeping with IFIC’s mission.

For more information contact IFIC Australia:
Email: ificaustralia@integratedcarefoundation.org
Web: integratedcarefoundation.org/ific-australia