Patients' Perceptions of Navigating "The System" for Arthritis Management: Are They Able to Follow Our Recommendations?

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ABSTRACT

Purpose: To understand whether a visit to a Hip/Knee Arthritis Assessment Centre (AC), where non-surgical candidates with arthritis are directed toward community resources and provided with a conservative treatment "prescription," contributes to patients' self-management and ability to access community resources. **Methods:** A purposive sample of non-surgical patients was contacted 3–10 months after their AC visit. Three focus groups ($n = 20$) and 20 semi-structured telephone interviews were conducted. Transcripts were systematically coded and analyzed using a qualitative descriptive research methodology. **Results:** While participants generally reported that the AC visit improved self-management, analysis identified an emergent theme about the inadequacy of conservative management in general, subdivided into two sub-themes related to (1) limited access to high-quality, non-surgical treatment, such as physiotherapy and (2) health care providers' attitudes and approaches, which do not embrace chronic disease prevention and management. **Conclusions:** An AC visit contributes to arthritis self-management; however, the current health care system does not adequately support conservative treatment of chronic conditions. Treatment guidelines need to be tailored to the local health care context in which they are applied.

Key Words: disease management; health services accessibility; osteoarthritis; survey.

RÉSUMÉ

Objectif: Pour comprendre si une visite à un centre d'évaluation de l'arthrite de la hanche ou du genou, où des personnes qui ne sont pas candidates à une intervention chirurgicale et ont de l'arthrite sont dirigées vers des ressources communautaires et reçoivent une « ordonnance » portant sur un traitement de conservation, contribue à l'autoprise en charge par les patients et à leur capacité d'avoir accès aux ressources communautaires. **Méthodes:** On a communiqué, pendant 3 à 10 mois après leur visite au centre d'évaluation, avec un échantillon choisi à dessein de patients non candidats à une intervention chirurgicale. On a organisé trois groupes de discussion ($n = 20$) et procédé à 20 entrevues téléphoniques semi structurées. Les comptes rendus ont été codés systématiquement et analysés au moyen d'une méthodologie de recherche descriptive qualitative. **Résultats:** Les participants ont signalé en général que les visites au centre d'évaluation amélioraient l'autoprise en charge, mais l'analyse a dégagé un thème émergent au sujet de l'insuffisance de la prise en charge conservatrice en général, subdivisé en deux sous-thèmes portant sur (1) l'accès limité à un traitement non chirurgical de grande qualité comme la physiothérapie et (2) les attitudes et les approches des fournisseurs de soins de santé qui n'adoptent pas la prévention et la prise en charge des maladies chroniques. **Conclusions:** Une visite à un centre d'évaluation contribue à l'autoprise en charge de l'arthrite, mais le système de santé actuel n'appuie pas adéquatement un traitement conservateur des problèmes chroniques. Il faut personnaliser les lignes directrices sur le traitement en fonction du contexte local des soins de santé où elles sont appliquées.

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Contributors: All authors designed the study; collected, analyzed, and interpreted the data; drafted or critically revised the article; and approved the final draft.

Competing Interests: None declared.

Funding for this study was provided by a Sunnybrook Practice Based Research Award.

This work was presented at the Canadian Physiotherapy Association Congress in St. John's, NL, in July 2010.

Acknowledgements: The authors acknowledge Fauzia Gardezi, James Falconer, and Moneet Dogra for their assistance with this research.

Physiotherapy Canada 2014; 66(3);264–271; doi:10.3138/ptc.2012-66

Osteoarthritis (OA), the most prevalent form of arthritis, affects 13% of Canadians and is a major contributor to long-term disability.¹ OA accounts for more difficulty in stair-climbing and walking than any other disease² and is the most common reason for performing total knee and hip replacements.³

For people whose arthritis is not yet severe enough to warrant surgery or who are unable to undergo surgery, best practice guidelines recommend education in self-management, physiotherapy, exercise, weight loss, walking aids, and acetaminophen.⁴⁻⁶ However, meeting recommendations for chronic disease management can be challenging in the Canadian health care system. Some people suggest that the system is designed to address acute episodes and lacks the necessary funding and structure to prevent and address chronic disease.⁷ Historically, gaps in the system that affect people with arthritis have included shortages of orthopaedic surgeons,⁸ insufficient access to physiotherapy,⁹⁻¹² and care that does not follow best practice guidelines.^{13,14} For example, through research in Ontario, Glazier and colleagues¹⁵⁻¹⁷ found that arthritis management provided by primary care physicians has been sub-optimal, with low use of options such as exercise, low rates of referral to other health care providers, and a lack of comprehensive recommendations for therapy.

The Ontario government's approach to mitigating the human and economic toll of arthritis has been to increase the number of surgeries and to set wait-time targets for hip and knee replacement surgery.¹⁸ In response to the Ontario Wait Times Strategy, the Sunnybrook Holland Orthopaedic and Arthritic Centre developed an innovative model of care for people with hip and knee arthritis, a key part of which is early assessment and triage at an Assessment Centre (AC).¹⁹ At the AC, a non-physician care provider (Advanced Practice Physiotherapist [APP] or Advanced Practice Occupational Therapist [APOT]) takes a history, performs a physical examination, assesses function, and reviews radiographic test results. Based on assessment findings, patients are then triaged into surgical and non-surgical streams. Those identified as non-surgical receive education on treatment options and are directed toward community resources. A summary of findings and treatment recommendations is sent back to the referring physician, most commonly a general practitioner (GP). Results from a 2007 survey showed very high patient satisfaction with the AC; for example, 94.1% of respondents ($n = 118$) responded that they were "very" or "extremely" satisfied with the "recommendations or advice (management of [their] problem and exercise/activity suggestions)" (unpublished data).²⁰

The AC model assumes that the patients in the non-surgical cohort benefit from the provision of education and direction to self-management resources during the visit, but the actual impact is difficult to ascertain because there is no routine follow-up. We therefore undertook a qualitative research study with a non-surgical

cohort of patients seen at the AC with the purpose of understanding whether and how an AC visit influences (1) arthritis management and (2) the patients' ability to access appropriate community resources.

METHODS

The study took place at the Sunnybrook Holland Orthopaedic & Arthritic Centre in Toronto, where more than 2,100 joint replacement surgeries are performed annually. Ethics approval for the study was obtained from the hospital's research ethics board, and all participants provided informed consent before taking part in the study.

We chose a qualitative methodology because of its suitability in exploring processes and issues and in developing a deeper understanding of patient perspectives.²¹ Our aim was to assess working assumptions about the effectiveness of the AC, which would enable us to make recommendations to refine our model of care and to influence the evolution of similar models now being used at many sites across Ontario.

We used purposive sampling²² with the intent of recruiting enough participants to ensure information-rich exploration of the phenomenon under study. Using a combination of convenience and maximum variation sampling, we contacted 158 patients with hip or knee arthritis who visited the AC from June to October 2008 and invited them to join our study. The selected sample reflected the diversity of the population seen at the AC with respect to age, sex, geographic location, and joint involvement (hip vs. knee). All patients' conditions had been assessed and deemed "non-surgical" at the time of their AC visit and the patients had been provided with education about arthritis and written recommendations for conservative management in accordance with the Osteoarthritis Research Society International guidelines.⁶

Potential participants were contacted by letter advising them about the study between 3 and 10 months after their index visit. The letter gave patients the phone number of one of the principal investigators and invited them to leave her a message if they did not wish to be contacted by telephone at a later date. All other patients were telephoned by a member of the AC team 2-3 weeks after their letters were mailed to inform them further about the study and invite them to participate in either a focus group or a telephone interview. Having two methods of data collection ensured richness of data and allowed those who could not attend a focus group in person to participate via telephone interview.^{23,24} We decided not to exclude participants who, for reasons of limited mobility, time, or geographic distance, could not attend a focus group, because this group might have important insights to share. However, those who did not speak English, lived outside the province, or had cognitive or significant communication impairments were excluded. To avoid any perception of obligation or coercion, patients were never contacted by the same APP

Box 1 Telephone Interview Questions

1. Can you describe your experience at your AC visit?
2. What were your expectations for your AC visit?
3. Did you find your AC visit helpful or not? Why or why not? What would make it more helpful?
4. Did you feel you had a better understanding of your hip/knee problem and possible treatment options after the AC visit? *Probe: If yes, how so? If no, why not?*
5. Did you feel that you had a plan for coping with your hip/knee problem after your AC visit?
6. What recommendations for dealing with your hip/knee problem were made to you at your AC visit? *(This will be cross-checked with the patient's chart. e.g., direction to an education or self-management program, physiotherapy, The Arthritis Society, use of gait aid, knee support, discuss medication with doctor, assistive devices, etc.)*
7. Did you follow-up with any of the recommendations made to you at your AC visit for dealing with your hip/knee problem? Which ones?
8. Did you make an appointment to see your doctor after your AC visit? Why or why not?

If saw doctor: go to question 9. If didn't see doctor: go to question 12.

9. What was the outcome of your follow-up visit with your doctor? *Probe for: physiotherapy referral obtained, discussed medication, etc.*
10. Did you follow-up with plans made at your doctor's appointment? *Probe for: attending physiotherapy, changing medication regimen, attending self-management program, etc.*

If NO: go to question 11. If YES: go to question 12.

11. Why didn't you follow-up on the plans made at your doctor's appointment? *Probe for: didn't think doctor would be receptive, too expensive, long wait, inconvenient, etc.*
12. Did you have any difficulties or face any barriers in following any of the recommendations made at your AC visit? If so, what were they? *Probe for: too expensive, long wait, inconvenient, transportation, etc.*
13. So far, has following the plan/recommendations made any difference? How?
14. Do you have any other thoughts/feelings about your AC visit that you'd like to share?

Box 2 Focus Group Questions

1. What were your expectations for your AC visit?
2. What recommendations for dealing with your hip or knee problem were made to you at your AC visit? *Probes may include: physiotherapy, The Arthritis Society, written information provided, self-management program, changed medication regimen, follow-up with general practitioner, start or change use of gait aid, modification of activities, change or add exercises, use of assistive devices, use of knee support, use of ice or heat, weight loss, fitness or pool program.*
3. Were you able to follow-up on any of them or did you face any barriers in trying to follow the recommendations?
4. Was the AC visit helpful for you? *Probe: If yes, in what way? If no, why not?*
5. Did your understanding of your hip/knee problem and treatment options change after your AC visit? How? *Probe for: understanding of diagnosis/prognosis, understanding of available resources and services, etc.*
6. Did your attitude/outlook about your hip/knee problem change after your AC visit? How? *Probe for: feeling of support, more or less confidence in care, more or less confidence in navigating health system, feeling there is a plan of care, discouraged re: diagnosis/prognosis, etc.*

or APOT who had conducted their assessment. We recruited a purposive sample²² of 40 patients to participate in one of three focus groups ($n = 20$) or a semi-structured telephone interview ($n = 20$). Interviews continued until saturation²⁵ (the point at which no new data emerged) was reached. Our team determined that saturation had been achieved after 19 interviews and conducted one more interview to confirm this assessment. The team met to discuss whether any new themes were emerging and agreed after three focus groups that saturation had been reached in relation to our research questions.

An experienced and independent qualitative researcher with a PhD in sociology (Fauzia Gardezi [FG]) was employed to conduct the focus groups and telephone interviews concurrently between January and May 2009. Interviews lasted approximately 30 minutes and were

conducted using a semi-structured interview guide (Box 1) that explored expectations of and experiences during the AC visit, follow-up on any of the recommendations, and impressions of the overall helpfulness of the AC visit. Focus groups were held in non-clinical areas of the Holland Centre and were facilitated by FG and co-moderated by a therapist who had not been involved in providing care to any of the participants. Each focus group had a maximum of eight participants and lasted between 75 and 100 minutes. The focus group guide (Box 2) consisted of questions designed to explore similar topics to those addressed in the interview guide. Focus groups and interviews were audio-recorded and then transcribed verbatim, with all actual and potential identifiers omitted; arbitrary participant identifiers were assigned to ensure confidentiality (e.g. TI-01 = Telephone

Interview participant #1; FG-02 = for Focus Group participant #2).

For analysis, we used a general descriptive qualitative research methodology, as described by Sandelowski.²⁶ A focus-group transcript and a sample of interview transcripts were read and discussed by a team of investigators, including multi-disciplinary staff of the AC, a qualitative research consultant, and a social science researcher; this process ensured reflexivity by allowing each member of the research team to discuss differences that emerged in their assumptions and biases during analysis. This process, together with the use of both focus groups and interviews, helped to ensure rigour in our study.^{22,27} Consensus was reached by developing a coding scheme, which was then applied to all the data by the research consultant (FG). NVivo8 (QSR International, Australia) qualitative data management software was used for data organization. Potential contradictions and discrepancies in interpretations were discussed with the principal investigators, and the resulting 86 codes were refined and grouped into 20 categories, from which five overarching themes emerged. Four of the themes are explored in a separate manuscript currently in preparation; this article focuses on the predominant theme, which relates to the inadequacy of conservative arthritis management.

RESULTS

The 40 participants ranged in age from 43 to 87 years (mean 68) at the time of the index AC visit; 25 were women. Thirty-three were referred for knee arthritis and seven for hip arthritis, reflecting the population seen at the AC during the period under study. Thirty-one participants lived in the Greater Toronto Area (GTA), four in cities outside the GTA, and five in rural areas. The participant profile was similar to that of patients typically seen at the AC. Similar themes emerged from the analyses of both focus groups and interview transcripts.

Generally, participants reported that the AC visit improved their self-management by increasing their understanding of their condition, appropriate exercise, and/or treatment options:

... she [APP] referred me to the sports clinic at [another hospital]. And I saw a rheumatologist, and I see the physio too. So I'm doing exercises trying to strengthen the muscles around my knee and delay having surgery. (TI-01, F, 65)

This participant definitely felt that her AC visit was beneficial, but we note that the benefits appear to be indirect: the perceived improvement in her condition can be more directly attributed to the resources to which she was directed. If she had not been able to access the resources, it is unknown how much benefit her AC visit would have granted.

Many participants reported experiencing barriers to self-management, including individual-level and systemic

barriers. An example of an individual-level barrier was lack of time:

Interviewer: Okay, and is there any problem you've had following up on physiotherapy?

TI-05 (F, 79): Yeah, that's what I told you, no time ... I'm really pressured for time now because there are things that we have to do with the estate in the spring [as I am executor for a deceased relative's will]. I sort of have a deadline to put the house on the market and other things like that, so I've got this huge job.

Self-management of chronic conditions imposes certain demands on individuals, including time commitment, that may limit their ability to engage in self-management strategies.

Many of the barriers to self-management that participants identified could be classified as systemic barriers, and a consistent theme that emerged was related to the inadequacy of our health care system's conservative management of arthritis. The theme can be divided into two sub-themes: (1) limited access to high-quality non-surgical treatment, and (2) attitudes and approaches of health care providers that do not embrace chronic disease prevention and management.

Limited access to high-quality, non-surgical treatment

Participants described a lack of access to resources such as self-management programs as a barrier:

Yeah, I was supposed to go for exercises to uh, [arthritis self-management program at a hospital]. And I did apply and I filled out all the forms and then when it came to it, they said, "Oh, sorry, uh, it's all booked ..." (TI-19, F, 73)

This patient could have benefited from her AC visit: she learned about a self-management program, was interested, and took the initiative to follow up on the recommendation. Because of a lack of available spots in the program, however, she was unable to follow through. If she had been a candidate for surgery, she would have been able to have her surgery within a provincially mandated wait time, but no such mandated wait times exist for self-management programs.

Participants also repeatedly mentioned a lack of access to physiotherapy resources. Many participants who were not covered by government (i.e., Ontario Health Insurance Plan [OHIP]) or third-party insurance could not access physiotherapy at all due to the cost, and many who were eligible for OHIP physiotherapy commented on the poor quality of service provided:

I discovered that most of the clinics don't want you because you're over age 65, and they only give you partial treatment. The treatment is limited by the government ... So they put you on a machine and they walk away. There's no hands on. And that seems to be Ontario's method of physiotherapy for seniors. (FG-13, M, 65)

Some participants were aware that reimbursement to physiotherapy clinics by OHIP is significantly less than

what is paid by third-party insurance or by patients who pay out-of-pocket. They perceive that this affects the quality of care they receive and that it also reflects the government's attitude toward the value of physiotherapy.

Moreover, the number of OHIP-funded clinics is limited, and many hospitals have closed their public outpatient departments:

I didn't go and see a physio, because now the hospitals don't have physio department for outpatients. (FG-16, F, 75)

For those who rely on OHIP-funded physiotherapy, a reduction in the availability of physiotherapy may discourage them from even attempting to access care. While this participant might have found physiotherapy services elsewhere, if she had known where to look, it is significant that she believed that no other physiotherapy resources were available. Since it is not currently within the AC's scope to do more than provide recommendations for treatment, the efficacy of the AC model is limited by the resources available in the broader community.

Health care providers' attitudes and approaches do not embrace chronic disease prevention and management

Participants suggested that, in the context of a health care system that does not place a high value on chronic disease management, there were gaps in the treatment of their arthritis:

I'd just like to understand what my problem is, so I—right now, I'm flying blind, and I'm finding my family physician wasn't good, my physiotherapist didn't help me. So having something to read, I think, would be helpful. (FG-19, M, 62)

This participant expressed frustration with the fact that until his AC visit, he had not been given any information about his chronic disease. In fact, many participants expressed gratitude for the information they received at the AC about their diagnosis and treatment options, particularly because they said they had not been given any information by their GPs.

Some participants told us that before their referral to the AC as possible candidates for major surgery, their condition had not been managed effectively. Many reported that their GPs did not initiate arthritis treatments early in the disease process, adequately coordinate care, or follow up on any treatments prescribed. Therefore, participants often felt they needed to self-advocate for care:

I have learned to be very, very proactive, and I go into the doctor with specific questions because I read up on things beforehand to see what's available. And since I didn't get the answers, I turned it around and I'm asking questions. How about some physiotherapy? (FG-3, F, 68)

Although numerous evidence-based strategies exist for preventing and managing arthritis symptoms, GPs may not direct patients to such strategies as part of their routine care. Several participants reported that during multiple visits with their GP over periods of years, they had never been directed to any treatment. GPs may be unaware of appropriate conservative treatment of arthritis or question its efficacy, or perhaps they do not perceive conservative management as their responsibility. As a result, some participants had learned how to advocate for their own care; those who do not self-advocate, however, may fall through the cracks in the system.

Because conservative management is not effectively integrated into the continuum of care, prevention strategies are not introduced at an appropriate time:

I did not get a lot of preventative advice from my GP, in terms of how I could best delay surgery ... the kind of advice that I got from the Assessment Centre could have, I could have used five years ago. (TI-13, M, 63)

The AC does not actively seek out "customers" at the optimal stage of their arthritis but rather relies on GPs, other primary care providers, and specialist physicians to refer their patients to the AC at an appropriate time. Unfortunately, many patients seen at the AC present with a significant degree of joint degeneration, pain, and/or functional disability; many could have benefitted from receiving conservative treatment advice about exercise, pain management, weight loss, and so on much earlier. The AC's potential to help patients manage their arthritis is somewhat limited when patients present with severe disease, at which point surgery may be the only viable option.

Participants felt that the medical community may not adequately understand the role of non-surgical management for OA:

My doctor said, "No, this is terrible. You need a knee replacement." And the physiotherapist [at the AC] said, no. She said the X-ray looks dreadful, but when she went through her countless questions and she said, "You're just fine." And I was fine. (FG-10, M, 63)

The experience of arthritis care for some patients could be summarized as "from no treatment to drastic treatment in no time flat": they receive no guidance until their arthritis is advanced, at which point they may be quickly directed to surgery. There is no reliable point at which they receive recommendations for conservative management. Moreover, the previous participant's experience reflects a common practice that demonstrates a failure to embrace chronic disease management: a GP may determine that surgery is required based solely on an X-ray showing joint degeneration without considering the patient's symptoms and functional decline, which may not be severe, despite the appearance of the joint on X-ray. Such a patient, therefore, may actually be

more appropriately managed by non-surgical treatment options.

DISCUSSION

The AC's purpose is to establish appropriate management pathways for both surgical and non-surgical patients.¹⁹ Participants in our study told us that they value the increased understanding of their diagnosis and treatment options that the AC provided; because the AC does not provide any ongoing treatment, however, its efficacy ultimately depends on patients' willingness and ability to access and follow the recommendations for conservative management.

There is high-quality evidence to support the efficacy of physiotherapy interventions—specifically, exercise and weight loss—in managing OA.²⁸ However, since 2005, many people in Ontario are no longer covered by OHIP for outpatient physiotherapy. Moreover, OHIP remuneration to physiotherapists for outpatient services is significantly below that paid by third-party or private health insurance. Participants in our study perceived the quality of care provided by OHIP clinics as inadequate.

Participants' experiences mirror the findings of multiple studies on the landscape of physiotherapy services in Ontario. One of the problems most frequently cited was lack of access to such services; this is unsurprising, given Landry and colleagues' finding that between 1996 and 2003, all 46 hospitals in the GTA reduced their physiotherapy services while 15% eliminated outpatient physiotherapy completely.²⁹ Another challenge to access is that many physiotherapy clinics have wait lists that are prioritized by acuity, meaning that people with chronic conditions experience excessive wait times.¹⁰ In 2005, the Ontario government partially de-listed community physiotherapy services from OHIP; therefore, many people are not eligible for any OHIP-covered physiotherapy: only people who are less than 19 or greater than 65 years of age, or who live in Long-Term Care facilities, or who require physiotherapy post-hospitalization, or who are receiving social services are eligible for any OHIP physiotherapy at all.³⁰ A prospective cohort study by Landry and colleagues looked at 118 patients before and after the partial de-listing and found that 17.7% who required physiotherapy were no longer able to access it after they were made ineligible for OHIP physiotherapy in 2005.³¹ Many people have little or no private insurance coverage for private physiotherapy,¹² which can be prohibitively expensive, while long wait times and ineligibility impede their access to publicly funded physiotherapy.^{9,11}

Treatment recommendations made at the AC follow best practice treatment guidelines, but there may be a disconnect between these recommendations and the availability of the services recommended. Treatment guidelines may need to be tailored to the local health care context in which they are applied to ensure that

they will be helpful to patients. For example, a referral to receive physiotherapy is not helpful to a patient who cannot access physiotherapy services, and other treatment options may therefore need to be considered.

Ontario's health care system is not well designed for managing chronic conditions^{32,33}: patients can have total joint replacement surgery within a maximum mandated waiting period,¹⁸ but may receive limited assistance up to the point of requiring surgery. Participants in our study repeatedly identified a need for better follow-up, support, and guidance to manage their arthritis conservatively before resorting to surgery. Several reported that the first treatment recommendation they ever received was to go for a surgical assessment. Our findings are consistent with those of other studies concluding that management of arthritis by primary care physicians was sub-optimal.^{13–17}

Modification of behavioural risk factors (e.g., activity levels and obesity) can play a role in arthritis management, but GPs' attitudes about incorporating lifestyle risk factor management into their practices influence their ability to provide effective lifestyle-modification interventions.³⁴ To encourage busy physicians, the health care system must support such interventions: Laws and colleagues found that the broader health care context (e.g., service policies and procedures, standard assessment processes, undergraduate education) may influence the likelihood of clinicians' tackling risk-factor management.³⁵ However, Ontario's current health care system does not adequately support chronic disease prevention and management. The benefits of putting extra government resources into providing surgery (increasing supply) is questionable in the absence of a parallel comprehensive strategy and funds to reduce the volume of patients needing surgery (reducing demand).⁷ Such a strategy could include providing incentives for primary care providers to manage chronic arthritis, improving access to physiotherapy, and reducing the prevalence of obesity.

Future research might explore how the needs of people with arthritis could better be met and how the AC could help patients access services. How could the system be better coordinated so that red flags are raised if a patient's needs are not being met?

A qualitative methodology provided a valuable understanding of patients' experiences, which we could not have gleaned from a quantitative survey. Because we reached data saturation³⁶, and because nearly all of our participants shared experiences with arthritis beyond those related to the AC, we believe that the results of this study are important and likely applicable to a wider population. Moreover, the Holland Centre receives a very high volume of referrals from a wide range of referring physicians; therefore, the population seen at the AC

would tend to reflect a wide spectrum of patients in Ontario.

In light of our study's findings, the Sunnybrook Holland AC has undergone several changes. A process for a follow-up visit has been established, enabling a more proactive approach to conservative management; educational materials provided to patients have been improved; existing ties with community organizations, including the Arthritis Society and the YMCA, have been strengthened, and programs and educational materials have been developed collaboratively with community organizations. These steps were taken with the goal of addressing gaps in the continuum of care between diagnosis and surgery.

Our study has a few limitations. First, we did not have the resources to include people who do not speak English; we also did not explore age and gender differences in participants' arthritis management. These factors should be explored in future research.

Second, including AC staff as part of the team that interpreted the results could create a potential for bias. However, the familiarity of these researchers with the patient population and the AC setting gives them the ability to judge whether the phenomena are being adequately described, thus helping to validate the findings and enhance dependability.²¹

CONCLUSION

Recent initiatives in Ontario to improve access to arthritis care by decreasing wait times for assessments, consults, and surgery have been markedly successful.³⁷ However, these initiatives have not addressed the gaps in resources and coordination of care experienced by those who do not yet need or want surgery. Best practice treatment recommendations made to these patients must be given with an understanding of the conservative management landscape in which patients are situated. Recommendations must be put directly into patients' hands so that they can help guide their own treatment and ask for the help they need. The findings from this study and future research will be critical in informing the continued evolution of the AC model to ensure its effective role in conservative arthritis management. In the meantime, we must continue to advocate on behalf of our patients for a health care system that supports proactive chronic disease prevention and management.

KEY MESSAGES

What is already known on this topic

Innovative models of care and system-wide changes have improved access to care for people with arthritis who are candidates for surgery. However, there are gaps in the health care system for the prevention and management of arthritis and other chronic diseases, including a lack of proactive conservative management by primary-care physicians and inadequate access to treatments such as physiotherapy.

What this study adds

An Assessment Centre (AC) model can play a key role in establishing appropriate arthritis management. This qualitative study found that patients perceive a benefit from their single AC visit and the recommendations they receive there. However, patients cannot fully realize the benefits of the recommendations due to a lack of access to resources. Patients feel that there is a lack of support for chronic disease prevention and management along the continuum of care.

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