Clinician's Commentary on Winter Di Cola et al.¹

The article by Di Cola and colleagues¹ highlights an important and disturbing reality in chronic disease management, namely that appropriate, coordinated, and high-quality care is available only when one is in crisis. For most people with hip and knee osteoarthritis (OA), this means that appropriate care and services can be readily accessed only at the end stage of the disease or when total joint arthroplasty (TJA) is required.

While comprehensive multidisciplinary care ought to be available to patients awaiting surgery, it is equally important to ensure that effective treatment is accessible to everyone with OA across the disease continuum. There is ample evidence that physical activity and exercise can reduce pain and improve both mobility and quality of life.²⁻⁴ For people who are obese, weight loss may reduce the risk of needing TJA in the future.⁵⁻⁷ Several clinical practice guidelines specifically recommend physical activity, therapeutic exercise, weight management, patient education, and acetaminophen for first-line management of knee and hip OA,^{8,9} yet these interventions are often not used. In their article, Di Cola and colleagues¹ offer examples of suboptimal care at the primary-care level in Ontario; a study published in 2011 found that in British Columbia (BC), only about one in four people with hip or knee OA received the necessary advice on exercise and weight management.¹⁰ The 2011 Canadian Community Health Survey also reported that more than 58% of people with arthritis were physically inactive during their leisure time, compared to 46% of those without arthritis.¹¹ In sum, the majority of people with OA are missing the benefits of effective and inexpensive interventions at the early stage of the disease. For patients deemed "non-surgical," Di Cola and colleagues found that some were unable to follow through on the advice they received from the advanced practice physiotherapist because they lacked the resources to access high-quality physiotherapy services or self-management support.

Di Cola and colleagues' study also sparks an important discussion about health care disparities for vulnerable populations resulting from factors beyond their health needs. The PROGRESS framework identifies these factors as *place of residence, race/ethnicity/culture, occupation, gender/sex, religion, education, socioeconomic status, and social capital and network*.¹² Age, disability, and sexual orientation have since been added to an updated framework, PROGRESS-Plus.¹³ Studies have found that people with OA from specific ethno-racial groups and those with lower socio-economic status are less likely to be offered effective treatment^{10,14,15} and more likely to receive poor-quality care.^{16,17} People with lower levels of education are less likely to receive advice on exercise;¹⁰ when they do receive such advice, it is likely to be less comprehensive than that offered to people with a higher level of education.¹⁵ Interestingly, among those who are overweight, men, older people, and people with less disability are less likely to receive weight-loss advice as part of OA management.¹⁰

Di Cola and colleagues are to be commended for using their research to inform service delivery at the Sunnybrook Holland Centre. By including a follow-up visit for non-surgical patients, the advance practice therapist can help them navigate the complex health care system and access resources to manage pain, achieve a healthy body weight, and be more physically active.

This type of follow-up will be particularly valuable for vulnerable populations.

OA is typical of chronic musculoskeletal conditions in that its effects include pain, fatigue, decreased mobility and physical function, and psychological impacts such as depression. For people with OA, a model of care that includes early diagnosis, treatment, and access to self-management support is the key to maintaining mobility independence and quality of life. In a recent study, about 40% of people who were informed they might have knee OA started exercising within the first month after receiving a pamphlet on OA and completing a volunteer-led self-management programme.¹⁸ It appears that a diagnosis of OA presents a teachable moment¹⁹ for engaging people in learning more about the condition and engaging in physical activity.

We need a model of care that is in line with best practices in chronic disease management. This means that people with OA should have access to periodic monitoring of pain, physical activity, and weight management status,²⁰ so that a physiotherapist can identify those who require more intensive interventions before their condition deteriorates. To this end, digital monitoring tools and online programmes may be useful to facilitate non-intrusive monitoring and smooth communication between patients and therapist.²¹

Now is the time to transform our crisis-focused model of care to one that is truly responsive to the needs of people with OA.

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