Allied health integration: Collaborative care for arthritis and other musculoskeletal conditions

Executive summary

Policy context
Musculoskeletal conditions, including rheumatoid arthritis, osteoarthritis and osteoporosis, are prevalent in the Australian population, and they impose a substantial burden on the health care system and the community, reflected by their status as a national health priority area. They are the main cause of impaired physical functioning globally. These conditions have high chronicity rates and often have a long term impact, leading to reduced mobility and dexterity, chronic pain, reduced capacity for employment, and negative impact on family and social life. Much of the care for these conditions is provided in primary health care (PHC) settings.

Allied health practitioners (AHPs) play a key role in the management of musculoskeletal conditions. However, there is a recognised need to improve the engagement and integration of AHPs into PHC in general. This was reflected in the 2010 National Primary Health Care Strategy, which highlighted better management of chronic conditions as a key priority for the sector and regional integration as a building block for such improvements. Although there is some evidence internationally relating to interdisciplinary support and AHP models for other specific conditions, such as diabetes, there has been little evaluation of the literature on collaborative models specific to musculoskeletal conditions. The aim of this report is to identify and summarise evidence related to models and mechanisms for the engagement of AHPs in collaborative care for chronic conditions based in the PHC sector.

Key findings
Benefits of collaborative care include the ability for AHPs to address non-medical, non-surgical needs of patients and target the multifaceted nature of their conditions. It is widely recommended that AHPs be involved in multidisciplinary teams providing care to patients with musculoskeletal conditions. However, there is evidence that this occurs only to a limited extent. There are some promising models and strategies to improve AHPs’ involvement in collaborative care, but as yet few have been evaluated rigorously. Furthermore, although multidisciplinary teamwork is a positive step, most often this practice reflects a form of ‘collaboration’ rather than fully integrated care.

Apart from pharmacists, who are involved primarily in a dispensary role, it is most often physiotherapists and occupational therapists who are involved in the care of patients with musculoskeletal conditions. Several models of integration between general practice and...
AHPs for the management of musculoskeletal disorders include physiotherapists and occupational therapists in prominent roles.

There are some examples of effective models from around the globe, particularly in relation to arthritis. Australian examples include the Osteoarthritis Chronic Care Program in New South Wales, which is based on musculoskeletal coordinators and multidisciplinary teams working closely with general practitioners (GPs), and the Western Australian Inflammatory Arthritis Model of Care, which enacts guidelines that emphasise multidisciplinary teamwork and inter-professional education. In Canada, The Arthritis Program is a longstanding model that incorporates a range of health professionals with a focus on shared visions, values and resources (i.e. ‘one patient, one chart’) and empowering patients to maintain their own health. A second Canadian model, the Advanced Clinician Practitioner in Arthritis Care program, focuses on training for extended roles.

Although there is some promising preliminary evidence of potential cost-effectiveness in Australia, some other evidence also suggests that multidisciplinary, multifactorial models are not always cost-effective when compared with usual care.

Barriers to AHP integration include:
- The complexity of the Australian health system and funding models
- Challenges stemming from workforce turnover and short-term positions
- Difficulties with access to technology
- Lack of rewards and financial incentives for integration
- Limited knowledge of different professionals’ skills
- Conflicting organisational culture and historical biases
- Insufficient evaluative evidence.

Although there is a moderate amount of information available about evidence-based practice by AHPs for musculoskeletal conditions, there seems to be limited uptake or translation of that evidence into practice in PHC, and a dearth of evidence about the extent, effectiveness, and cost-effectiveness of allied health integration into PHC.

In addressing barriers, some potential mechanisms to enable integration have been suggested. These include:
- Raising awareness of different professionals’ skills and the benefits of collaborative care, often through inter-professional education
- Developing infrastructure for shared resources and supporting co-location (e.g. GP Super Clinics)
- Encouraging effective communication and referral processes
- Providing financial incentives for collaboration (e.g. Medicare rebates)
- Guidance by champions and leaders
- Developing trust and respectful relationships.

Policy considerations
Based on the findings of this report, the following points may be considered:

Data collection and terminology
- To provide more accurate information about AHP involvement in care, data collection needs to be improved because privately funded AHP services are currently not recorded in Medicare or public hospital statistics, which are the main sources of data.
• Routine monitoring of outcomes, including key performance/clinical indicators and patient and health professional perspectives, should be implemented to evaluate the benefits of collaborative and integrated care.
• When referring to the involvement of ‘allied health’ practitioners/professionals in integrated care, it is important for publications, policies and programs to be explicit as to which practitioners are included, which services they provide, for which disease states, and at which stages on the care continuum these services are proffered.
• Policies and programs need to be consistent in definitions of terms such as ‘integration’ and ‘collaboration’.

Benefits of AHP involvement
• AHPs have the skills to address many non-medical, non-surgical needs of patients (e.g. independent living and falls prevention).
• AHPs have the skills to coordinate multidisciplinary evidence-based care.

Models of integrated care
• Some current models show promise, but they need to be evaluated, with findings made publicly available.
• Models that include a musculoskeletal coordinator (e.g. the Osteoarthritis Chronic Care Program in New South Wales) seem to be particularly promising.
• Evaluations should incorporate both quantitative and qualitative components, including health economic analyses, and should evaluate both process and outcomes, including effectiveness and cost-effectiveness.
• Based on infrastructure and principles of co-location and shared resources, GP Super Clinics and other PHC organisations offer potential for encouraging integrated practices, but there is a need for research into whether and how collaboration occurs in these settings.

Tackling barriers and supporting enabling mechanisms
• Consistent multidisciplinary guidelines for musculoskeletal care, including appropriate referrals to AHPs, should be developed, adequately disseminated, incentivised, and adhered to.
• Governance processes should be investigated, with the introduction of coordinators to connect the different health professionals and support patients’ need for continuity of care.
• Financial incentives that not only encourage collaborating between specific individuals (e.g. referral processes) but also incentivise teamwork could be implemented. For example, rewards for case management approaches which involve care coordination meetings.
• The Enhanced Primary Care program (or a variation) could be reviewed with the aim of restructuring and renewing the program to provide an avenue for financial incentives to support collaboration.
• The continued support of the National Broadband Network and electronic health records will encourage the use of technology and ability to share resources.
• Based on success with training days and education programs, inter-professional education needs to be encouraged, including consideration of what can be done at a university curriculum level.
• There is a need to reflect on organisations’ and health professional groups’ histories and cultures and the impact they might have on the implementation of policies and practices.
Methods
A rapid review of the literature on the involvement of AHPs in the management of musculoskeletal conditions was undertaken, specifically seeking evidence of successful strategies and models to improve the integration of AHPs into PHC. A selection of relevant academic databases was searched (PubMed, the Cochrane Library, CINAHL [Cumulative Index to Nursing and Allied Health Literature], the Informit databases [including Australasian Medical Index and AgeLine]), and Google Scholar.

Searches were restricted to English language publications and the accepted time period was primarily 2009–2013. A snowballing technique was used to identify additional relevant studies from bibliographies of sourced citations. Individual experts and organisations relevant to multidisciplinary musculoskeletal care were also contacted for information.

For more detail, see Full Report.