

Uptake of Best Arthritis Practice in Primary Care — No Quick Fixes



Arthritis is one of the most common chronic conditions and is a leading cause of pain, physical disability, and use of healthcare resources¹. The Canadian Community Health Survey conducted in 2000 demonstrated that arthritis and other rheumatic conditions affect nearly 4 million Canadians aged 15 years and older². By 2026, it has been estimated that this figure will rise to over 6 million Canadians.

In the UK the National Institute for Health and Clinical Excellence developed recommendations for the management of rheumatoid arthritis³ and osteoarthritis (OA)^{4,5}. For primary care the first message that emerges from the reviews and guidelines, particularly for OA, is that there is a range of simple interventions for which there is evidence of efficacy. By contrast, evidence that these same interventions are being systematically and widely put into practice, and evidence about how to do this, is singularly lacking^{6,7,8}. There is increasing recognition that implementation of change for the better management of arthritis is very different from simply disseminating information^{9,10}.

Despite many published treatment guidelines there is often a gap between the care that is recommended and the care that such patients receive¹¹; therefore numerous studies have demonstrated the need for improved arthritis management within primary care^{12,13}. Unfortunately, their abundance can often make it difficult for healthcare professionals to determine which guidelines should be employed within clinical practice¹⁴. It has been shown that passive distribution of guidelines has limited impact¹⁵, and evidence of the implementation of health education interventions aiming to increase the uptake of arthritis guidelines in primary care is scarce¹⁶.

Lineker, *et al*¹⁷ suggested that the dissemination of treatment guidelines through a multifaceted intervention may be a method of changing provider behavior and thus improving arthritis management. As a result, the Getting a Grip on Arthritis[®] education program developed by Glazier, *et al*¹⁸, which consists of an accredited interprofessional workshop and 6 months of reinforcement activities, aims to improve

the diagnosis and treatment of arthritis in primary care in Canada.

The extensive work undertaken in the development and evaluation of this intervention, including surveys with primary care practitioners and qualitative work^{17,19,20}, is impressive. Pilot work of the intervention demonstrated clear changes in the management of arthritis in primary care¹⁸, and as a result the program received funding for national implementation through Health Canada's Primary Health Care Transition Fund.

In this issue of *The Journal*, Lineker, *et al*²¹ describe the evaluation of the national rollout of the Getting a Grip on Arthritis[®] program. In all, 553 primary healthcare professionals (30.9% nurses, 22.5% rehabilitation professionals, 22.5% physicians, 10.9% nurse practitioners, 13.1% other healthcare providers/nonclinical staff/students) from 254 sites took part. The influence of the program was evaluated by a previously validated survey to highlight self-report management of 3 case scenarios, with best-practice scores (number of recommended best practices a participant would undertake) calculated for each scenario at baseline and 6 months post-workshop. This survey also assessed perception of barriers to physiotherapy, occupational therapy, social work or rheumatology, confidence in the management of arthritis, and satisfaction with their ability to deliver arthritis care.

About one-half completed the followup survey. Overall best-practice scores improved for all scenarios at 6 months, but an analysis by discipline showed that only nurse practitioners and rehabilitation therapists (occupational therapists and physiotherapists) achieved a clinically significant improvement. Baseline scores were low for all 3 scenarios, with the best post-training score being achieved by nurse practitioners for the management of OA. Many best practices did not show any increase, but there was a noticeable increase in the recommendations for education for all scenarios, and weight management for OA. The latter (a notoriously difficult topic to address) more than tripled, although from a very low base. With regard to satisfaction and confi-

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dence, both improved significantly at 6 months, and perception of barriers to all services decreased significantly.

The authors acknowledge that the study had a number of limitations: there was no control group, there was a low response to the followup survey, and self-report behavior is an uncertain proxy measure of actual practice. So the improvements seen in this study may not have been due to the program or may not have been seen in all participants, nor followed through into day-to-day practice. However, the article illustrates the complexity of evaluating the effect of such initiatives and the difficulty of getting evidence into practice. Such educational programs often result in only small changes in professional behavior²², but the rigorous approach taken to the delivery and evaluation of this program ensures that lessons can be learned on how to improve subsequent initiatives. The authors conclude that such inter-professional education may be an effective method for improving the uptake of clinical guidelines, with potential to improve the management of arthritis in primary care.

Similar initiatives are being developed elsewhere. For example, in the UK the National Institute of Health and Clinical Research (NIHR) has funded a number of research initiatives to study the implementation of guidelines into primary care. This work is also supported by the leading arthritis charity in the UK, the Arthritis Research UK, and patient groups like Arthritis Care.

Our own group is studying how best to implement the National Institute for Health and Clinical Excellence (NICE) OA recommendations and optimize the consultation for OA in primary care with patients, general practitioners, practice nurses, and the broader multidisciplinary team. A whole-systems approach is needed, which engages with practitioners and service organizations as well as the patient. Similar to the Canadian approach, we have identified suitable models and theories to develop such training and implementation strategies, including the WISE model (“Whole system Informing Self-management Engagement”)²³, implementation theory²⁴, and behavior change theories^{25,26}. A whole-systems approach envisages informed patients receiving support and guidance from those trained practitioners who are working within a healthcare system geared up to be responsive to patients’ needs²³. To evaluate this approach we have adopted the toolkit (<http://www.normalizationprocess.org/>) proposed by the Normalisation Process Theory^{27,28} — a medium-range sociological theory concerned with understanding how complex interventions become embedded in routine clinical practice.

The Canadian model represents a major contribution to the mechanism by which evidence-based practice can be implemented in the real world. It highlights the complexities and challenges of delivering training to health professionals in order to change the way in which they consult with individuals with rheumatoid arthritis and OA, and in turn to support individuals in the uptake of best care.

The model is attractive because of its widespread adoption and influence; and while its limitations are acknowledged, the complexities of such research cannot be overlooked. We have much to learn from this work.

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REFERENCES

1. Girard F, Guillemin F, Novella JL, Valckenaere I, Krzanowska K, Vitry F, et al. Health-care use by rheumatoid arthritis patients compared with non-arthritic subjects. *Rheumatology* 2002; 41:167-75.
2. Statistics Canada. Canadian Community Health Survey (CCHS), Cycle 1.1, derived variable (DV) specifications. Ottawa, Ontario: Statistics Canada, Health Statistics Division; 2002.
3. National Institute for Health and Clinical Excellence. Rheumatoid arthritis: the management of rheumatoid arthritis in adults. London: National Institute for Health and Clinical Excellence; 2009. [Internet. Accessed February 25, 2011.] Available from: www.nice.org.uk/CG79
4. National Institute for Health and Clinical Excellence. Osteoarthritis: national clinical guideline for care and management in adults. London: National Institute for Health and Clinical Excellence; 2008. [Internet. Accessed February 25, 2011.] Available from: www.nice.org.uk/CG59
5. Conaghan PG, Dickson J, Grant RL. Care and management of osteoarthritis in adults: summary of NICE guidance. *BMJ* 2008;336:502-3.
6. Peat G, Croft P, Hay E. Clinical assessment of the osteoarthritis patient. *Best Pract Res Clin Rheumatol* 2001;15:527-44.
7. Porcheret M, Jordan K, Jinks C, with the Primary Care Rheumatology Society. Primary care treatment of knee pain: a survey in older adults. *Rheumatology* 2007;46:1694-700.
8. Dziedzic KS, Hill JC, Porcheret M, Croft PR. New models for primary care are needed for osteoarthritis. *Phys Ther* 2009; 89:1371-8.
9. Dieppe P, Doherty M. Contextualizing osteoarthritis care and the reasons for the gap between evidence and practice [review]. *Clin Geriatr Med* 2010;26:419-31.
10. Hunter DJ. Quality of osteoarthritis care for community-dwelling older adults [review]. *Clin Geriatr Med* 2010;26:401-17.
11. Steel N, Bachmann M, Maisey S, Shekelle P, Breeze E, Marmot M, et al. Self reported receipt of care consistent with 32 quality indicators: national population survey of adults aged 50 or more in England. *BMJ* 2008;337:a957.
12. Glazier RH. The role of primary care physicians in treating arthritis. In: Williams JL, Badley EM, editors. *Arthritis and related conditions: an ICES practice atlas*. Toronto: Institute for Clinical Evaluative Sciences; 1998:63-92.
13. Jawad AS. Analgesics and osteoarthritis: Are treatment guidelines reflected in clinical practice? *Am J Ther* 2005;12:98-103.

14. Rosser WW, Davis D, Gilbert E. Assessing guidelines for use in family practice. *J Fam Pract* 2001;50:974-5.
 15. Grol R, Grimshaw J. From best evidence to best practice: effective implementation of change in patients' care. *Lancet* 2003; 362:1225-30.
 16. Lineker SC, Husted JA. Educational interventions for implementation of arthritis clinical practice guidelines in primary care: Effects on health professional behavior. *J Rheumatol* 2010;37:1562-9.
 17. Lineker SC, Bell MJ, Boyle J, Badley EM, Flakstad L, Fleming J, et al. Implementing arthritis clinical practice guidelines in primary care. *Medical Teacher* 2009;32:230-7.
 18. Glazier RH, Badley EM, Lineker SC, Wilkins AL, Bell MJ. Getting a grip on arthritis: an educational intervention for the diagnosis and treatment of arthritis in primary care. *J Rheumatol* 2005;31:137-42.
 19. Glazier RH, Dalby DM, Badley EM, Hawker GA, Bell MJ, Buchbinder R, et al. Management of the early and late presentations of rheumatoid arthritis: a survey of Ontario primary care physicians. *Can Med Assoc J* 1996;155:679-87.
 20. Glazier RH, Dalby DM, Badley EM, Hawker GA, Bell MJ, Buchbinder R, et al. Management of common musculoskeletal problems: a survey of Ontario primary care physicians. *Can Med Assoc J* 1998;158:1037-40.
 21. Lineker SC, Bell MJ, Badley EM. Evaluation of an inter-professional educational intervention to improve the use of arthritis best practices in primary care. *J Rheumatol* 2011;38: 931-7.
 22. Forsetlund L, Bjørndal A, Rashidian A, Jamtvedt G, O'Brien MA, Wolf F, et al. Continuing education meetings and workshops: effects on professional practice and health care outcomes. *Cochrane Database Syst Rev* 2009;2:CD003030.
 23. Kennedy AP, Rogers AE, Bower P. Support for self care for patients with chronic disease. *BMJ* 2007;335:968-70.
 24. Grol R, Wensing M, Eccles M. *Improving patient care — The implementation of change in clinical practice*. London: Elsevier; 2004.
 25. Michie S, Johnston M, Abraham C, Lawton R, Parker D, Walker A; Psychological Theory Group. Making psychological theory useful for implementing evidence based practice: a consensus approach. *Qual Saf Health Care* 2005;14:26-33.
 26. Michie S, Johnston M, Francis J, Hardeman W, Eccles M. From theory to intervention: Mapping theoretically derived behavioural determinants to behaviour change techniques. *Appl Psychol* 2008;57:660-80.
 27. May T. *Social research: Issues, methods and process*. Buckingham: Open University Press; 1993.
 28. May C, Finch T. Implementing, embedding and integrating practices: an outline of Normalisation Process Theory. *Sociology* 2009;43:535-54.
- J Rheumatol* 2011;38:791–3; doi:10.3899/jrheum.110093