

BMJ Open Priority strategies to reduce socio-gendered inequities in access to person-centred osteoarthritis care: Delphi survey

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ABSTRACT

Objectives Osteoarthritis (OA) prevalence, severity and related comorbid conditions are greater among women compared with men, but women, particularly racialised women, are less likely than men to access OA care. We aimed to prioritise strategies needed to reduce inequities in OA management.

Design Delphi survey of 28 strategies derived from primary research retained if at least 80% of respondents rated 6 or 7 on a 7-point Likert scale.

Setting Online.

Participants 35 women of diverse ethno-cultural groups and 29 healthcare professionals of various specialties from across Canada.

Results Of the 28 initial and 3 newly suggested strategies, 27 achieved consensus to retain: 20 in round 1 and 7 in round 2. Respondents retained 7 patient-level, 7 clinician-level and 13 system-level strategies. Women and professionals agreed on all but one patient-level strategy (eg, consider patients' cultural needs and economic circumstances) and all clinician-level strategies (eg, inquire about OA management needs and preferences). Some discrepancies emerged for system-level strategies that were more highly rated by women (eg, implement OA-specific clinics). Comments revealed general support among professionals for system-level strategies provided that additional funding or expanded scope of practice was targeted to only formally trained professionals and did not reduce funding for professionals who already managed OA.

Conclusions We identified multilevel strategies that could be implemented by healthcare professionals, organisations or systems to mitigate inequities and improve OA care for diverse women.

INTRODUCTION

Osteoarthritis (OA) is the most common type of arthritis with >527.8 million cases in 2019, most often affecting hands, hips and knees.¹ OA arises from joint degradation including changes to cartilage and bone, manifesting with inflammation and pain and disrupting the activities of daily living and quality of life.² Clinical guidelines recommend early or 'first-line' intervention, which

STRENGTHS AND LIMITATIONS OF THIS STUDY

- ⇒ We employed rigorous methods, complied with research standards for conducting and reporting Delphi studies, and identified strategies from multiple sources (published research, guidelines, policies and interviews with diverse women and professionals of differing specialties) through primary research.
- ⇒ We actively engaged a 13-member advisory group of diverse women in planning and executing this study.
- ⇒ Strategies were rated by a larger number of respondents than is typical of most Delphi studies to ensure that participants reflected the varied perspectives of diverse women and professionals from across Canada; and we employed a high threshold to yield strong consensus.
- ⇒ As volunteers, the participants may have a particular interest in OA, thus their views may be biased.
- ⇒ Because we focused on ethno-culturally diverse Canadian women, the prioritised strategies may not be relevant to those from other disadvantaged groups, or to women or professionals in settings outside of Canada with differing health systems.

may include education, self-management, physical activity and weight loss. Other interventions include pharmacological and non-pharmacological pain control, heat and/or therapeutic cooling, braces/orthoses or cognitive behavioural therapy.^{3–4} OA can worsen over time, and is often associated with comorbid conditions such as depression, diabetes and heart disease. Joint replacement may be required if OA progresses to end-stage disease.^{3–5} Clearly, OA exerts a profound detrimental impact on the function and well-being of persons worldwide.

Women are disproportionately impacted by OA. Prevalence, severity and OA-related comorbid conditions are greater among women compared with men.^{1–6} However, women are less likely than men to be diagnosed with OA, prescribed or advised of



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first-line therapies, or counselled in self-management.^{7 8} Such inequities are even more pronounced among racialised or immigrant women,^{9 10} who face numerous gendered, cultural and socioeconomic barriers of access to OA care and self-management including household or family priorities, unfamiliar with strategies to optimise health such as physical activity, and limited time or funds for self-care due to low-paying or multiple forms of employment.¹¹

We lack knowledge of the strategies needed to reduce these inequities or enhance access to and quality of OA care for diverse disadvantaged women because prior research largely focused on describing compliance with OA management guidelines or identifying barriers of compliance.^{12–15} A review of research conducted before 2010 identified only 10 studies of strategies to overcome inequities in OA care experienced by disadvantaged groups,¹⁶ and an updated review identified only 11 such studies published from 2010 to 2022.¹⁷ In both reviews, few studies focused solely on women. The earlier review included only one study that compared women with men,¹⁶ and the updated review included only two studies focused on women only.¹⁷ Strategies largely consisted of education or support for self-management for persons affected by OA. This may overcome patient-level barriers such as lack of knowledge about OA or self-management, but are unlikely to address additional known barriers at the healthcare professional (eg, OA not considered serious) or system level (eg, availability of support services) that contribute to gendered inequities in access to and quality of OA care.^{14 15} Furthermore, research shows that self-management programmes have minimal, non-sustained impact on patient OA knowledge, self-efficacy, behaviour and symptoms¹⁸ unless self-management is facilitated by physicians via person-centred approaches including ongoing counselling, tailored action plans and referral to other sources of OA management or support.^{19 20} However, research involving healthcare professionals in five countries identified challenges to person-centred OA care: healthcare professionals lack knowledge of how to manage OA, their personal beliefs differ from guideline recommendations and they perceive that patients have unrealistic expectations.²¹

Given the prevalence and profound impact of OA,^{1–5} evidence of gendered inequities in OA care and lack of insight on how to reduce inequities caused by multilevel factors,^{6–11} the overall aim of this study was to generate consensus on the strategies needed to mitigate challenges contributing to inequities. The specific objective was to engage diverse women and healthcare professionals in prioritising multilevel strategies that may improve OA care for diverse women. Those strategies could be adopted and promoted by healthcare organisations or systems to assist diverse women in accessing early interdisciplinary care, and support healthcare professionals in achieving person-centred OA care.

METHODS

Approach

To identify priority strategies, we employed the Delphi technique, a widely used method for establishing consensus on healthcare recommendations, indicators or quality improvement approaches.^{22–24} The Delphi technique involves surveying persons with lived experience or expertise in two or more rounds until consensus emerges. To optimise rigour, we complied with criteria for conducting online surveys and the Conducting and Reporting of Delphi Studies to optimise rigour^{25 26}; and the research team, comprised a 13-member ethno-culturally diverse women's advisory group, healthcare professionals (family physician, rheumatologists, physiotherapist, pharmacist) and health services researchers with expertise in the topics of OA, person-centred care, equity and women's health, provided input at all stages over 2 years culminating in the Delphi survey. To minimise drop-out, we conducted two rounds.^{22–24}

Sampling and recruitment

Delphi studies involve panels that range widely in number (median 17, range 3–418).²⁷ Because reliability increases with panel size,²⁸ and to capture the perspectives of diverse women and healthcare professionals from across Canada, we aimed to establish a panel of at least 40 members including at least 50% women. Because OA disproportionately affects women in general, and in particular, women of visible minorities, we included both Caucasian and ethno-culturally diverse women. Accordingly, we recruited women with OA aged 18+ years including those of the most common ethno-cultural immigrant groups in Canada (East Asian, South Asian, African or Caribbean Black)²⁹ through OA advocacy groups, referral from our women's advisory group, university cultural clubs, community health clinics and immigrant settlement agencies. We recruited healthcare professionals representing those who provide care or advice to persons with OA (family physicians, nurse practitioners, therapists, pharmacists) or oversee or study OA health services (managers, policymakers, researchers) through professional societies, family health teams, arthritis research or practice networks and academic organisations. These organisations shared study information on our behalf by verbal, print and email notification that directed interested persons to contact the study coordinator. We did not include rheumatologists who typically focus on rheumatoid arthritis.

Survey development

We identified strategies through our prior research including a review of published research, content analysis of OA guidelines and policies and qualitative interviews with diverse women and healthcare professionals.^{17 30–32} To derive strategies that populated the survey, from the aforementioned primary research,^{17 30–32} we collated recommended strategies, and to these, added additional

unique recommendations informed by determinants (eg, enablers or barriers of equitable access to OA care) framed as recommendations (online supplemental appendix 1). We organised strategies as patient-level (offered to persons with OA to improve knowledge, confidence, behaviour, OA symptoms or quality of life); clinician-level (offered to clinicians to improve OA knowledge, skills or behaviour) or system-level (developed or offered by healthcare organisations or government to improve access to or quality of OA care, advice or support). The research team reviewed the strategies to refine wording. We created a round 1 online survey in Research Electronic Data Capture prompting panellists to rate the importance of each strategy on a 7-point Likert scale (1 strongly disagree, 7 strongly agree), comment on the relevance or wording of each strategy if desired and suggest additional strategies not already included in the survey.

Data collection and analysis

We emailed a link to the survey along with instructions to panellists on 13 February 2023, and emailed reminders at 1, 2 and 3 weeks.^{25 26} Although the original Delphi technique defined consensus as agreement by at least two-thirds of panellists,^{26 27} we used 80% to generate strong consensus. We prepared a report of round 1 Likert scale response frequencies and comments for each strategy including those retained (rated by at least 80% of panellists as 6 or 7), discarded (rated by at least 80% of panellists as 1 or 2) or with no consensus (all others), along with newly suggested unique strategies. We emailed panellists the report and a link to the round 2 survey of strategies that did not achieve consensus and those newly suggested on 6 April 2023 with a reminder at 1, 2 and 3 weeks. We similarly analysed and summarised the round 2 results.

Patient and public involvement

A 13-member ethno-culturally diverse group of women with OA contributed to study planning and execution.

RESULTS

Panellists

A total of 35 women and 29 professionals completed the round 1 survey. Of those, 84.4% (32 women, 22 professionals) completed the round 2 survey (table 1).

Delphi results

Online supplemental appendix 2 details the strategies that panellists agreed to retain or discard, and those that did not achieve consensus in rounds 1 and 2. Figure 1 summarises the number of strategies retained, discarded or with no consensus in each round. Of the 28 initial and 3 newly suggested strategies, 27 achieved consensus to retain: 20 in round 1 and 7 in round 2. Notably, consensus was high both within (eg, similar across women by ethno-cultural group) and between groups (eg, similar between women and healthcare professionals).

Prioritised strategies

Participants achieved strong ($\geq 80.0\%$) consensus to retain 7 patient-level, 7 clinician-level and 13 system-level strategies (table 2). Of those, four patient-level, three clinician-level and two system-level strategies achieved consensus among 90.0% or more of participants.

Comparison by group

Online supplemental appendix 2 compares ratings between women and professionals and online supplemental appendix 3 shows all comments offered by respondents about strategies.

Patient-level strategies

Women and professionals differed in the rating of a single strategy. Professionals (93.1%) agreed to retain: involve interpreters (family or professional) to translate spoken language during healthcare appointments. Women did not (71.4%), but overall, the strategy was retained in round 1. Comments did not clarify this discrepancy, as only two women said that translators could help those with English as a second language to understand their

Table 1 Characteristics of panellists who completed round 1 survey

Group	Subgroup	Round 1		Round 2	
		N	%	N	%
Women n=35 round 1; n=32 round 2	White	11	31.4	10	31.3
	East Asian (Chinese, Filipino)	10	28.6	10	31.3
	South Asian (Indian, Pakistani)	8	22.9	7	21.9
	Black (African, Caribbean)	6	17.1	5	15.6
Healthcare professionals n=29 round 1; n=22 round 2	Therapist (chiropractor, physiotherapist, occupational therapist)	15	51.7	13	59.1
	Healthcare leaders (manager, policymaker)	5	17.2	1	4.6
	Primary care clinician (family physician, nurse practitioner)	5	17.2	4	18.2
	Community pharmacist	2	6.9	2	9.1
	Researcher	2	6.9	2	9.1

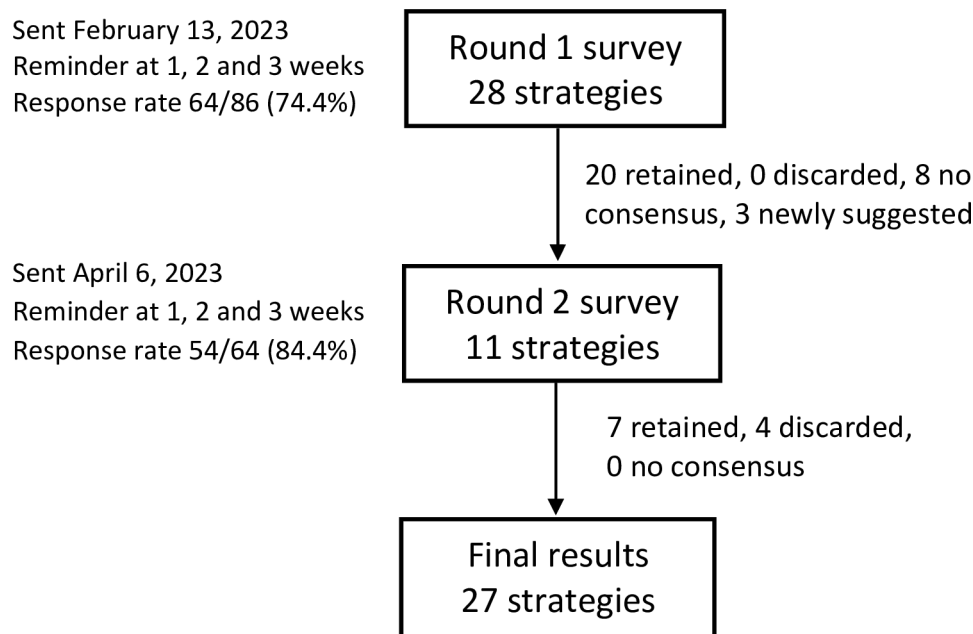


Figure 1 Delphi summary.

diagnosis, and two professionals said that translators were integral to culturally safe care but not widely accessible, particularly in primary care.

As an immigrant, English not my first language. Translation is very important to avoid misunderstand in medical issue (woman)

Family interpreters often miss words and meaning and do not provide full translation (healthcare professional)

Clinician-level strategies

Women and professionals agreed to retain all six strategies in round 1.

System-level strategies

Women and professionals differed in the rating of five strategies. Women (85.7%) agreed to retain: allow persons with OA to self-refer to clinics or self-management programmes. Professionals did not (75.9%), but overall, the strategy was retained in round 1. Comments from two women clarified that, once diagnosed with OA, they should be able to self-refer, which could reduce the length of time they wait for services, thereby lessening pain or other issues. Comments from two professionals suggested they were not opposed to self-referral, but highlighted the need for dedicated government funding of healthcare human resources to support the potentially increased volume of self-referred patients, noting this should not replace or reduce funding for professionals who routinely manage OA.

Would be strongly agree for patients who have already been diagnosed with OA...Why do we need to be re-referred every 6–12 months. It's not like the OA is suddenly go away or be cured. Self-referral could

allow shorter wait times for OA patients and less time with pain or other issues (woman)

Funding is always an issue. Self-referrals should be promoted but not at the expense of the health care professionals that deal with this... ie, the government should have special funding for these self-referral programs (healthcare professional)

Women in round 1 (82.9%) and round 2 (90.6%) agreed to retain: expand the scope of practice of professionals (eg, physiotherapists, occupational therapists, pharmacists) so that they can refer persons with OA for tests or services. Professionals did not (round one 72.4%, round two 54.6%), and the strategy was discarded. Comments from five professionals emphasised that this strategy should only be considered if professional colleges provided formal training in OA to avoid inappropriate testing.

This strategy is of the highest priority, not only for the many without a primary care physician, but because OA patients engage on a regular basis with our pharmacist, physio therapist, etc (woman)

I only recommend this if the healthcare profession has adequate training on everything OA...There are already enough professions which have adequate training in the matter in my opinion (healthcare professional)

While neither group in round 1 agreed to retain: increase diversity of healthcare professionals and policy-makers (eg, more ethnically diverse or women providers), in round 2, women agreed to retain it (81.3%), professionals did not (68.2%) and the strategy was discarded. Comments did not reflect these ratings. Two women

Table 2 Strategies that achieved consensus to retain

Level	Strategy	Panellists who rated to retain (%)
Patient 7 of 8 strategies retained	Consider patients' cultural needs and economic circumstances when offering treatment, self-care advice and/or programmes (eg, language, cost of services from physiotherapists, chiropractors, dietitians, etc)	93.8
	Offer education sessions about OA and self-management to persons with OA (women-only, group, in-person and virtual, multiple languages, across Canada, free, at workplaces or community centres)	90.6
	Provide educational material about OA to persons with OA (brochures physicians can hand out, posters in community settings and online, in multiple languages, include culturally relevant information)	90.6
	Healthcare professionals that first learn about patients' OA concerns or symptoms should refer them for manual therapy (eg, physiotherapy, chiropractic therapy, occupational therapy)	90.6
	Involve interpreters (family or professional) to translate spoken language during healthcare appointments	81.3
	Have regular follow-up visits with patients to monitor progress (eg, following self-management advice, symptom control)	81.3
	Offer peer support groups for persons with OA to help with self-care (virtual and in-person, multiple languages)	81.3
Clinician 7 of 7 strategies retained	Healthcare professionals should engage patients by inquiring about OA management needs and preferences (suggested in round 1)	98.1
	Ensure that all healthcare professionals have a full picture of patients' health history via shared records	93.8
	Provide healthcare professionals with OA educational materials to give to patients	92.2
	Provide healthcare professionals with information or tools to help them diagnose and treat OA in persons from disadvantaged groups	89.1
	Provide healthcare professionals with training on bias and cultural sensitivity	87.5
	Provide healthcare professionals with timely access to interpreters	87.5
	Provide medical school education and education about how to diagnose and manage OA	85.9
System 13 of 16 strategies retained	Develop public spaces in all communities that promote physical activity (eg, bicycle/walking paths)	93.8
	Evaluate the equity of OA programmes or policies in healthcare organisations using existing tools (eg, surveys, measures, instruments) that are designed to assess equity of access to and quality of care among disadvantaged groups	90.7
	Implement OA-specific clinics or centres (eg, one-stop clinics where patients can access various healthcare professionals (family physicians, physiotherapists, chiropractors, social workers, etc))	89.1
	Engage diverse persons with OA, healthcare professionals to develop a Canadian OA strategy	89.1
	Engage diverse women and other disadvantaged groups in planning OA policies, strategies and programmes	87.0
	Advocate for and fund research on equitable access to and quality of OA care (suggested in round 1)	87.0
	Publicly fund services for OA management (eg, ensure that provincial health insurance covers services from physiotherapists, chiropractors, dietitians, etc)	85.9
	Implement primary care hubs in underserved areas for disadvantaged groups that include primary care physicians and nurses in community agencies	84.4
	Collect and share data about the health experiences of disadvantaged groups (eg, diverse women) to understand their specific OA needs and preferences	84.4
	Train lay health leaders or community health workers from disadvantaged communities to assist persons with OA in their community with OA self-management	84.4

Continued

Table 2 Continued

Level	Strategy	Panellists who rated to retain (%)
	Fund OA diagnosis and management (eg, primary care, manual therapy, exercise therapy, self-management education, etc) as part of home care services (suggested in round 1)	81.3
	Allow persons with OA to self-refer to clinics or self-management programmes (eg, patients do not need to rely on primary care provider for a referral)	81.3
	Offer health promotion campaigns to the public on how to prevent and manage OA in a variety of formats and settings including but not limited to social media, billboards, cultural media, shops, places of worship, etc	81.3
OA, osteoarthritis.		

recommended hiring the best person for the job regardless of sex or ethnicity, and one professional emphatically agreed on the need for greater diversity in the healthcare workforce.

Just hire the best person for the job (woman)

Absolutely. By 'ethnically diverse women' for 'ethnically diverse women', type of idea (healthcare professional)

Women agreed (91.4%) to retain: publicly fund services for OA management (eg, ensure that provincial health insurance covers services like physiotherapy), although they offered no related comments, while professionals did not (79.3%). Overall, the strategy was retained in round 1. Comments from two professionals agreed with this strategy provided funding was targeted to professionals trained in OA regardless of specialty.

I love this idea! As long as the funding only goes to professionals who are adequately trained on OA (healthcare professional)

Women agreed (90.6%) to retain the strategy suggested in round 1: fund OA diagnosis and management (eg, primary care, manual therapy, exercise therapy, self-management education, etc) as part of home care services. Professionals did not (68.2%), but overall, the strategy was retained in round 2. Three women agreed with this strategy, particularly if delivered in a non-threatening manner by providers who speak their language, noting benefits for those with mobility issues and for ethno-culturally diverse women who may be looking after children and older parents, and not have time, money or knowledge to access outside services. Three professionals also agreed, particularly for older persons with mobility issues, many of whom do not have coverage for extended health benefits. In contrast, one professional said that affected persons should be encouraged to leave their home because physical activity is a best practice for OA management.

Fund OA diagnosis and management (eg primary care, manual therapy, exercise therapy, self-management education, etc) as part of home care services—this is extremely important. Most seniors

do not have extended health insurance and that presents as a huge barrier to getting the proper care and guidance (woman)

Important as many of these folks will be more willing and able to be accessed via home care as they may be looking after children and older parents/multi-generational households and not have time, money or knowledge to access outside services (healthcare professionals)

DISCUSSION

Ethno-culturally diverse women with OA and healthcare professionals from across Canada achieved consensus on 27 of 31 strategies to support equitable access to person-centred care for women with OA including 7 patient-level, 7 clinician-level and 13 system-level strategies. Consensus was strong as we defined consensus as 80% or greater of all respondents rating strategies either 6 or 7 on a 7-point Likert scale, and of the 27 that achieved consensus, at least 90% of respondents agreed. Women and professionals agreed on all but one patient-level strategy and all clinician-level strategies. Some discrepancies emerged for five system-level strategies that were more highly rated by women. Analysis of comments revealed general support among professionals for these five system-level strategies provided that additional funding or expanded scope of practice was targeted to only formally trained professionals and did not reduce funding for professionals who already managed OA.

This research builds on and expands prior efforts to describe optimal OA health services. For example, an international Delphi study generated 70 capabilities of professionals who manage OA that largely reflected clinical management and included 5 items categorised as person-centred care that emphasised engaging persons with OA in their care but did not address inequities or intersectional factors such as gender or ethno-cultural group.³³ Of 173 respondents, 26 were consumers, but consumer characteristics were not reported.³³ An analysis of 6 international OA guidelines generated 46 clinical interventions to manage OA that were subsequently rated by 16 respondents from across Europe.³⁴ While items rated

were referred to as patient-centred standards of care, they represented clinical management, and while the respondents included patients, the number and characteristics of patients was not reported.³⁴ A panel of 5 females and 5 males aged 52–80 years in the UK attended four meetings, and through ranking and discussion, generated 15 quality indicators of OA management in primary care.³⁵ The indicators refer to giving information, advice, support or referrals to self-manage OA, but none directly address inequities or intersectional factors, and the characteristics of participants were not reported.³⁵ While important to set standards of OA care, these initiatives did not identify concrete strategies needed to achieve equitable person-centred OA care, which may require healthcare reforms such as those identified in our study.³⁶ Furthermore, it is not clear if these initiatives engaged ethno-culturally diverse women and whether the outputs reflect their perspectives. Therefore, our study has generated unique insight on multilevel strategies that could mitigate challenges contributing to inequities, and improve access to and quality of OA care for diverse women.

These findings raise several implications. One obstacle to implementing these strategies may be the sheer number, necessitating a phased approach potentially informed by priority level. For instance, while 27 strategies achieved strong consensus ($\geq 80\%$), 9 strategies achieved very high consensus ($\geq 90\%$) including 4 patient-level, 3 clinician-level and 2 system-level strategies. Hence, healthcare organisations or governments with strained resources could proceed to first focus on these nine strategies as a means of launching beneficial change while undertaking planning that might enable implementation of additional strategies in the future. Yet another way to prioritise strategy implementation is to consider comments offered by respondents, which reflect relevance and feasibility.

Some strategies may be relatively straightforward to implement, for example, develop a national OA strategy. To do so, insight could be gained from prior initiatives. For example, Australia designated OA as health priority and established a national OA policy in 2002, but subsequent evaluation revealed only two examples of service redesign, and authors concluded that the lack of reformed service models and support for healthcare professionals hampered improvements.³⁷ Another study compared 41 national policies relevant to musculoskeletal health including OA, and generated 47 principles that could support the implementation of OA policy across 8 domains: service delivery, workforce, medicines and technologies, financing; data and information systems, leadership and governance; citizens, consumers and communities and research and innovation.³⁸

Other prioritised strategies may be more challenging to implement due to resource implications, for example, allow persons with OA to self-refer may require the implementation of systems to accommodate such referrals and additional human resources to manage the volume. The same is true of including OA diagnosis and management in home care programmes, implementing primary care

hubs or OA-specific centres, developing a built environment in all communities and publicly funding OA management for all. Some of these strategies may require the compilation of existing evidence or generation of new evidence to inform how they could be implemented.

Other strategies prioritised in this study inform ongoing research: conduct research on equitable access to and quality of OA care, and evaluate the equity of current OA policies and programmes. It will be essential to engage diverse persons with lived experience in planning health-care policies and programmes; this has become a standard means of ensuring that health services reflect and address the clinical requirements, individual circumstances and personal preferences of diverse persons.³⁹ Considerable guidance has accumulated on the capacity and processes needed to engage diverse persons with lived experience in a meaningful way.^{40–43}

This study has several strengths. We employed rigorous methods and complied with research standards for conducting and reporting Delphi studies.^{22–26} We actively engaged a 13-member advisory group of diverse women in planning and executing this study. We identified strategies from multiple sources (published research, guidelines, policies, diverse women, professionals of differing specialties) through primary research.^{17 30–32} Strategies were rated by a larger number of respondents than is typical of most Delphi studies to ensure that participants reflected varied perspectives of women and professionals from across Canada to generate national consensus, and because larger sample size has been shown to enhance reliability.^{27 28} Prioritised strategies reflect strong consensus within and across groups of women and professionals, and because they are multilevel, stand to address barriers identified at the patient-level, clinician-level and system-level.^{14 15 18–21} We must also mention potential study limitations. As volunteers, the participants may have a particular interest in OA, thus their views may be biased. Because we focused on ethno-culturally diverse women, the prioritised strategies may not be relevant to those from other disadvantaged groups. The prioritised strategies may not be relevant to women or professionals outside of Canada with differing health systems.

CONCLUSIONS

We identified 27 multilevel strategies (7 patient-level, 7 clinician-level and 13 system-level) that have the potential to mitigate inequities, and improve access to and quality of OA care for diverse women. If needed, implementation could be prioritised to strategies that achieved 90% or greater agreement, or based on respondent comments about relevance and feasibility. Further research may be needed to establish how best to implement these strategies.

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Correction notice: priority strategies to reduce socio-gendered inequities in access to person-centred osteoarthritis care: Delphi survey

Iziduh S, Abenoja A, Theodorlis M, *et al* Priority strategies to reduce socio-gendered inequities in access to person-centred osteoarthritis care: Delphi survey. *BMJ Open* 2024;14:e080301. doi: 10.1136/bmjopen-2023-080301

The above mentioned article is corrected since it was published. The second author is changed from “Angela Abenoja” to “Angelina Abbaticchio”.

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Supplementary File 1. Strategies to improve equitable, person-centred OA care by strategy level and source**Patient-level strategies**

“Patient-level strategies” are those *offered to persons with OA to improve knowledge, confidence, behaviour, OA symptoms, OA status, or quality of life.*

Strategy		Source				
		Review	Guidelines	Policies	Professionals	Women
1	Involve interpreters (family or professional) to translate spoken language during healthcare appointments				X	X
2	Offer education sessions about OA and self-management to persons with OA (women-only, group, in-person and virtual, multiple languages, across Canada, free, at workplaces or community centres)				X	X
3	Provide educational material about OA to persons with OA (brochures physicians can hand out, posters in community settings and online, in different languages, include culturally relevant information)	X	X	X	X	X
4	Provide question prompt tools to persons with OA to help them prepare to ask questions, raise concerns, and offer information during healthcare appointments				X	X
5	Consider patients’ cultural needs and economic circumstances when offering treatment, self-care advice and/or programs (e.g., language, cost of services such as physiotherapy)	X			X	X
6	Healthcare professionals that first learn about patients’ OA concerns or symptoms should refer them for manual therapy (e.g., physiotherapy)				X	X
7	Have regular follow-up visits with patients to monitor progress (e.g., following self-management advice, symptom control)					X
8	Offer peer support groups for persons with OA to help with self-care (virtual and in-person, multiple languages)					X

Clinician-level strategies

“Clinician-level strategies” are those *offered to healthcare professionals to improve OA knowledge, confidence, behaviour, or skills.*

Strategy		Source				
		Review	Guidelines	Policies	Professionals	Women
9	Provide medical school education and mandatory (i.e. required) continuing education about how to diagnose and manage OA				X	X
10	Provide healthcare professionals with training on bias and cultural sensitivity			X	X	X
11	Provide healthcare professionals with timely access to interpreters				X	X
12	Provide healthcare professionals with OA educational materials to give to patients				X	X
13	Provide healthcare professionals with information or tools to help them diagnose and treat OA in persons from disadvantaged groups		X		X	
14	Ensure patient health records are linked so that all healthcare professionals have a full picture of patients’ health status				X	

System-level strategies

“System-level strategies” are those *developed and/or offered by health systems or government to improve access to OA care, advice and support.*

Strategy		Source				
		Review	Guidelines	Policies	Professionals	Women
15	Allow persons with OA to self-refer to clinics or self-management programs (e.g., patients do not need to rely on primary care provider for a referral)				X	
16	Offer health promotion campaigns to the public on how to prevent and manage OA in a variety of formats and settings (e.g., social media, billboards)				X	X
17	Expand the scope of practice of healthcare professionals (e.g. physiotherapists, occupational therapists, pharmacists) so that they can refer persons with OA for tests or services				X	X
18	Increase diversity of healthcare professionals and policymakers (e.g., more ethnically diverse or women providers)				X	X
19	Publicly fund services for OA management (e.g., ensure that provincial health insurance covers services like physiotherapy)				X	X
20	Offer a telephone support line that persons with OA can call for information about OA				X	
21	Implement OA-specific clinics or centres (e.g., one-stop clinics where patients can access various healthcare professionals such as family physicians, physiotherapists, social workers)				X	X
22	Develop a Canadian OA strategy and clinical pathway (e.g., collaboration between governments and healthcare professionals to create policies and guidelines to improve OA care)				X	
23	Develop public spaces in all communities that promote physical activity (e.g., bicycle/walking paths)				X	
24	Engage diverse women and other disadvantaged groups in planning OA policies, strategies and programs				X	
25	Implement primary care hubs in underserved areas for disadvantaged groups that include primary care physicians and nurses in community agencies				X	
26	Collect and share data about the health experiences of disadvantaged groups (e.g., diverse women) to understand their specific healthcare needs and preferences				X	
27	Evaluate the equity of programs or policies in healthcare organizations using formal tools or frameworks			X		
28	Train lay health leaders or community health workers from disadvantaged communities to assist persons in their community with OA in self-management			X		

Supplementary Appendix 2. Delphi results

Patient-level strategies

Item	Strategy	Suggested revision from Round One	Round 1 (rating)	Round 2 (rating)	Decision
1	Involve interpreters (family or professional) to translate spoken language during healthcare appointments	None	Retain (81.3%)	---	Retain
2	Offer education sessions about OA and self-management to persons with OA (women-only, group, in-person and virtual, multiple languages, across Canada, free, at workplaces or community centres)	None	Retain (90.6%)	---	Retain
3	Provide educational material about OA to persons with OA (brochures physicians can hand out, posters in community settings and online, in multiple languages, include culturally relevant information)	None	Retain (90.6%)	---	Retain
4	Provide question prompt tools to persons with OA to help them prepare to ask questions, raise concerns, and offer information during healthcare appointments	Provide question prompt tools (pre-formed list of questions considered important by diverse persons with OA) to persons with OA to help them prepare to ask questions, raise concerns, and offer information during healthcare appointments	No consensus (76.6%)	79.6%	Discard
5	Consider patients' cultural needs and economic circumstances when offering treatment, self-care advice and/or programs (e.g., language, cost of services such as physiotherapy)	Consider patients' cultural needs and economic circumstances when offering treatment, self-care advice and/or programs (e.g., language, cost of services from physiotherapists, chiropractors, dieticians, etc.)	Retain (93.8%)	---	Retain
6	Healthcare professionals that first learn about patients' OA concerns or symptoms should refer them for manual therapy (e.g., physiotherapy)	Healthcare professionals that first learn about patients' OA concerns or symptoms should refer them for services that include but are not restricted to manual therapy, exercise therapy or education, self-management programs, nutrition counseling, etc.	50.00%	90.7%	Retain

7	Have regular follow-up visits with patients to monitor progress (e.g., following self-management advice, symptom control)	None	Retain (81.3%)	---	Retain
8	Offer peer support groups for persons with OA to help with self-care (virtual and in-person, multiple languages)	None	Retain (81.1%)	---	Retain

Clinician-level strategies

Item	Strategy	Suggested revision from Round One	Round 1 (rating)	Round 2 (rating)	Decision
9	Provide medical school education and mandatory (i.e. required) continuing education about how to diagnose and manage OA	Provide medical school education and mandatory (i.e. required) continuing education about how to diagnose and manage OA	Retain (85.9%)	---	Retain
10	Provide healthcare professionals with training on bias and cultural sensitivity	None	Retain (87.5%)	---	Retain
11	Provide healthcare professionals with timely access to interpreters	None	Retain (87.5%)	---	Retain
12	Provide healthcare professionals with OA educational materials to give to patients	None	Retain (92.2%)	---	Retain
13	Provide healthcare professionals with information or tools to help them diagnose and treat OA in persons from disadvantaged groups	None	Retain (89.1%)	---	Retain
14	Ensure patient health records are linked so that all healthcare professionals have a full picture of patients' health status	Ensure patient health records are linked so that all healthcare professionals have a full picture of patients' health status history	Retain (93.8%)	---	Retain

System-level strategies

Item	Strategy	Suggested revision from Round One	Round 1 (rating)	Round 2 (rating)	Decision
15	Allow persons with OA to self-refer to clinics or self-management programs (e.g., patients do not need to rely on primary care provider for a referral)	None	Retain (81.3%)	---	Retain
16		Offer health promotion campaigns to the public on how to prevent and manage OA in a variety of		81.5%	Retain

	Offer health promotion campaigns to the public on how to prevent and manage OA in a variety of formats and settings (e.g., social media, billboards)	formats and settings including but not limited to social media, billboards, cultural media, shops, places of worship, etc.)	No consensus (79.7%)		
17	Expand the scope of practice of healthcare professionals (e.g. physiotherapists, occupational therapists, pharmacists) so that they can refer persons with OA for tests or services	Expand the scope of practice of healthcare professionals such as physio- or occupational therapists, chiropractors, pharmacists, etc. along with training so that they can refer persons with OA for tests or services	No consensus (78.1%)	75.9%	Discard
18	Increase diversity of healthcare professionals and policymakers (e.g., more ethnically diverse or women providers)	None	No consensus (78.1%)	75.9%	Discard
19	Publicly fund services for OA management (e.g., ensure that provincial health insurance covers services like physiotherapy)	Publicly fund services for OA management (e.g., ensure that provincial health insurance covers services from physiotherapists, chiropractors, dieticians, etc.)	Retain 85.9%	---	Retain
20	Offer a telephone support line that persons with OA can call for information about OA	None	No consensus (67.2%)	67.3	Discard
21	Implement OA-specific clinics or centres (e.g., one-stop clinics where patients can access various healthcare professionals (family physicians, physiotherapists, chiropractors, social workers, etc.)	Implement OA-specific clinics or centres (e.g., one-stop clinics where patients can access various healthcare professionals (family physicians, physiotherapists, chiropractors, social workers, etc.)	Retain (89.1%)	---	Retain
22	Develop a Canadian OA strategy and clinical pathway via collaboration of governments and healthcare professionals to improve OA care	Engage diverse persons with OA, healthcare professionals to develop a Canadian OA strategy	Retain (89.1%)	---	Retain
23	Develop public spaces in all communities that promote physical activity (e.g., bicycle/walking paths)	None	Retain (93.8%)	---	Retain
24	Engage diverse women and other disadvantaged groups in planning OA policies, strategies and programs	None	No consensus (79.7%)	87.0%	Retain
25		None	Retain (84.4%)	---	Retain

	Implement primary care hubs in underserved areas for disadvantaged groups that include primary care physicians and nurses in community agencies				
26	Collect and share data about the health experiences of disadvantaged groups (e.g., diverse women) to understand their specific OA needs and preferences	None	Retain (84.4%)	---	Retain
27	Evaluate the equity of OA programs or policies in healthcare organizations using formal tools or frameworks	Evaluate the equity of OA programs or policies in healthcare organizations using existing tools (e.g. surveys, measures, instruments) that are designed to assess equity of access to and quality of care among disadvantaged groups	No consensus (78.1%)	90.7%	Retain
28	Train lay health leaders or community health workers from disadvantaged communities to assist persons with OA in their community with OA self-management	None	Retain (84.4%)	---	Retain

Additional strategies

Recommended by Round One respondents and rated only in Round Two

Item	Strategy	Suggested revision from Round One	Round 1 (rating)	Round 2 (rating)	Decision
29	Fund OA diagnosis and management (e.g. primary care, manual therapy, exercise therapy, self-management education, etc.) as part of home care services	---	---	81.5%	Retain
30	Advocate for and fund research on equitable access to and quality of OA care	---	---	87.0%	Retain
31	Healthcare professionals should engage patients by inquiring about OA management needs and preferences	---	---	98.1%	Retain

Supplementary Appendix 3. Respondent comments about strategies

Patient-level strategies

Item	Strategy	Comments	
		Women	Professionals
1	Involve interpreters (family or professional) to translate spoken language during healthcare appointments	<ul style="list-style-type: none"> I feel it's very important for people who do not speak English to have a proper understanding of their diagnosis of OA As an immigrant, English not my first language. Translation is very important to avoid misunderstand in medical issue. 	<ul style="list-style-type: none"> Family Interpreters often miss words and meaning and do not provide full translation. Interpreters are not accessible to primary care outside of CHCs
2	Offer education sessions about OA and self-management to persons with OA (women-only, group, in-person and virtual, multiple languages, across Canada, free, at workplaces or community centres)	<ul style="list-style-type: none"> Early OA seems to be mandatory education and a preventative strategy since 60% of women get OA in later life. In addition to teaching and education on OA, include education that pain is not a normal part of wellness and encourage persons with OA to seek support or seek support for loved ones. 	<ul style="list-style-type: none"> The education material focuses on anatomy which is not always the best way to approach pain. Pain is multi-factorial but the education usually focuses on the one anatomical structure that is causing pain. Also, exercises/lifestyle changes are not always relevant, i.e. going to a gym, aquafit, someone wearing athletic clothes
3	Provide educational material about OA to persons with OA (brochures physicians can hand out, posters in community settings and online, in multiple languages, include culturally relevant information)	<ul style="list-style-type: none"> Offer educational materials to both persons with OA and family, friends, children etc. Or placed strategically in e.g., pharmacies, gym, spiritual centers Have information to educate. Patient can study first, less worry and anxiety. It best to get the patient fully involved and well informed about their health care plan so as to give a good compliant treatment from the patient. 	<ul style="list-style-type: none"> Although I believe that education is important, what will work best re how this education or 'self-learning' takes places needs to be determined by the patient.
4	Provide question prompt tools (pre-formed list of questions considered important by diverse persons with OA) to persons with OA to help them prepare to ask questions, raise concerns, and offer information	<ul style="list-style-type: none"> Providing prompt question tools would be so helpful I am not sure what 'question prompt tools' are. It would be most beneficial for your organization or another to provide a list of questions which diverse women think are important so that healthcare practitioners can offer the lists to their patients May be challenging for people who may not speak English 	<ul style="list-style-type: none"> Not sure if I agree with prompting questions, especially if they are leading the patient to ask certain types of questions. I would ask - "What do you want to know?" What are you hoping to achieve from attending this appointment" Maybe have prompting questions that promote individual learning and self-management that is meaningful to them People may not realize what they do not know, so having questions may assist with them identifying their learning needs. Tools would need to be clear. Providing a list of pre-formed questions for OA patients to ask, would be similar to providing pre-

	during healthcare appointments	<p>well, and/or lack confidence in communicating with health professionals. Encouraging people to bring someone they trust with them to appointments to help with communication would be another good strategy.</p> <p>Strategy 5 may be challenging for people to access, either due to a lack of time or a lack of money - if there is any charge for these services.</p> <p>Physiotherapy, for example, is difficult to access in some provinces if you cannot pay for a private physio.</p>	<p>set questions and answers about OA and to offer information, in the patient information brochures that are going to be provided to these patients at the doctor's offices. Hence, it's best to let each person bring their own personal questions to each visit.</p>
5	Consider patients' cultural needs and economic circumstances when offering treatment, self-care advice and/or programs (e.g., language, cost of services from physiotherapists, chiropractors, dieticians, etc.)	<ul style="list-style-type: none"> - Also agree that patients should have the proper resources and connections for treatment and support in order for them to be able to control their pain and know that they are not the only ones that have OA - All of these are no brainers to me that they would help; providing services in the language the patients speaks and understands, is simply inclusive. - Providing workshops and training for just women helps to support cultures/religions that have limits around interactions with men, and also provides a uniquely tailored learning environment to address the needs of women. - It is very professional to consider patients' cultural needs as Canada is a multicultural community with immigrants all over the world. 	<ul style="list-style-type: none"> - Given this work is really to target more of the racialized communities you really need to make sure the interventions are being provided in the language they understand and MUST be culturally safe.
6	Healthcare professionals that first learn about patients' OA concerns or symptoms should refer them for services that include but are not restricted to manual therapy, exercise therapy or education, self-	<ul style="list-style-type: none"> - Recommend manual therapy should be free for those that do not have insurance coverage or consider free for all otherwise this is a cost that many groups may not be able to pay for. This is a preventive measure that would potentially reduce overall patient health care - Note manual therapy indicates passive therapies performed on patient - i.e. joint mobilization, manipulation, massage, etc. 	<ul style="list-style-type: none"> - This referral should be made but should be partnered with the education piece that manual therapy would be a helpful supportive care method but is not expected to be curative. - Referrals for manual therapy is very specific to issue where there is joint or soft tissue restriction, instead, need referral for exercise and education...could be an athletic therapist., physio, kinesiologist, exercise therapy etc. - Referring patients directly to manual therapy (chiropractic, physiotherapy) could be very beneficial. However, cost might be a deterrent as well as make the patient more reliant on passive

	management programs, nutrition counseling, etc.	<p>Whereas physiotherapy itself, while it can include these things, should be focussed primarily on exercise as first line treatment for OA. So this question may be confusing the way it is written.</p> <ul style="list-style-type: none"> - I believe exercise prescriptions can be as valuable and less costly than manual therapy or passive interventions in the treatment of OA. Dietician counselling can also be of value - I am uncertain if manual therapy is always the first step in treatment of symptoms. But, I do feel assessment by a physiotherapist would be of benefit. - Mental Wellness to improve quality of life of OA patients. - Proactive informed self-assessment supported by health care professionals. When in doubt, consult without feeling guilty. - Who is covering the costs? If the person does not have private insurance through work or spouse, then I recommend that some of these options be available to those who can not pay for them. These costs do get expensive especially if you have no additional/supplemental insurance to pay for it. - Health care should be a collaboration between the professional and the patient. Both need information. - Free access to needed care is important as most do not have insurance to cover these costs. - Referral to other services is fine but would be more helpful with "in-house" services in the same building, as well as cost concerns/ support as those asking for help often have little extra money for these "extra" services. Often those wanting help do not want those referring them by asking WHERE those services are located. Having someone from 	<p>care when active care techniques are most important.</p> <ul style="list-style-type: none"> - Physiotherapy should be affordable - Generally referring to physiotherapy is a great first step. I would just caution on "manual therapy" as OA generally requires exercise based treatment and not solely passive modalities (ie. manual therapy, massage, IFC/TENS). If a patient has severe OA, sending them to physiotherapy alone and not to a specialist/HK RAC for review of surgical options may prolong their pain and course of care. I think referral to physiotherapy should ALWAYS occur for active exercise based treatment but may also require referral to specialist. - I do not believe that all OA patients require manual Physiotherapy but can benefit from other offerings by PT. OA patients do not necessarily need a lot of professional follow-up for each course of care; a self-management program that is presented thoroughly can be a valuable tool. It is also important to gauge a client's readiness for change and provide them contacts to reach out as this increases. - Manual therapy is not the only type of treatment so really don't agree with everyone being referred to a passive modality for management. - Healthcare providers talking about OA management needs and preferences needs to be built into already existing clinical pathways or it may be forgotten - perhaps through a custom form when doing annual exams for example? - The only concerns is access to some of these services... nutrition counseling and manual therapy are often quite costly and not covered for many patient. Also, manual therapy is a bit of a vague term... should elaborate if the includes physiotherapy, chiropractics, athletic therapy.... - It is essential for patients to learn about how to self manage OA, but these services are very limited/not easy to access. E.g. hip and knee rapid access clinics only see patients once for surgical triage, and we know it takes time and reinforcement for patients to change behaviours & adopt the lifestyle changes necessary to manage effectively. - Depending on the degree of OA a patient has, it may pertinent to refer on to a specialist at the time that the HCP first learns about the patients OA in order to ensure timely access. This doesn't meant hey can't ALSO refer for physiotherapy/exercise therapy etc. This can be done in tandem. Want to make sure that it doesn't come across that every patient should be referred for conservative management BEFORE referring to a specialist, this may be required in tandem.
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		<p>their home community accompany them to the first appointment instead of just referral would be of more help/ more successful.</p> <ul style="list-style-type: none"> I strongly recommend healthcare professionals to have the basic knowledge of OA before a patient is being referred to OA specialists 	<ul style="list-style-type: none"> There is a view that patients are "over-treated" with conditions such as OA. While in some cultures it is seen as a natural form of aging and they will adapt behaviours and self-manage. Referral to programs implies that they are prioritizing their time, money, and resources towards treatment options that may or may not be more effective than activity modification and self-management. (i.e. if it hurts when I do x then I don't do x). These patients should be given the chance to have earlier referrals, knowing that earlier intervention and access to manual therapy and rehab are essential, and can help improve QOL for these patients.
7	Have regular follow-up visits with patients to monitor progress (e.g., following self-management advice, symptom control)	none	<ul style="list-style-type: none"> I think that this would be helpful, but I am not aware of any evidence which recommends an appropriate timeframe for supportive follow-up visits. Are you? If this is an agreed on recommendation, I highly recommend we come to a consensus for a timeframe of follow-up (monthly, bi-monthly, etc) Self-management of OA is key, and would be a priority for referring
8	Offer peer support groups for persons with OA to help with self-care (virtual and in-person, multiple languages)	<ul style="list-style-type: none"> Have a support group even better to share the tips how to cope with and manage the pain and daily activities. I think offering peer support groups is a great idea since peers find it very easy to communicate amongst each other and free enough unlike with other people who are not of their age or class etc. 	<ul style="list-style-type: none"> I'm not sure what you mean by "peer support group". And if such support groups are provided, how likely are individuals with OA to attend these, whether in person or virtual, and how beneficial can these really be? If this includes individuals with OA who manage their own symptoms and can now offer support to those who are currently having OA symptoms but have a hard time managing it, then how much can they really offer, given one strategy might work for one person, and not so much for another.

Clinician-level strategies

Item	Strategy	Comments	
		Women	Professionals
9	Provide medical school education and continuing education about how to diagnose and manage OA	<ul style="list-style-type: none"> Continuous education for healthcare professionals is very valuable with most updated medical information. With good training and awareness on the new skills, care provider will have adequate resources to help in prompt diagnosis and treatment of the patient. Again are you not doing these things? How very very sad. This survey is disappointing in that I am shocked to see that this isn't a strategies you are using. Sorry but have you been hiding under a rock? Go to any health department and these strategies are already in play. The admin person should be catching cultural needs and flagging the medical file as needing 	<ul style="list-style-type: none"> There is an overwhelming evidence for incorporating degenerative joint disease into the medical school curriculum. I disagree with the concept of "mandatory continuing education" as all continuing education is based on the professional identifying learning needs and as an adult learner, they should have choice in what they engage in. It would better to have practitioners with a certain level of post graduate OA education to receive a certificate or recognition level such that they can promote their skills and attract patients with OA to a practitioner with additional skills. Mandatory training does not translate into practice skill unless the practitioner wishes to focus their skills. "Mandatory" is too strong a term for CPD

		<p>this. If I have to have 200 hours to keep of training every 5years to keep my ECE licence I would hope doctors have mandatory training as well. Yes! Yes to everything.</p> <ul style="list-style-type: none"> While an advantage, I wonder how practical it is to set a goal of "continuing" education for ALL healthcare professionals. I'd rather see some "know a lot," rather than all know "some." 	<ul style="list-style-type: none"> There is a lot of content to cover in school to be prepared for work in the real world. Continuing education is very person specific and should address a population that you provide care for.
10	Provide healthcare professionals with training on bias and cultural sensitivity	none	<ul style="list-style-type: none"> I could not agree more with the need to provide healthcare professional with training on bias and cultural sensitivity. New research is showing DEI training (although not the same as what is asked in the question) does not necessarily help to overcome peoples' bias.
11	Provide healthcare professionals with timely access to interpreters	<ul style="list-style-type: none"> Rating based on reasonable translation. If outside French, English or language of doctor then a family member should be acting as a translator. Make sure interpreters can not only translate the spoken and printed word correctly in "healthcare jargon" but can also provide the flavour/details of what the patient sees as their area(s) of concern and what they (the patient) believes they need to know/where the patient wants help. Interpreters need to have the confidence of the patient and represent the patient's concerns accurately to healthcare professionals. 	none
12	Provide healthcare professionals with OA educational materials to give to patients	<ul style="list-style-type: none"> Getting knowledge about the tools that professionals should use to prevent OA is awesome since having enough knowledge is not just a factor but the most important thing to a doctor when taking a patient like one with OA. 	<ul style="list-style-type: none"> Some standardized materials to distribute would be nice, but they must include thorough education, reassurance, options of care, prognosis, etc. if they are to actually be used.
13	Provide healthcare professionals with information or tools to help them diagnose and treat OA in persons from disadvantaged groups	---	---
14	Ensure that all healthcare professionals	<ul style="list-style-type: none"> —A holistic system of patient health records can include and track OA awareness, education and follow up for 	<ul style="list-style-type: none"> Very important as patient sometimes forget or does not want to disclose that they have seen other health professionals.

	have a full picture of patients' health history	<p>vulnerable women. Sadly, current focus is on seniors, too late for prevention or remedial support.</p> <ul style="list-style-type: none"> It's very important for the healthcare professional to know exactly what the patient's history involving OA diagnosis is. For example tests and procedures that might have been done on the patient is good for the doctor to review before they see the patient to better understand their history. The linking of patient records to have a full picture is also very important and hope that clinicians use it before meeting with clients. Sometimes they look so rushed and ask the same questions, you know they did not even read the patient records. 	<ul style="list-style-type: none"> Linking records will make a difference for all healthcare of persons Health records should be linked and if not bc most PT care is private than there should be another form of communication between providers. Would be nice, but another reasonable method would be to emphasize inter-professional communication about an OA diagnosis and what the practitioner is doing about it. Optimal but still unrealistic. Linking HCR for all HCP to have a full picture of a patient's health history is ideal, but not realistic. Many facilities use different EHR's, some may not be compatible. Different doctors have different approaches to obtaining patient health history. Why not have the patient equipped with their health history in an app on their smart devices, which they can carry with them to doctor's visits, and the doctors can obtain this information upon request? Many patients from disadvantaged groups access healthcare through community partners/health teams. They may not feel comfortable coming to a large hospital and may not have a family doctor that can refer them to specialist care. Therefore health records or communication between community partners (i.e. Access Alliance) and our hospitals need to be coordinated.
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System-level strategies

Item	Strategy	Comments	
		Women	Professionals
15	Allow persons with OA to self-refer to clinics or self-management programs (e.g., patients do not need to rely on primary care provider for a referral)	<ul style="list-style-type: none"> Strongly agree. Allow persons with OA to self-refer to clinics or self-management programs (e.g., patients do not need to rely on primary care provider for a referral) Would be strongly agree for patients who have already been diagnosed with OA. They should need to be referred once by a physician the first time to make sure that it is not another medical issue and is most likely OA. Once diagnosed and referred you should be able to contact services yourself, Physiotherapy or Occupational Therapy, or see a social worker. Why do we need to be re-referred every 6-12 months. It's not like the OA is suddenly go away or be cured. Self referral could allow shorter wait times for OA patients and less time with pain or other issues. 	<ul style="list-style-type: none"> Funding is always an issue. Self-referrals should be promoted but not at the expense of the health care professionals that deal with this... i.e. the government should have special funding for these self-referral programs. I am not sure we have the resource capacity to support the potential volumes if patients were to self-refer. As it is we have gone from a wait of 2-4 weeks from referral to consult RAC clinic, to 4-8 weeks wait post COVID due to increased volumes. Ministry funds only 1.8 FTE APP role, and we use donor/physician funding for additional resources. We will not be able to meet the demand unless we are funded for additional APP bodies for triage and management.
16	Offer health promotion campaigns to the	<ul style="list-style-type: none"> I would rather see money that would go into a publicity campaign that could only be general in nature be 	<ul style="list-style-type: none"> Strategies should promote improving clients knowledge on how to manage arthritis

	public on how to prevent and manage OA in a variety of formats and settings including but not limited to social media, billboards, cultural media, shops, places of worship, etc.)	<p>used to offer training to healthcare workers such as nurse practitioners, physiotherapists etc.</p> <ul style="list-style-type: none"> – Billboards, various media need to be in local multi-cultural newspapers, etc. where the population will come into contact with it eg. food markets, places of worship – Just as women's heart health matters, Osteoporosis, breast cancer public campaigns have increased public awareness, govt funding & service delivery, Osteoarthritis can be elevated as a major medical issue for women – Would recommend multilingual so that everyone could approach – Very important to educate patients on OA as some believe it is the end of their active days – Promoting 'we can still live happily with OA coping skills' – Public health promotion generates earlier self-assessment, health self-management and use of multilingual community medical services. I no longer want doctors to tell me whether my pain is real or not. It's probably more cost effective due to the proactive strategy for self-care 	<ul style="list-style-type: none"> – Prevention is the first level of healthcare. system-level strategies are the only organizations that have the funding and pull to promote OA prevention at this level. Very important! – Health promotion - this is ultimately the strategy for improving overall wellness. Maintaining healthy weight, healthy eating, literacy for 'physical fitness' and healthy coping mechanisms with mood are the pillars for effective OA care – MAKE SURE Health Promotion and ALL promotions? (OA) programmes aimed at this demographic is multilingual as are the presenters (if at all possible) – Sure, if this is what we think patients with OA need, then why not. But instead of talking about it, we should just do it.
17	Expand the scope of practice of healthcare professionals such as physio- or occupational therapists, chiropractors, pharmacists, etc. along with training so that they can refer persons with OA for tests or services	<ul style="list-style-type: none"> – As both a person with OA & an advanced practice clinician, many patients are sent for unnecessary/incorrect imaging that does not change management plan when a good clinical exam can diagnose OA and then management is fairly straightforward (exercise & pain control) It would be more beneficial to teach clinicians how to assess/diagnose OA using clinical exam and best practice management (e.g. better dissemination of the OA tool amongst allied health clinicians). Have seen many chiropractors send patients for unnecessary x-rays and then only offer manual therapy afterwards – This strategy is of the highest priority, not only for the many without a primary care physician, but because OA patients engage on a regular basis with our pharmacist, physio therapist, etc. It is much like the current strategy at many dental practices to check 	<ul style="list-style-type: none"> – Having allied professionals ordering tests like imaging should come with formal training first, so not to have unnecessary tests being ordered due to lack of provider training – Enhancing scope for practitioners to order test for OA does not make sense given that tests are rarely indicated I would worry about an increase in inappropriate ordering – These practitioners can already refer to medical specialties for novel interventions for OA. That being said, diverse women may not be able to afford chiro or physios. You should ask them which professions would be most convenient for them to help them manage their OA – I believe that between chiro and physios, who seem to exist on every corner of every town, there is already adequate practitioners with scope of practice to manage OA patients. – I believe that this may lead to unnecessary imaging requests (especially MRI) or bloodwork. I think expanding the scope for specific designated HCP's (ie. ACPAC trained clinicians, NPs, Advanced Practice Providers)

		<p>blood pressure of patients, providing a valuable service.</p> <ul style="list-style-type: none"> – Services must be available in their area 	<p>is fine but community PTs/chiro/OTs may not have the skillset/expertise to assess what is needed and what is not. We don't want to have patients undergo imaging or bloodwork if it is not needed/appropriate. Referral for bracing and services should be able to be done by any registered healthcare profession.</p> <ul style="list-style-type: none"> – I only recommend this if the healthcare profession has adequate training on everything OA, or their college is determined to provide the training on the matter before expanding their scope. There are already enough professions which have adequate training in the matter in my opinion – The ACPAC program is a perfect example of extended scope training to address this patient population. I don't think simply allowing PT/OTs to diagnosis and order imaging etc. is the answer. These professions need to have adequate training in orthopedics and inflammatory arthritis (as is provided in the ACPAC program) to allow for effective management of this patient population – Ideally for multiple MSK conditions to optimize resource to need ratio – Expanding the scope of allied healthcare professionals is a controversial topic (especially with the recent pharmacist role expansion). As physicians, we have seen such initiatives in the past create more cost to the health care system and more work for us to correct error or misinterpretations of tests which create unnecessary patient anxiety. Proper training is needed for many such initiatives, but often is not considered or done properly – Yes, easy access to images and tests by HCPs can definitely reduce doctor visits (for a need to get a referral from MD first), and reduced wait times. HCP's are also able to interpret diagnostic images results, so there is no need to go back to MD
18	Increase diversity of healthcare professionals and policymakers (e.g., more ethnically diverse or women providers)	<ul style="list-style-type: none"> – Just hire the best person for the job 	<ul style="list-style-type: none"> – Increase diversity of healthcare professionals and policymakers (e.g., more ethnically diverse or women providers). I would prefer that you pick the brightest and best! I don't care about their sex or ethnicity. I want them to be skilled and knowledgeable, that is way more important – Absolutely. By "ethnically diverse women" for "ethically diverse women", type of idea
19	Publicly fund services for OA	none	<ul style="list-style-type: none"> – I love this idea! As long as the funding only goes to professionals who are adequately

	management (e.g., ensure that provincial health insurance covers services like physiotherapy) (85.9%)		<p>trained on OA, and doesn't discriminate on the trained professional based on their profession</p> <ul style="list-style-type: none"> - Access to primary care is an obstacle for many of these patients, especially newcomers. - Access to publicly funded Physiotherapy clinics is also very limited
20	Offer a telephone support line that persons with OA can call for information about OA	<ul style="list-style-type: none"> - I question the value of a phone support line believing one-on-one assistance would be superior - A telephone helpline is only as helpful as the information which can be provided and the nuance and insight the staff can provide. If you call a health-line and the licensed practical nurse on the other side just reads off of a website script and doesn't have any OA experience, it's not useful. If they escalate you to a registered nurse you just tells you to go see your family doctor/chiropractor, then that's useless as well. This service would be provided by people who have experience managing OA in their patients who would like to volunteer their time or get a small paycheque to work for the phone line for a few hours per week. We actually appreciate the variety in our work days 	<ul style="list-style-type: none"> - When you implement supports like telephone supports. It is often those who are educated/privileged etc. who access these resources because they are savvy enough to search and find the resources that they need to help with their condition - I like this better than the brochures in the doctor's offices, and if this is implemented, it will also eliminated the need for pre-formed questions and answers, which was asked in the patient-level strategies
21	Implement OA-specific clinics or centres (e.g., one-stop clinics where patients can access various healthcare professionals (family physicians, physiotherapists, chiropractors, social workers, etc.))	<ul style="list-style-type: none"> - Develop OA specific clinic is a good 	<ul style="list-style-type: none"> - Offering OA specific clinics might turn into an MVA-clinic, where lots of different providers offer basic, generic care, using standard methods, and the patient-centred aspect of care might diminish over time - We currently have 2.2M Ontarians without access to a primary care provider - referrals from PCPs into a program like this is not going to be feasible if there are restrictions. Any OA specific clinics MUST be integrated with the already existing health services...including EMR integration and feedback in and out
22	Develop a Canadian OA strategy and clinical pathway via collaboration of governments and healthcare professionals to improve OA care	<ul style="list-style-type: none"> - There is already OA Tool https://www.cfpc.ca/CFPC/media/Resources/Education/OATOOL_FINAL_Sept14_ENG.pdf would be better to spend on creating awareness & uptake of this tool - In theory yes, but it is my belief that these collaborations are often very expensive and do not benefit patients the same way they benefit government and policy makers. Too many times the money is wasted on 	---

		ideas that don't work instead of therapies and services that benefit OA patients	
23	Develop public spaces in all communities that promote physical activity (e.g., bicycle/walking paths)	<ul style="list-style-type: none"> - Suggested add some health equipment in park or walking path so that we can do exercise in the park and no need to go to Gym to do it. Like bicycle etc. 	<ul style="list-style-type: none"> - Public spaces to promote physical activity needs to keep separate areas for elderly individuals walking at a slow pace, and a biking route for those who want to ride through, to reduce the chance of bikers impacting those walking slowly on their path
24	Engage diverse women and other disadvantaged groups in planning OA policies, strategies and programs	<ul style="list-style-type: none"> - Yes, serve your patients! - Most important to get diverse women and other disadvantaged groups planning OA policies, strategies programs and supports. - Need to really look at ways to communicate to smaller towns and areas to support people of diverse backgrounds, socially and economically, on managing OA. Whether this is city/town exercise programs to help with OA or questions about the disease. Look at video tapes that can be available at library/town halls in smaller communities. Look at video tapes for exercise programs if no instructor is in you area 	<ul style="list-style-type: none"> - Ideally the proportion of women in health care & as policymakers, etc. should equal the proportion of women in general population - This is great. Maybe through telephone or online surveys
25	Implement primary care hubs in underserved areas for disadvantaged groups that include primary care physicians and nurses in community agencies	<ul style="list-style-type: none"> - Helping the disadvantaged is a lofty goal. Got to figure a way to educate in a cost effective manner - Listen to your patients. Come on now this is basic stuff. Just because they are diverse doesn't mean you don't do this 	<ul style="list-style-type: none"> - Should also include physiotherapy
26	Collect and share data about the health experiences of disadvantaged groups (e.g., diverse women) to understand their specific OA needs and preferences	none	none
27	Evaluate the equity of OA programs or policies in healthcare organizations using existing tools (e.g. surveys, measures, instruments) that are designed to	<ul style="list-style-type: none"> - I don't even understand the question - evaluate, yes; but what are "formal tools or frameworks?" - Access to equitable OA care, should be available to all, regardless of economic or social circumstances. If the readily available in person, look for online / Zoom/ In-person if someone is trained 	<ul style="list-style-type: none"> - Well, if we want to know where we're going, we have to first understand where we are. It's important to evaluate what is already in place, before we can make changes

	assess equity of access to and quality of care among disadvantaged groups		
28	Train lay health leaders or community health workers from disadvantaged communities to assist persons with OA in their community with OA self-management	<ul style="list-style-type: none"> – Train lay health leaders ... to lead (not follow) with what they know works in their community 	

Strategies added after round #1 survey

Item	Strategy	Women	Professionals
29	Fund OA diagnosis and management (e.g. primary care, manual therapy, exercise therapy, self-management education, etc.) as part of home care services	<ul style="list-style-type: none"> – More funding for preventative measures, access to allied professionals should be considered for all (not sure what you mean by home care, but it should be offered to all who require it) – Fund OA diagnosis and management (e.g. primary care, manual therapy, exercise therapy, self-management education, etc.) as part of home care services - this is extremely important. Most seniors do not have extended health insurance and that presents as a huge barrier to getting the proper care and guidance – As part of home care services?? Best practice for the OA population with respect to exercise/mobility is around outpatient care. So supporting services that force the patient to go outside of their home for walks, community programs, exercise and physiotherapy is just as important if not more important than having those services come into their home. For some severe or bedbound patients or those in rural areas home care options are important but for others it is important to get them out of the home 	<ul style="list-style-type: none"> – First line treatment based on best evidence is exercise & pain control regardless of location of joint with OA. I would remove manual therapy from this, it is not economically efficient to fund ongoing manual therapy for patients when in my 10y experience of working in arthritis care exercise is cost effective and much more effective long term for pain management of OA joints. – Due to mobility issues, in-home health care services would alleviate self-care management in aging. Empowering patients about needs & preferences lead to more self-accountability. The predicted increase in the aging population implies the need for more advocacy, funding & research. It's social evolution – Important as many of these folks will be more willing and able to be accessed via home care as they may be looking after children and older parents/ multi-generational households and not have time, money or knowledge to access outside services. Having programs/ visits more like a visit from a friend in their first language should be more successful/ less threatening – Support early OA education and prevention over management in home care – Yes, for elderly individuals who may not have easy access to facilities, or may not be able to get out of the house easily, it's best to have funding and peace of mind that they can self-manage and do their exercises, even funding for supervision initially

30	Advocate for and fund research on equitable access to and quality of OA care	<ul style="list-style-type: none"> - Is the OA care not accessed in a equitable way? I don't see this as a problem. Provide care to all who need it. Have information like pamphlets etc. available in multiples languages. Provide interpreter when needed. Are you not doing this? Follow the same guidelines as VCH or BCCFA and you will be fine. Put money into programs, and free PT and OT and education - Yes, any research that goes into this will help with future policy making, planning and patient care - Is the OA care not accessed in a equitable way? I don't see this as a problem. Provide care to all who need it. Have information like pamphlets etc. available in multiples languages. Provide interpreter when needed. Are you not doing this? Follow the same guidelines as VCH or BCCFA and you will be fine. Put money into programs, and free PT and OT and education 	<ul style="list-style-type: none"> - Yes, any research that goes into this will help with future policy making, planning and patient care
31	Healthcare professionals should engage patients by inquiring about OA management needs and preferences	<ul style="list-style-type: none"> - The more time you show that you are interested in your patients' health, you engage and involve them in the planning of their treatments, the more the patients become more open, and cooperate fully to the success of their treatment regimen - Yes, this should be part of the patient history taking, so it's a given 	<ul style="list-style-type: none"> - Yes, this should be part of the patient history taking, so it's a given