

## 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"> <li>I feel it's very important for people who do not speak English to have a proper understanding of their diagnosis of OA</li> <li>As an immigrant, English not my first language. Translation is very important to avoid misunderstand in medical issue.</li> </ul>	<ul style="list-style-type: none"> <li>Family Interpreters often miss words and meaning and do not provide full translation.</li> <li>Interpreters are not accessible to primary care outside of CHCs</li> </ul>
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"> <li>Early OA seems to be mandatory education and a preventative strategy since 60% of women get OA in later life.</li> <li>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.</li> </ul>	<ul style="list-style-type: none"> <li>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</li> </ul>
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"> <li>Offer educational materials to both persons with OA and family, friends, children etc. Or placed strategically in e.g., pharmacies, gym, spiritual centers</li> <li>Have information to educate. Patient can study first, less worry and anxiety.</li> <li>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.</li> </ul>	<ul style="list-style-type: none"> <li>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.</li> </ul>
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"> <li>Providing prompt question tools would be so helpful</li> <li>I am not sure what 'question prompt tools' are.</li> <li>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</li> <li>May be challenging for people who may not speak English</li> </ul>	<ul style="list-style-type: none"> <li>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"</li> <li>Maybe have prompting questions that promote individual learning and self-management that is meaningful to them</li> <li>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.</li> <li>Providing a list of pre-formed questions for OA patients to ask, would be similar to providing pre-</li> </ul>

	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"> <li>- 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</li> <li>- 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.</li> <li>- 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.</li> <li>- It is very professional to consider patients' cultural needs as Canada is a multicultural community with immigrants all over the world.</li> </ul>	<ul style="list-style-type: none"> <li>- 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.</li> </ul>
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"> <li>- 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</li> <li>- Note manual therapy indicates passive therapies performed on patient - i.e. joint mobilization, manipulation, massage, etc.</li> </ul>	<ul style="list-style-type: none"> <li>- 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.</li> <li>- 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.</li> <li>- 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</li> </ul>

	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"> <li>- 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</li> <li>- 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.</li> <li>- Mental Wellness to improve quality of life of OA patients.</li> <li>- Proactive informed self-assessment supported by health care professionals. When in doubt, consult without feeling guilty.</li> <li>- 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.</li> <li>- Health care should be a collaboration between the professional and the patient. Both need information.</li> <li>- Free access to needed care is important as most do not have insurance to cover these costs.</li> <li>- 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</li> </ul>	<p>care when active care techniques are most important.</p> <ul style="list-style-type: none"> <li>- Physiotherapy should be affordable</li> <li>- 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.</li> <li>- 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.</li> <li>- Manual therapy is not the only type of treatment so really don't agree with everyone being referred to a passive modality for management.</li> <li>- 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?</li> <li>- 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....</li> <li>- 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 &amp; adopt the lifestyle changes necessary to manage effectively.</li> <li>- 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.</li> </ul>
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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"> <li>I strongly recommend healthcare professionals to have the basic knowledge of OA before a patient is being referred to OA specialists</li> </ul>	<ul style="list-style-type: none"> <li>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.</li> <li>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).</li> <li>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.</li> </ul>
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"> <li>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)</li> <li>Self-management of OA is key, and would be a priority for referring</li> </ul>
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"> <li>Have a support group even better to share the tips how to cope with and manage the pain and daily activities.</li> <li>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.</li> </ul>	<ul style="list-style-type: none"> <li>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.</li> </ul>

### 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"> <li>Continuous education for healthcare professionals is very valuable with most updated medical information.</li> <li>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.</li> <li>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</li> </ul>	<ul style="list-style-type: none"> <li>There is an overwhelming evidence for incorporating degenerative joint disease into the medical school curriculum.</li> <li>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.</li> <li>"Mandatory" is too strong a term for CPD</li> </ul>

		<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"> <li>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."</li> </ul>	<ul style="list-style-type: none"> <li>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.</li> </ul>
10	Provide healthcare professionals with training on bias and cultural sensitivity	none	<ul style="list-style-type: none"> <li>I could not agree more with the need to provide healthcare professional with training on bias and cultural sensitivity.</li> <li>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.</li> </ul>
11	Provide healthcare professionals with timely access to interpreters	<ul style="list-style-type: none"> <li>Rating based on reasonable translation. If outside French, English or language of doctor then a family member should be acting as a translator.</li> <li>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.</li> </ul>	none
12	Provide healthcare professionals with OA educational materials to give to patients	<ul style="list-style-type: none"> <li>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.</li> </ul>	<ul style="list-style-type: none"> <li>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.</li> </ul>
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"> <li>—A holistic system of patient health records can include and track OA awareness, education and follow up for</li> </ul>	<ul style="list-style-type: none"> <li>Very important as patient sometimes forget or does not want to disclose that they have seen other health professionals.</li> </ul>

	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"> <li>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.</li> <li>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.</li> </ul>	<ul style="list-style-type: none"> <li>Linking records will make a difference for all healthcare of persons</li> <li>Health records should be linked and if not bc most PT care is private than there should be another form of communication between providers.</li> <li>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.</li> <li>Optimal but still unrealistic.</li> <li>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?</li> <li>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.</li> </ul>
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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"> <li>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)</li> <li>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.</li> </ul>	<ul style="list-style-type: none"> <li>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.</li> <li>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.</li> </ul>
16	Offer health promotion campaigns to the	<ul style="list-style-type: none"> <li>I would rather see money that would go into a publicity campaign that could only be general in nature be</li> </ul>	<ul style="list-style-type: none"> <li>Strategies should promote improving clients knowledge on how to manage arthritis</li> </ul>

	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"> <li>– 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</li> <li>– Just as women's heart health matters, Osteoporosis, breast cancer public campaigns have increased public awareness, govt funding &amp; service delivery, Osteoarthritis can be elevated as a major medical issue for women</li> <li>– Would recommend multilingual so that everyone could approach</li> <li>– Very important to educate patients on OA as some believe it is the end of their active days</li> <li>– Promoting 'we can still live happily with OA coping skills'</li> <li>– 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</li> </ul>	<ul style="list-style-type: none"> <li>– 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!</li> <li>– 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</li> <li>– MAKE SURE Health Promotion and ALL promotions? (OA) programmes aimed at this demographic is multilingual as are the presenters (if at all possible)</li> <li>– 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.</li> </ul>
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"> <li>– As both a person with OA &amp; 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 &amp; 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</li> <li>– 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</li> </ul>	<ul style="list-style-type: none"> <li>– 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</li> <li>– 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</li> <li>– 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</li> <li>– 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.</li> <li>– 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)</li> </ul>



		<p>blood pressure of patients, providing a valuable service.</p> <ul style="list-style-type: none"> <li>– Services must be available in their area</li> </ul>	<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"> <li>– 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</li> <li>– 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</li> <li>– Ideally for multiple MSK conditions to optimize resource to need ratio</li> <li>– 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</li> <li>– 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</li> </ul>
18	Increase diversity of healthcare professionals and policymakers (e.g., more ethnically diverse or women providers)	<ul style="list-style-type: none"> <li>– Just hire the best person for the job</li> </ul>	<ul style="list-style-type: none"> <li>– 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</li> <li>– Absolutely. By "ethnically diverse women" for "ethically diverse women", type of idea</li> </ul>
19	Publicly fund services for OA	none	<ul style="list-style-type: none"> <li>– I love this idea! As long as the funding only goes to professionals who are adequately</li> </ul>



	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"> <li>- Access to primary care is an obstacle for many of these patients, especially newcomers.</li> <li>- Access to publicly funded Physiotherapy clinics is also very limited</li> </ul>
20	Offer a telephone support line that persons with OA can call for information about OA	<ul style="list-style-type: none"> <li>- I question the value of a phone support line believing one-on-one assistance would be superior</li> <li>- 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</li> </ul>	<ul style="list-style-type: none"> <li>- 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</li> <li>- 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</li> </ul>
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"> <li>- Develop OA specific clinic is a good</li> </ul>	<ul style="list-style-type: none"> <li>- 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</li> <li>- 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</li> </ul>
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"> <li>- There is already OA Tool <a href="https://www.cfpc.ca/CFPC/media/Resources/Education/OATOOL_FINAL_Sept14_ENG.pdf">https://www.cfpc.ca/CFPC/media/Resources/Education/OATOOL_FINAL_Sept14_ENG.pdf</a> would be better to spend on creating awareness &amp; uptake of this tool</li> <li>- 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</li> </ul>	---

		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"> <li>- 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.</li> </ul>	<ul style="list-style-type: none"> <li>- 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</li> </ul>
24	Engage diverse women and other disadvantaged groups in planning OA policies, strategies and programs	<ul style="list-style-type: none"> <li>- Yes, serve your patients!</li> <li>- Most important to get diverse women and other disadvantaged groups planning OA policies, strategies programs and supports.</li> <li>- 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</li> </ul>	<ul style="list-style-type: none"> <li>- Ideally the proportion of women in health care &amp; as policymakers, etc. should equal the proportion of women in general population</li> <li>- This is great. Maybe through telephone or online surveys</li> </ul>
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"> <li>- Helping the disadvantaged is a lofty goal. Got to figure a way to educate in a cost effective manner</li> <li>- Listen to your patients. Come on now this is basic stuff. Just because they are diverse doesn't mean you don't do this</li> </ul>	<ul style="list-style-type: none"> <li>- Should also include physiotherapy</li> </ul>
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"> <li>- I don't even understand the question - evaluate, yes; but what are "formal tools or frameworks?"</li> <li>- 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</li> </ul>	<ul style="list-style-type: none"> <li>- 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</li> </ul>

	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	– 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"> <li>– 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)</li> <li>– 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</li> <li>– 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</li> </ul>	<ul style="list-style-type: none"> <li>– First line treatment based on best evidence is exercise &amp; 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.</li> <li>– Due to mobility issues, in-home health care services would alleviate self-care management in aging. Empowering patients about needs &amp; preferences lead to more self-accountability. The predicted increase in the aging population implies the need for more advocacy, funding &amp; research. It's social evolution</li> <li>– 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</li> <li>– Support early OA education and prevention over management in home care</li> <li>– 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</li> </ul>

30	Advocate for and fund research on equitable access to and quality of OA care	<ul style="list-style-type: none"> <li>- 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</li> <li>- Yes, any research that goes into this will help with future policy making, planning and patient care</li> <li>- 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</li> </ul>	<ul style="list-style-type: none"> <li>- Yes, any research that goes into this will help with future policy making, planning and patient care</li> </ul>
31	Healthcare professionals should engage patients by inquiring about OA management needs and preferences	<ul style="list-style-type: none"> <li>- 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</li> <li>- Yes, this should be part of the patient history taking, so it's a given</li> </ul>	<ul style="list-style-type: none"> <li>- Yes, this should be part of the patient history taking, so it's a given</li> </ul>