MSK foot health services in the brave new world

Professor Anthony Redmond

Foot and Ankle Studies in Rheumatology (FASTER) Program
Academic Unit of Musculoskeletal Disease
School of Medicine, University of Leeds

The scale of the need (an update)

- Musculoskeletal Disorders (MSDs)
  - 1 in 4 of all adults have an MSD at any one time
  - 1 in 2 of over 75s
  - In 2/3 of people MSK problems are multi-joint
- Foot problems
  - 20% of all adults had foot pain in the past month
  - 60% in the past six months
  - One quarter of all over 55s have ongoing foot pain
  - MSK problems cause 2x symptoms
    - 68% hyperkeratoses
    - 24% digital lesions
    - 17% ulcerations

Foot problems and consultation

- NorStOP
  - 13,986 participants aged >50 years
  - ‘Have you had any problems with your feet over the last year?’ or ‘Have you had pain in the last year in and around the foot?’
  - 18/12 follow up re consultation

Menz et al Rheumatology 2010: 49.11

CiPCA (N.Staffs)

- 12 GP practices reviewed for 2006
- 55,033 MSK consultations
- 4500 (8%) = foot and ankle
- 79% of these non traumatic
- M:F = 45:55%
- Increased demand with age to 74 years

Menz et al Rheumatology 2010: 49.11

NorStOP

- 3858 with foot problems had not consulted already
- Only 9% consulted in the next 18/12
- Main drivers
  - Pain (2x more likely)
  - Expectation of treatment (1.5x)
  - Frequent flyers (1.7x)
Department of Health

- MSK on the radar
- Embarrassed in EU
- Anne Milton (LTC) now has MSK portfolio
- ARMA and MSK associations all lobbying for:
  - National Clinical Director for MSK
  - National Strategy for MSK

NICE CG - podiatry

- **Recommendation 14** All people with RA and foot problems should have access to a podiatrist for assessment and periodic review of their foot health needs
- **Recommendation 15** Functional insoles and therapeutic footwear should be available for all people with RA if indicated.

Department of Health

- National Quality Board
- Bruce Keogh positive about MSK
- QOF
  - Osteoporosis
  - RA
- This week DH announced that RA is on list for NICE Quality Standards
- AQP......

Musculoskeletal conditions

- Rheumatoid arthritis
- Osteoarthritis
- Metabolic disease
  - Gout
  - Pseudogout
- Connective tissue disease
  - Lupus
  - Scleroderma
- Sero-negative disease
  - Psoriatic arthritis
  - Ankylosing spondylitis
  - Reactive arthritis
- Soft tissue problems
- Sports’ injuries
- Misc MSK
- Pod biomechanics
- Orthopaedics
- Rehab medicine
- Pod surgery

NICE RA guidelines

- Feb 2009
- Highly influential in mainland UK
- Widely endorsed
- Covers all aspects of RA care
- Specific podiatry section

Opportunities eg new model of RA care

- Medical management much improved in last 10 years
  - Early aggressive Tx
  - Biologics
- Diminishing numbers of patients with uncontrolled/end stage RA/PsA/AS/CTDs
**Disease staged management**
- Better medical management
- Opportunity for better podiatric management
- Needs vary over the lifetime/course of the disease(s)
- Getting the timing of Tx right
- Better use of skill mix

**General foot care**
- Nail cutting, corn and callus reduction, provision of padding.
  - MSK conditions = increased need for a range of basic foot care services (Muir-Gray 1994)
  - 3/4 of rheumatology outpatients require routine foot care (Williams & Bowden 2004)
  - Evidence for benefit of callus reduction in RA ‘equivocal’. (Donny et al. 2005)
  - Desperate need for evidence
    - CoP trial

**What podiatrists currently provide**
Foot health service provision for rheumatology falls into five categories.
- Education and self management advice, including footwear advice
- General foot care, nail cutting, corn and callus reduction, provision of padding
- Provision of, or assistance with finding orthoses and footwear
- High risk management of the vasculitic or ulcerative foot
- Extended Scope Practice (ESP) and surgery

**Need for evidence**
- Eg REFORM
- CoP trial
- NIHR
  - Opportunity for dialogue
  - AHP specific schemes
  - Local engagement (RfPB)

**Education and self management advice**
- Education programs commonplace.
- Self management = improved health status (Rao & Hootman 2004), but….
- Education allows patients to participate in their management
- Provision of information/education is considered a minimum standard in the care of RA (ARMA 2004)
- Promotion of independence and self directed care a real opportunity

**Footwear education**
- Footwear advice
- Examples of footwear
- Brochures to take away
- Internet sites
- Good local knowledge – up to date
- Build up a departmental footwear resource pack for other health professionals
High risk footcare

Management of the ‘high risk’ vasculitic or ulcerative foot.
- Accounts for approximately ¼ of Leeds rheumatology foot health clinic’s appointments
- Rheumatology patients made up 6% of the total caseload of one multi-system wound care service (Steed et al. 1993)
- Prevention and management of lesions in the high risk foot is an important part of the foot health service in rheumatology (Korda & Balint 2004)
- Some big business initiatives in MSK eg Tracleer in SSc/scleroderma

Extended scope practice

Extended Scope Practice
- Enhanced investigations – ultrasound, a revolution on the horizon
- Interventions
  - Injectable steroids (ARMA 2004)
  - Supplementary/independent prescribing
- Support for extending AHP roles (Cay 2007)
  - Government
  - Professions
  - Rheumatologists
- Issues relating to cost effectiveness

No one thought TVs would be in every room either.
Real time example

Case 1
Diagnosis/referral – the AQP black hole

Three criteria for suspecting IA in primary care (after Emery et al 2002) - early referral!

1. pain on lateral squeeze MTP/MCP joints
2. ≥3 swollen joints
3. morning stiffness of ≥30 minutes

http://www.arthritisresearchuk.org/

• Early/first presentation in small joints (RA, PsA) or entheses (AS)
• Early/first presentation in the feet and ankles
  - RA (20-50%)
  - AS (enthesitis in 20-50% [Clinical vs US]): Foot pain first presentation in 25%
  - PsA [nails, dactylitis]
Early intervention

- Pathology (macrophagic phase vs fibroblastic phase)
- Diagnosis and ACR/EULAR classification criteria
- Anti-CCP antibody (ACPA) testing vs Rh factor

Early Tx
- Delay reduces chance of any remission
- Very early Tx = possible drug free remission?


AQP

AQP in musculoskeletal foot disorders

- 90% or more of community dwelling podiatry patients probably suitable for primary care podiatry.
- However... the few % who are not can be exposed to serious risk of harm.
- Significant USP in our expertise
AQP – the importance of good information

Core podiatry - the assessment, diagnosis and treatment of common foot pathologies associated with the toenails, soft tissues and the musculoskeletal system with the purpose of sustaining or improving foot health’

AQP in musculoskeletal foot disorders

- Does cover
  - Long Term conditions where the risk of foot ulceration and infection is low, e.g. low risk diabetes, stable and low risk rheumatoid arthritis, multiple sclerosis, Parkinson’s disease
  - Structural and functional abnormalities
  - “Non-specialised biomechanical clinics”

AQP in RA

“Management of podiatric need of patients with rheumatoid arthritis.”

- To be responsible for the podiatric assessment, diagnosis, planning and implementation, delivery and evaluation of people with rheumatoid arthritis assessed as Low Current Risk
- Excluding the at risk rheumatoid foot as defined by:
  - Current use of TNF blockers, other biological disease modifying agents, or systemic immunosuppressants.
  - A history of more than five years of medication with oral steroids.
  - Current or recent vasculitis in the past 12 months.
  - A history of ulceration and/or skin infection related to their inflammatory disease.
- No reference at all to NICE, NWCEG

AQP specification

- Includes patients with RA (but not with ‘inflammatory arthritis’)
- Now excludes anyone requiring anti-TNF or immunosuppression
- “Does not cover”
  - Personal foot care
  - Specialist podiatry covering diabetes; peripheral arterial disease; systemic musculo-skeletal disorders; immune mediated connective tissue disorders;
  - Complex biomechanics.

AQP response

- Commissioners/referrers need to be shown that the transistor of AQP increases likelihood of harm for a small number of patients
  - Limit damage from inappropriate downstream referrals
  - Provide clear examples of upstream re-referral
- NHS providers can demonstrate excellence and USP
- Commissioned services at threat around periphery of AQP
  - Communication
  - Skill mix
  - USP
Standards of Care (PRCA/ARMA)

- Recommendations relate to the needs of patients
- The standards acknowledge that those planning and delivering foot health services around the UK face differing demographic, geographic and economic factors
- The standards are not treatment guidelines or algorithms of care, though they refer to these where available.
- Generic Foot Health Standards
  - standards of foot health care that everyone with musculoskeletal foot health problems should be able to expect.
- Disease Specific Foot Health Standards
  - supplementary standards that are additional to the generic standards and are unique to those with specific musculoskeletal conditions.
    - Inflammatory arthritis, osteoarthritis, back pain, metabolic bone disease, connective tissue disorders

Summary

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Further reading

- Redmond and Helliwell. Musculoskeletal Disorders in Neale’s Disorders of the Foot 8th Ed. Churchill Livingstone 2010
- PRCA/ARMA Standards of Care
  www.prcassoc.org.uk/standards-project
- NICE Guidelines
  OA- http://guidance.nice.org.uk/CG59
  RA- http://guidance.nice.org.uk/CG79