
Reporting on Access to Care

By Henry L. Aaverns, MBChB, FRCP(UK), FRCPC; and Michel Zimmer, MD, FRCPC

We are pleased to update you on the key activities that the Access to Care Committee (ATCC) over the past year. Our focus continues to be on improving care for the Aboriginal population, working with the Wait Time Alliance (WTA), and collaborating with the Arthritis Alliance of Canada (AAC) and the Ontario Rheumatology Association (ORA).

We have successfully improved the Limited Use Criteria for provision of biologic therapy to patients covered by the Non-Insured Health Benefits (NIHB) program. CRA members have been very kind in passing on further advice to us that was shared with the NIHB program over the summer. Some of the discomfort about the forms and processes has been shared, but there are many systematic barriers impeding the pace we wish to set. We are embarking on a new project to focus on access to medication for pediatric patients. These discussions progress slowly but steadily, and whilst we feel our relationship with the team at the NIHB program is a good one, we have to develop modest ambitions for the timeframe of change.

At the CRA Annual General Meeting (AGM) we held a session for CRA members interested in the specific challenges faced by the indigenous population. Dr. David Robinson described his research interests, involving the development of a program to train nurses in remote communities to share the care and help deliver services to patients. We will repeat this event at the next CRA meeting.

Dr. Nigil Haroon has now completed his term as Chair of the WTA; his leadership until this point has been invaluable. Whilst the CRA defines its commitment to the process, Dr. Aaverns will assume the role of Chair, but this is a responsibility that will ultimately be taken on by another CRA member once we have a better definition of the scope of the tasks that lie ahead. If you are interested in this area please contact Dr. Aaverns via his website, www.rheumors.com. The WTA is comprised of several national medical specialty societies who work in collaboration with stakeholders. The rheumatology benchmarks have been submitted under the section "Arthritis Care".

Current clinical conditions and their respective benchmark wait times are on the WTA website; these include rheumatoid arthritis (RA), spondyloarthritis (SpA), psoriatic arthritis (PsA), systemic lupus erythematosus (SLE), juvenile idiopathic arthritis (JIA), and JIA uveitis screening.

The WTA met in September to continue exploring ways of collecting and communicating reliable and meaningful data to inform our strategies. Its role has shifted from a data collecting watchdog to one of seeking solutions for Canadian patients. We also met with some MPs to share our concerns and to raise the profile of wait times with the federal government.

The AAC, in collaboration with the provinces and key stakeholders in the health system, recently published *A Pan-Canadian Approach to Inflammatory Arthritis Models of Care*. The report establishes a framework for the development of high-quality models of inflammatory arthritis (IA) care that are evidence-based and reinforced by best practices. To complement the report, the AAC developed an "IA Care Path and Tool Kit", a comprehensive map of each step of the patient's journey through the health care system.

Together with the provinces and key stakeholders, the AAC is defining system-level performance measures for IA care in Canada. These measures will serve as a toolkit for healthcare decision-makers to evaluate health systems and inform system changes with the goal of developing safe, cost-effective, efficient, high-quality care for patients.

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