

Optimal Care Committee

By Henry L. Averbs, MBChB, FRCP(UK), FRCPC

I have continued my role as Chair, aware that such joy should be shared with others, and keen therefore to pass on the honour to someone new. Please form an orderly line up at the next CRA meeting or email me if you are interested.

The Optimal Care Committee—formerly Access to Care—continues to focus on our relationship with the Non-Insured Health Benefits Program (NIHB); to this end I have continued to meet with them twice a year to discuss issues raised by our members and to offer advice on future guidelines and processes. Our relationship is a good one. Occasionally I have to hear pharmacists report on less satisfactory phone calls with our colleagues, and perhaps this is an opportunity to remind you that I am happy to be a conduit for your frustrations. I met recently with them to help with the process of developing guidelines for the use of biologic therapies in patients with psoriatic arthritis (PsA). We also discussed which outcomes are reasonable to expect to be recorded when requesting access to these agents; I chose to steer more towards robust outcomes such as swollen joint count, and to try to avoid scores requiring access to lab work, which is often challenging on the day of the consultation with the patient.


The NIHB continues to request information specifically to inform their policies regarding the pediatric population and I repeat my request for members to offer any advice or examples of issues to be shared with the Optimal Care Committee. Meanwhile Dr. Brent Ohata is developing some educational tools for improving the knowledge of fellows, and ultimately members, on the unique challenges and needs of our indigenous population. We look forward to hearing more from him at the next CRA meeting.

It is with a heavy heart that I must announce that the Wait Time Alliance (WTA) members have not met this year, and have enjoyed a period of hibernation and reflection. Many of you are aware that this is a meeting that I keenly anticipate each year. Of course, our commitment to defining benchmarks for reasonable waits remains strong, but at present our role is to develop more robust frameworks allowing collection of reliable and meaningful data.

While a specific release date has not yet been decided, the WTA plans to provide the new Minister of Health with a report card in the early days of the new government. Wait-time data were taken from provincial wait-time websites in spring and early summer of 2015. Those provinces that did

well in 2014 continue to be the best performers in 2015, namely, Saskatchewan, Ontario, and Newfoundland and Labrador. In terms of specific rheumatology data, we have a series of question marks and no data at all at present, which I think gels pleasingly with many of my consultations. One suspects that in Ontario, trying to persuade rheumatologists to balance a 6% fee cut with better wait times might not receive universal acclaim. So it is with a tear falling to the page that I dip my quill for a final time.

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