Strategic Clinical Networks

By Dianne Mosher, MD, FRCPC; and Joanne Homik, MD, FRCPC

Alberta's 15 Strategic Clinical Networks (SCNs) were created to engage healthcare workers, patients, researchers and administrators to find new and innovative ways to deliver care and provide improved clinical outcomes and better quality care with demonstrated cost effectiveness.

The Bone and Joint Health Strategic Clinical Network (BJH SCN) is Alberta's primary vehicle for provincial bone and joint strategies that aim to keep Albertans healthy, provide high-quality care when they are sick, ensure they have access to care when they need it, and improve their journey through the health system. In Alberta, someone enters a doctor's office every 60 seconds seeking treatment for a bone or joint problem. This rate of demand will only increase as Alberta's population grows, ages and lives longer. The BJH SCN will help manage and reduce the impact of bone and joint health issues on our system while improving patient care.

Key successes include a reduction in hospital stay for hip and knee replacement from 4.7 to 3.8 days, the introduction of 13 physiotherapy clinics delivering the GLA:D program (Good Living with osteoArthritis: Denmark), and screening 14,455 Albertans with signal fracture for osteoporosis.

The Arthritis Working Group of the SCN has identified two key factors for improving care for patients suffering from Inflammatory Arthritis (IA) in Alberta: (1) increase capacity for care, and (2) decrease disparity in clinical care and outcomes. Both were addressed in a shared care model for IA and an accompanying measurement framework. Presently three successful models are being evaluated for key learnings: (1) The nurse-led clinical team at South Health Campus; (2) On-TRAAC program in Edmonton; and (3) Telemedicine program in Pincher Creek. These clinics provide exemplary cases of shared care that should be replicated to improve access and reduce disparities.

Dr. Dianne Mosher, Professor of Medicine, Division Head, Rheumatology, University of Calgary, Calgary, AB

Dr. Joanne Homik, Associate Professor, Department of Medicine, Division of Rheumatology, University of Alberta, Edmonton, AB

Extended-Role Practitioners Improve Access to Care for Ontarians

By Katie Lundon, BSc (PT), MSc, PhD; Vandana Ahluwalia, MD, FRCPC; and Rachel Shupak, MD, FRCPC

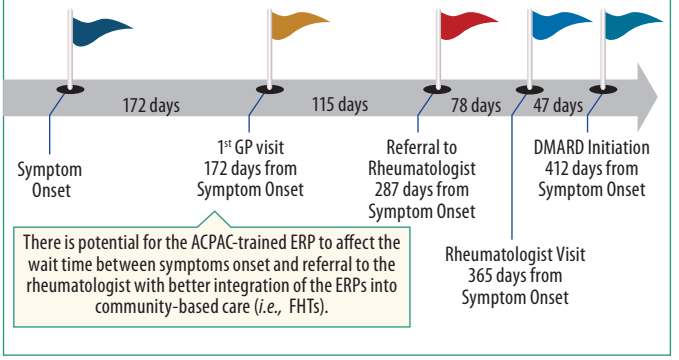
Since its inception in 2005, the Advanced Clinician Practitioner in Arthritis Care (ACPAC) Program[1] (*acpacprogram.ca*) has successfully graduated 69 extended-role practitioners (ERPs) practising across Canada. It is an Ontario-based, formal, post-licensure training program for appropriately chosen health care providers already experienced in arthritis care that ensures acquisition of the advanced skills and knowledge necessary to support the development of extended practice roles.

Utilization of ACPAC ERPs in interprofessional shared-care models of arthritis management has optimized scarce human health resources in rheumatology and has specifically achieved success at the system level as follows:

- Excellent agreement between an ACPAC-trained ERP and rheumatologist in independently determining inflammatory arthritis (IA) vs non-inflammatory disease, and improved access to rheumatologist care with a 40% reduction in time-to-treatment decision.[2]
- Centralized paper triage of rheumatology referrals by an ACPAC ERP reduced wait times for patients with suspected IA by more than 50% (15.5 days) compared to the traditional rheumatologist model of care (33.8 days).[3]
- Triage by an ACPAC ERP resulted in a high number of patients with suspected IA/connective tissue disease being correctly prioritized for a rheumatology consultation with wait times decreased to below the provincial median.[4]

Figure 1

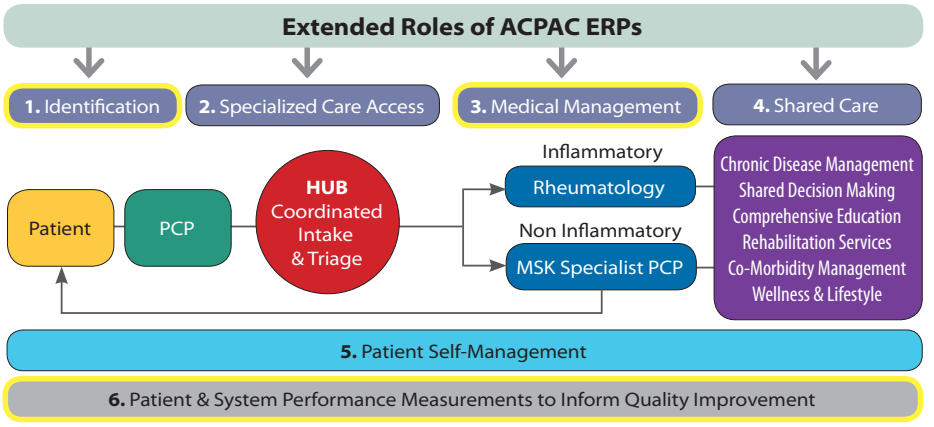
Rheumatology Wait-times Along IA Care Pathway (Solo Rheumatologist)



In summary, an ACPAC-trained and experienced ERP can shorten the time-to-rheumatologist assessment (Figure 1) allowing an earlier diagnosis and treatment decision for patients with IA.[2] ACPAC ERPs, with some evolution in policy, could plausibly be even better positioned at the community level (*e.g.*, Family Health Team) to identify and triage patients with suspected IA for expedited referral to a rheumatologist (Figure 1).

A trained ERP can be positioned at multiple points to support identification, access, medical management and shared care in accordance with the Arthritis Alliance of Canada (AAC) model of arthritis care framework (Figure 2).

Figure 2.
The AAC Model of Arthritis Care Framework



Dr. Katie Lundon, Program Director, Advanced Clinician Practitioner in Arthritis Care (ACPAC) Program, Office of Continuing Professional Development, Faculty of Medicine, University of Toronto, Toronto, ON

Dr. Vandana Ahluwalia, former Corporate Chief of Rheumatology, William Osler Health System, Brampton, ON

Dr. Rachel Shupak, Associate Professor, Department of Medicine, University of Toronto; Physician, St. Michael's Hospital, Toronto, ON

References:
1. Lundon K, Shupak R, Schneider R, et al. Development and early evaluation of an inter-professional post-licensure education programme for extended practice roles in arthritis care. Physiotherapy Canada 2011; 63:94-103.
2. Ahluwalia V, Larsen T, Lundon K, et al. An advanced clinician practitioner in arthritis care can improve access to rheumatology care in community-based practice. Manuscript submitted, 2017.
3. Farrer C, Abraham L, Jerome D, et al. Triage of rheumatology referrals facilitates wait time benchmarks. J Rheumatol 2016; 43:2064-67.
4. Bombardier C, et al. The Effect of triage assessments on identifying inflammatory arthritis and reducing rheumatology wait times in Ontario [abstract]. Arthritis Rheumatol 2016;68 (suppl 10). Available at *acrabstracts.org/abstract/the-effect-of-triage-assessments-on-identifying-inflammatory-arthritis-and-reducing-rheumatology-wait-times-in-ontario/*. Accessed March 7, 2018.

Rheumatology Nurses Improve Access to Care in British Columbia

By Michelle Teo, MD, FRCPC

In 2011, BC rheumatologists were awarded funds for integration of nurses into patient care. From that, the Multidisciplinary Conference fee schedule ("Nursing code" as we affectionately refer to it) was born. The "Nursing code," which can be billed every six months per patient, allows a rheumatologist to hire a Licensed Practical Nurse (LPN) or Registered Nurse (RN) to support the management of patients with inflammatory arthritis. The nurses provide a wide variety of services to patients, including disease and medication counselling, methotrexate and biologic injection training, vaccine administration and tuberculosis skin testing.

Rheumatology nurses not only allow us to provide enhanced care to our patients, but can also improve access to care in underserviced areas. Some nurses work in an interdisciplinary care model, where side by side with the rheumatologist they provide care for new and follow-up patients. This approach has improved patient access by reducing wait times for new referrals and has allowed follow-up patients to be seen more promptly when needed.

During 2016-2017, 53 of the 86 rheumatologists in BC used the "Nursing code," with an estimated 55 rheumatology nurses employed across the province. We celebrate the success of this programme and it is with excitement that we enter this new era, where established rheumatologists and new graduates alike realize the power of integrating allied health, such as nursing, into the modern day rheumatology practice.

Dr. Michelle Teo, Rheumatologist, Balfour Medical Clinic, Penticton, BC; Clinical Instructor, Department of Medicine, University of British Columbia, Vancouver, BC