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The Journal of the Canadian Rheumatology Association

Spotlight on:
Healthcare Delivery and Models of Care

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References: 1. Data on file, Janssen Inc.
2. REMICADE® Product Monograph, Janssen Inc., April 26, 2016.

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EDITORIAL

The Cheque is NOT in the Mail

"The cheque is in the mail."[1]
"I'm from your government, and I am here to help you."[1]
"It's not the money, it's the principle of the thing."[1]

By Philip A. Baer, MDCM, FRCPC, FACR

Medicine is a calling and a profession, but it is also a business. Cash flow is the lifeblood of a business, with monthly, quarterly and annual expenses requiring a matching source of funds to cover them. With a single-payer healthcare system, the easiest payer from which to obtain income is your provincial healthcare plan. The number of fee codes used routinely is small, billing takes a few mouse clicks after each clinical encounter, and electronic submissions of batches of bills is easy, at least when the government's web portal is up and running (just don't use one of the many browsers it can't handle). Payments turn up monthly in my practice bank account, with very few claims rejected. The only hitch is that fiscal pressures on government budgets currently result in arbitrary fee discounts of 4.45% on every bill where I practice, with no end in sight. In fact, the Ontario government now proposes to fix the pot of physician payments with a hard cap, and add risk-sharing to the payment equation, which at best will see physicians receiving a fixed income for the foreseeable future. Better pray for low inflation and no tax hikes!

Theoretically, non-government payers should be more attractive to deal with. No clawbacks, the possibility of future raises, and income diversification are among the benefits. However, invoicing and collecting for work from these entities is a little more challenging. I have already written about the difficulties of obtaining payments for online surveys in a prior editorial. What about industry and other private payers? Let me share a few personal examples.

Advisory boards: These were the subject of a CRAJ Joint Count survey (Summer 2016 issue). For those who don't frequent these events, let me tell you that the easy part is attending. The paperwork beforehand and the payment process are harder. First to arrive is an invitation and a registration form. With many companies, no matter how many times I have worked with them before, the registration form is blank, even if they should already know my demographic details, company name and HST number. Each new rep and each new third-party CME company seems to start from scratch. Where is Big Brother when needed? Next comes a 7-page contract, in which I swear I am not a government official, will take the company's secrets to the grave, *etc.* I must admit I rarely actually read this boilerplate. I applaud the few companies which allow electronic document signing, rather than forcing me to print out, manually sign, and scan everything back. More and more, there are also requests for my CV and credentials. I now keep all those files on my phone so I can fire them back upon request.

Following the meeting, being paid on the spot is a rarity. Payments usually drift in over 4-8 weeks, after which time it is wise to start making enquiries. Interestingly, the deadlines to complete pre-meeting paperwork are often very tight, but all urgency disappears after I have completed the contracted work. Once, I did not send in an expense form, as I had none to report. When no payment arrived, I found out that this particular company did not process honoraria without a completed expense form, even if they were nil. Lesson learned–I now send them a signed expense form each time. Of course, this incentivizes behaviour like charging $16 for an orange juice (Bev Oda, former federal cabinet minister), or $3 for tea and cookies while receiving a $3000/day consulting fee (Ontario's e-health consultants). Try to avoid that. My record is waiting five months to be paid $17 of expenses–it would have been better not to have billed for those.

I have almost given up trying to have honoraria paid to my company, and personal expenses repaid separately to me personally. Apparently, this is too difficult for the accounting systems of most multi-national companies, as they would have to set me up as 2 different vendors. I may have to rethink this, as another trend is for companies to issue T4A slips years after the fact, after they have been audited by the other CRA. Only my accountant profits from the ensuing need to amend prior tax returns. Remember to transfer repayments of personal expense out of your practice account if they are substantial, to minimize unnecessary taxation.

The HST came into effect in 1991, but after over a quarter century, collecting it remains challenging as well. Sometimes, I miss the line in the contract specifying the payee: if it is not my company, HST will likely be omitted, even if I have provided my HST number elsewhere. I always try to calculate the actual HST and write it on the contract or expense schedule. Despite that, one recent cheque which should have been for $663 was printed as $366. Computer dyslexia and failure to use an auto-calculating spreadsheet program likely explain that one.

Another GST/HST nuance: I live in Ontario, so I add 13% HST to my invoices, and send the collected HST quarterly to the other CRA. Recently, a multi-national company with hundreds of employees across Canada, headquartered outside Ontario, started only paying 5% GST. They justify this on the basis that they have only a single physical office in Canada, and it is not in Ontario. A call to their accounting department produced documents justifying their position, which no other company I deal with duplicates. More bookkeeping headaches, and more bills from my accountant will surely result. Even more interesting, this same company pays the 13% HST if I speak for them, but only 5% GST if I merely attend one of their advisory boards.

Direct deposit setups are the best. No more concerns about Canada Post strikes for one thing. No waiting for a company representative to show up in my office with a cheque (note to all payers: I can be trusted to know what to do with an envelope containing a cheque if it arrives in the mail). No excuse that someone put my cheque in the trunk of their car and then couldn't find it (true story). No playing tag with couriered cheques, most of which arrive looking like someone has left them on the floor of a delivery truck and walked all over them with muddy shoes. Recently, one couriered cheque was scheduled to arrive at the office while I was away. I was notified in advance, and I asked to have it delivered instead 2 weeks later, after my vacation. No problem, supposedly. What actually happened was that the original cheque was accepted in my absence by the pharmacy in our building, which then sat on it for weeks before delivering it to me. Around the same time, I received a replacement cheque, and had to figure out which one to cash, as payment had been stopped on one. Multiple emails later, we resolved the issue. On other occasions, cheques from reputable payers have bounced for a variety of reasons (corporate account closed, duplicate payments issued), embarrassing everyone involved.

Always keep all correspondence related to such work until after payment is received. Recently, I received a letter thanking me for my work on a project, and stating that my payment of $x was enclosed. The actual cheque was for $0.5x, a substantial difference. More emails and phone calls, a cheque to be returned, and a new demand for an invoice for the proper amount.

Ah, invoices. I used to provide them without being asked, as they provide me with a standard audit trail, and include my company details and HST info. Then, I was told the invoices confused the accounting department, so it was better not to provide them. Lately, some companies have taken the opposite position, requiring an invoice from me if HST is to be paid. But not just any invoice. One company sent me a guide to invoices, with 10 essential items they required in a certain order. Other companies aren't that prescriptive, but the key for them is to bill the company under its legal Canadian corporate name, which may be quite different from the name they use in day-to-day correspondence.

Anecdotal payment story which also allows me to nominate a colleague as Canada's most honest rheumatologist: I completed an on-line survey over two weeks, late in 2015, for a promised three-figure honorarium. After six months, I enquired as to the status. I was told the survey was just wrapping up, and to allow up to 60 business days for payment processing. Three months later, I sent another email query and received another assurance that payment would be forthcoming. Finally, ten months after study completion at my end, my colleague Dr. Lynn Hamilton called and informed me that the honorarium, made out to me, had been delivered to her home address. But for her honesty, I would never have been paid. Thank you, Lynn!

Dr. Roman Jovey, a colleague and specialist in pain management, also helped me out when he received a cheque made out to me for expenses, in an envelope incorrectly addressed to his home.

Non-governmental work is great if you can get it, but actually receiving payments requires far more work than you may have realized.

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My First CRA ASM Experience as CEO

By Ahmad M. Zbib, MD, CPHIMS-CA

When I joined the CRA earlier this year, prep for the Annual Scientific Meeting (ASM) had kicked into high gear and the CRA team (staff, committee members and contractors) were working around the clock aiming to be the ultimate hosts. Fast forward to February 19, and the minute my plane touched down in Vancouver my "host anxiety" was peaking–it felt like the first time you host your soon-to-be in-laws to announce your engagement and you hope you leave a lasting and favorable impression.

While the 2018 ASM in Vancouver was not my first CRA ASM, my role was significantly different this time around, as you may imagine. That said, it was everything I imagined and then some. The team going through their checklists like the pros they are, members and other participants expressing their amazement at how beautiful the venue was and how friendly the hotel's staff were; and the smile on my face was getting bigger as the energy was building in the main exhibit area.

The striking and prevailing feeling for me is how tight and welcoming the rheumatology community is. Members and other stakeholders from patient/disease organizations, allied healthcare professional groups and industry sponsors were reaching out, introducing themselves and complimenting the great work that the team had done in putting this event together.

The other thing that was quite striking was a dichotomous feeling of pride and humility. It dawned on me that I am now leading an organization of internationally renowned experts, whose discoveries informed the science behind the textbooks I used in school. This group is, first and foremost, inspired by their patients to unlock disease pathways aiming for a cure. That humanity-loving aspect of medicine is what drew me to it. It was refreshing to hear many of the speakers reference their first patient who inspired them to get into rheumatology.

Ahmad Zbib attended his first CRA Annual Scientific Meeting in February as CEO of the CRA.

It is not all science though, just like with any family, and serious matters are part of but not the whole discussion. This group knows how to have fun. From the Great Debate to the awesome moves on the dance floor, having fun and enjoying what you do is part of the DNA of the CRA and its members. Did I also mention the fashion sense?

In closing, I want to thank the CRA family for their warm welcome. For those who attended the ASM but have not connected with me, please send me an email at *azbib@rheum.ca.* As for those who didn't have a chance to join us in Vancouver, I look forward to meeting you in Montreal at the 2019 ASM taking place February 27-March 2 at the Fairmont Queen Elizabeth Hotel. Just remember to grab your most fashionable outfit (and a pair of shoes to rock the dance floor) for our gala.

Ahmad M. Zbib, MD, CPHIMS-CA
Chief Executive Officer,
Canadian Rheumatology Association
Mississauga, Ontario

Everything You Wanted to Know About CIORA Grants (but Were Afraid to Ask)

At the most recent CRA Annual Scientific Meeting in February, Drs. Michelle Teo and Elizabeth Stringer presented a workshop entitled, "Everything You Wanted to Know About CIORA Grants (but Were Afraid to Ask). In this quarter's CIORA column, we'd like to share this information with you to help you with your CIORA applications.

CIORA, which stands for the Canadian Initiative for Outcomes in Rheumatology Care, focuses on three main pillars: (1) Awareness/Advocacy/Education, which includes sub-pillars on Health Economics, Sustainability of Healthcare, and Quality Improvement; (2) Early Access for All Rheumatic Disease Patients, and (3) Multidisciplinary Teams. The CIORA Grant Terms of Reference (ToR) has examples of research questions and measurable outcomes for each pillar.

There are two types of grants available:
(1) One-year funding to a maximum of $75,000
(2) Two-year funding to a maximum of $120,000

All grants are peer reviewed and awarded based on the recommendations of the CRA Research Committee. The principal applicant or co-applicant must be a rheumatologist practicing in Canada and a member of the CRA. As well, all proposed funding must be for Canadian research and funds must be spent in Canada. The grant application must be no more than 10 pages.

Practical tips for the application:

- Read the ToR very carefully–deliver everything that is required and be explicit about it.
- Tell a very clear, logical, and convincing story in every section of the proposal, particularly the background.
- Provide opportunity for feedback and revisions from co-investigators or external peer review (establish this as an expectation from your co-investigators at the beginning and include a timeline).
- Consider a flow-chart and/or diagram to supplement your proposal (a picture is worth a thousand words but could take up only a page).
- Review fundable items for your budget–be detailed in your justification of costs.
- The grant is uploaded electronically by section–don't leave it until the last minute to upload.

For more information, on grant submission applications and deadlines and to view the full CRA presentation, please visit *rheum.ca/en/research*.

2018 CRA Abstract Awards

Best Abstract on SLE Research by a Trainee – Ian Watson Award
Ms. Lily Wang
University of Toronto
Supervisor: Dr. Amanda Steiman

Best Abstract on Clinical or Epidemiology Research by a Trainee – Phil Rosen Award
Dr. Sophie Wojcik
McGill University
Supervisor: Dr. Murray Baron

Best Abstract on Basic Science Research by a Trainee
Dr. Jessica Salituri
McGill University
Supervisor: Dr. Marie Hudson

Best Abstract by an Undergraduate Student
Mr. Sujay Nagaraj
University of Calgary
Supervisor: Dr. Cheryl Barnabe

Best Abstract on Research by Young Faculty
Dr. Kimberley Legault
McMaster University
Supervisor: n/a

Best Abstract on Paediatric Research by Young Faculty
Dr. Roberta Berard (Western University) & Dr. Dax Rumsey (University of Alberta)
Supervisor: n/a

Best Abstract by a Rheumatology Resident
Dr. Mary Choi
University of Calgary, Cumming School of Medicine
Supervisors: Drs. Marvin Fritzler and Ann Clarke

Best Abstract by a Medical Student
Mr. Tedi Qendro
McGill University
Supervisor: Dr. Marie Hudson

Best Abstract by a Post-Graduate Research Trainee
Ms. Victoria Stefanelli
Georgia Institute of Technology
Supervisor: Dr. Thomas Barker

Best Abstract on Quality Care Initiatives in Rheumatology
Dr. Arielle Mendel
McGill University
Supervisor: Dr. Evelyne Vinet

Models of Care: The International Perspective

By Professor Anthony D. Woolf, BSc, MBBS, FRCP

Musculoskeletal conditions have a major impact on individuals and society, affecting most people at some point in their lives. They are the greatest cause of disability in most parts of the world–rich and poor.[1] Their burden is increasing with the aging of the population and also with increases in sedentary lifestyles, obesity and injuries through sports and occupation. Good musculoskeletal health allows people to be physically active, to live independently, and to lead productive lives. There is a compelling case for investing in musculoskeletal health and the effective management of musculoskeletal conditions using treatments that will prevent disability. Despite this, musculoskeletal conditions are seldom a priority and the knowledge we have is not implemented effectively.

A call for action has been made by the Global Alliance for Musculoskeletal Health that requires actions at all levels–by the public and patients, public health, community care and secondary care as well as by policy makers. It is the responsibility of all of us. The recent WHO Europe Noncommunicable Disease (NCD) Strategy[2] recognizes the importance of investing in musculoskeletal health and preventing musculoskeletal conditions where possible through good nutrition, avoiding obesity, preventing injuries and keeping physically active. The importance of mobility is now being recognized for active healthy aging.[3] People must also have access to appropriate and timely management that supports them to self-manage their conditions, as well as ensuring they have access to appropriate treatment. These recent changes in priority are not yet reflected in policies, and there is a lack of services to appropriately manage these problems in most parts of the globe.

People need to receive the right care in the right place at the right time to ensure they optimize their outcomes. Such person-centred care needs all the expertise to be brought together to work in an integrated way, following clear pathways of care that are explicit about everyone's role from the patient, and primary care through to secondary care. Such models of care provide guidance of what works and how to implement it, streamlining the pathways to avoid people entering a healthcare maze. It requires new ways of working and improving the capabilities of parts of the workforce. Initiatives are happening across the globe to achieve this.

This issue of the *CRAJ* highlights the commendable work in Canada to overcome these challenges by providing practical solutions. Projects are also underway in other countries such as Sweden, the UK, Australia, and Kenya to develop and implement person-centred models of care, in particular for common musculoskeletal conditions.[4-9] Digital approaches also need to be used to share data and enable people in isolated communities to be supported. Core data sets for both clinical use and to measure health systems are needed and must be able to support economic evaluation.

Most importantly, we need to share the challenges and the solutions that have been found to improve care so we can avoid duplication. We need flexible systems and services to enable rapid adoption and implementation of advances in knowledge. We as clinicians have to be prepared to adapt to ensure we meet the needs and expectations of people with arthritis and other musculoskeletal conditions. The implementation of models of care that have been developed by the community for the community is a good way of achieving this.

Professor Anthony D. Woolf, BSc, MBBS, FRCP, International Coordinating Council, Global Alliance for Musculoskeletal Health, Chair, Arthritis and Musculoskeletal Alliance, UK; Bone and Joint Research Group, Royal Cornwall Hospital, Truro, UK

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Minister of Health Ministre de la Santé

Ottawa, Canada K1A 0K9

Message from the Minister of Health Arthritis Alliance of Canada

Arthritis affects around 5 million Canadians. The joint stiffness and swelling it causes can make it very painful to move and can substantially reduce one's quality of life. Seniors are particularly affected by this condition; it is estimated that a third of senior men and half of senior women live with arthritis. As the population ages and the prevalence of arthritis increases, it has become more important than ever to find solutions to prevent and treat this disorder.

The Arthritis Alliance of Canada has been a leading voice in this area. Through collaborative research and advocacy, the Alliance members–health care professionals, researchers, funding agencies, governments, charities, industry partners, and patient groups–have demonstrated their steadfast commitment to improving the lives of Canadians living with arthritis.

The Government of Canada shares this commitment. Through the Canadian Institutes of Health Research, we invest approximately $20 million per year in arthritis research. While we have yet to find a cure, we continue to make progress in this field and have discovered a number of behaviours that can help to reduce symptoms in many people. These include regular moderate-intensity physical activity, maintaining a healthy weight, not smoking, avoiding alcohol, and eating a healthy diet that is low in sugar.

On behalf of the Government of Canada, I congratulate the Alliance and its members on developing innovative models of care for arthritis, and on successfully publishing those results in *The Journal of the Canadian Rheumatology Association*. It is my sincere hope that these models of care will take us a few steps closer to a world where we can all live free of the pain of arthritis.

The Honourable Ginette Petitpas Taylor, P.C., M.P.

Canada

About the Arthritis Alliance of Canada

By Vandana Ahluwalia, MD, FRCPC; Dianne Mosher, MD, FRCPC; and Michel Zummer, MD, FRCPC

Arthritis directly affects the lives of *6 million Canadians* and is the leading cause of workplace disability. From the young to the elderly, one in eight Canadians is forced to live with one, or more, of the 100 different types of arthritic conditions. It is estimated that by the year 2040, *one in four* Canadian lives will be affected by arthritis.

The Arthritis Alliance of Canada (AAC) was formed in 2002 to improve the lives of Canadians with arthritis. The AAC brings together arthritis healthcare professionals, researchers, funding agencies, governments, voluntary sector agencies, industry and–most importantly–representatives from arthritis patient organizations from across Canada.

Through consultations with a national network, the AAC has designed and developed a Models of Care framework, with practical clinical tools that can be used by clinicians in their daily practice. Our work has included six specific initiatives over the past five years:

1) A Tool for Developing and Evaluating Models of Care
2) Pan-Canadian Approach to Inflammatory Arthritis Models of Care
3) Inflammatory Arthritis Care Map and Toolkit
4) Inflammatory Arthritis System-Level Performance Measures
5) The Osteoarthritis Clinical Assessment Tool
6) The Rheumatoid Arthritis Core Clinical Dataset (in collaboration with the CRA)

We invite you to learn more about the positive results of our efforts in the "Models of Care in Action" section of this issue. We believe these successes and best practices need to be expanded and implemented across Canada. This will help to ensure that Canadians affected by arthritis receive a timely diagnosis and appropriate treatment so they can remain productive members of their families and communities. Our ultimate goal is to improve the lives of Canadians living with arthritis.

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

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

Dr. Michel Zummer, Associate Professor, Université de Montréal; Rheumatologist, CH Maisonneuve-Rosemont, Montréal, QC

The AAC and CRA: Working Better Together

By Joanne Homik, MD, FRCPC; Christine Charnock; and Cheryl Barnabe, MD, FRCPC

As a Member Organization of the Arthritis Alliance of Canada (AAC), the CRA and many of its members have contributed research data, experience and expertise to champion the efficient and effective delivery of inflammatory arthritis care in Canada.

CRA members have been balancing evidence and knowledge with the realities of limited human resources in rheumatology in Canada. Beginning with the development of a business case led by Drs. Bombardier, Hawker and Mosher, the magnitude of the growing burden of arthritis and how it could be mitigated by awareness, education, and future interventions was laid out. This created the pathway for a national framework to improve arthritis care in Canada, led by Drs. Bombardier, Mosher and Zummer, through early diagnosis and targeted treatment. Drs. Ahluwalia, Mosher and Zummer developed a toolkit and supporting documentation for the pan-Canadian Models of Care. CRA members from across the nation are now employing these new models of care to ensure the optimal delivery of arthritis care.

The CRA and AAC collaboration is also focused on ensuring quality of rheumatology care in Canada. Led by Dr. Claire Barber and pertinent to the activities of the CRA's Optimal Care Committee, system-level performance measures for inflammatory arthritis have been developed. These measures can be used to reflect the impact of system organization and structure on processes that contribute to care outcomes. Performance measures and quality indicators at the individual patient-provider level are in development, and will provide quality assurance data to inform practice improvement.

Through these collaborative activities, the CRA and AAC fulfill their mandates, and ensure the delivery of high-quality and timely rheumatology care across Canada.

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

Ms. Christine Charnock, former Chief Executive Officer, Canadian Rheumatology Association, Newmarket, ON

Dr. Cheryl Barnabe, Associate Professor, Rheumatologist, University of Calgary, Calgary, AB

JOINT COMMUNIQUÉ

A Call to Action:

New Models of Care in Inflammatory Arthritis and Osteoarthritis

By Michel Zummer, MD, FRCPC; and Gillian Hawker, MD, MSc, FRCPC

In 2012, the Arthritis Alliance of Canada (AAC) decided to prioritize the development of a framework for models of care for arthritis. The overarching goal was to define a care path for people presenting with musculoskeletal symptoms. The first step was to create the Tool for Developing and Evaluating Models of Care (2012) to validate the components of a proposed Model of Care.

More than 150 stakeholders collaborated to produce A pan-Canadian Approach to Inflammatory Arthritis Models of Care (2014). The six key elements of the framework are shown in the figure below (adapted from the Ontario Rheumatology Association [ORA] Rheumatology Model of Care Framework).

Efforts were next directed at disseminating the model amongst the various stakeholders to document and tailor the components that would be adopted. Quality measurement projects have also been initiated.

Initially developed for inflammatory arthritis, other musculoskeletal conditions including osteoarthritis (OA) were subsequently integrated into the model to expand its applicability. Osteoarthritis is the most common type of arthritis, with a substantial societal burden. Barriers to optimal OA diagnosis and treatment include the societal belief that OA reflects normal aging, and the high co-prevalence of OA with other chronic conditions, which represent competing demands and make treatment challenging.

Recognizing these barriers and the need to do better for OA patients, a partnership was established between the AAC, the College of Family Physicians of Canada (CFPC) and the Centre for Effective Practice to integrate previously identified standards of OA prevention and management into primary care. A toolkit for primary care providers was developed to assist family physicians and other healthcare providers to effectively identify, assess, diagnose and manage OA. The Tool is available at *arthritisalliance.ca/en/osteoarthritis-toolbox*.

Work is ongoing to increase awareness of the tool and to evaluate strategies for its effective and efficient implementation into primary care.

Dr. Michel Zummer, Associate Professor, Université de Montréal; Rheumatologist, CH Maisonneuve-Rosemont, Montréal, QC

Dr. Gillian Hawker, Sir John and Lady Eaton Professor, Department of Medicine, Division of Rheumatology, University of Toronto, Toronto, ON

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1. Arthritis Alliance of Canada. Pan-Canadian Approach to IA Models of Care. Available at *arthritisalliance.ca/en/initiativesen/pan-canadian-approach-to-ia-models-of-care*. Accessed March 2018.
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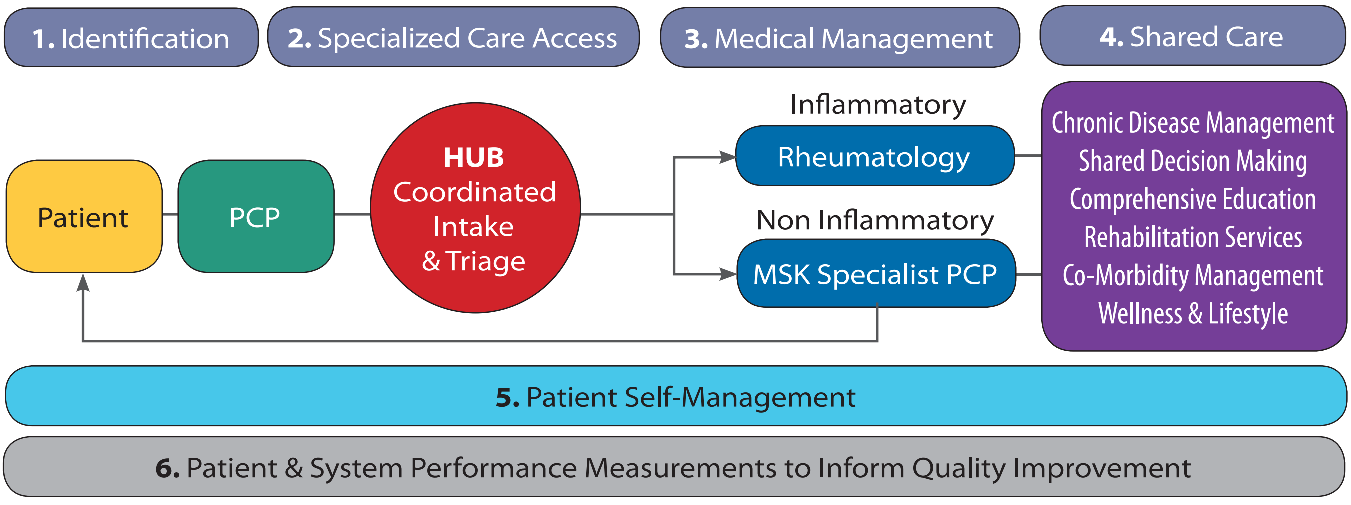
Figure 1.
Six Key Elements of Framework



Adapted from the Ontario Rheumatology Association (ORA) Rheumatology Model of Care Framework.

Models of Care in Action: Implementation into Practice

1) Identification

Patients and the Primary Care Provider

A New Patient Charter Outlines Arthritis Patients' Rights and Responsibilities

By Dawn P. Richards, PhD; Linda Wilhelm; and Laurie Proulx

The Canadian Arthritis Patient Alliance (CAPA) undertook a grassroots campaign in 2014 to update the Canadian Arthritis Patient Bill of Rights.[1] The goal was to bring new life to this important document, which largely served as an advocacy piece, and to emphasize the key role of arthritis patients in recognizing symptoms and accessing care.[2]

The Arthritis Patient Charter was a collaborative effort spearheaded by CAPA with input and feedback from over 730 community stakeholders from across Canada. From its initial draft to its final inception, the Arthritis Patient Charter took only eight months to complete, a testament to the Canadian arthritis community's enthusiasm and ability to mobilize its resources.

The Arthritis Patient Charter is available at CAPA's website (*arthritispatient.ca/projects/arthritis-patient-charter/*) in English and French, in an easily accessible format.[3]

Dr. Dawn P. Richards, PhD, Vice President, CAPA, Toronto, ON

Ms. Linda Wilhelm, President, CAPA, Midlands, Kings Country, NB

Ms. Laurie Proulx, 2nd Vice President, CAPA, Ottawa, ON

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1. Canadian Arthritis Bill of Rights, 2001. Available at *www.arthritis.ca/document.doc?id=565.*
2. Richards DP. The Arthritis Patient Charter. CRAJ 2014; 24(4):8-9.
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The Patient's Perspective

Patient Experiences of Rheumatoid Arthritis Models of Care: An International Survey

By Cheryl Koehn

In 2016, Arthritis Consumer Experts led the formation of a global network of 18 patient organizations working on behalf of people living with rheumatoid arthritis (RA). To complement the Arthritis Alliance of Canada (AAC) Inflammatory Arthritis Models of Care (IA MOC) work, the network's first project was an online survey aimed at uncovering RA Models of Care (RA MOC) gaps by surveying patients living with the disease.

The survey, which was the first crowd-sourced research of its kind, was conducted in Canada and 24 other countries from March-June 2017. Questions focused on five domains of the AAC's own IA MOC work: 1) patients recognize symptoms and seek care; 2) access to a specialist; 3) medical management; 4) shared chare; and 5) patient self-management.

Several RA MOC gaps were identified among the 2,690 respondents, including:

- 51% reported a delay of 4-6 months to over 2 years from symptom onset to receiving an RA diagnosis;
- 93% reported they helped their rheumatologist diagnose their RA through their description of symptoms; only 57% reported having a thorough joint and skeletal system examination;
- 58% were currently treated with methotrexate only;
- 30% said it took from 4 months to "never" for an effectiveness review of their first initiated medication;
- Approximately half lacked knowledge when describing their current treatment as biological or not;
- 14-45% needed more disease information or would like to talk with other patients or their rheumatologist about their RA;
- 82% and 46% reported their main source of RA information was through internet searches or social networks, respectively.

These survey results will guide the Global RA Network's development of pan-country and specific country initiatives to work towards closing RA MOC gaps at the patient level. For more information, please visit *globalranetwork.org*.

Ms. Cheryl Koehn, President, Arthritis Consumer Experts, Vancouver BC, on behalf of the Global RA Network

Reference:

Koehn C et al. Patient experiences of rheumatoid arthritis models of care: an international survey. Poster presented at the 2017 ACR Annual Meeting, 3-8 November 2017, San Diego, CA. Abstract #353.

Successfully Implementing MOCs in Primary Care: The OA Tool for Family Practice

By The College of Family Physicians of Canada

An evidence-based osteoarthritis (OA) toolkit for use in primary care was recently launched in September 2017 to help close the knowledge to practice gap for OA care. This toolkit was a collaborative effort between the Arthritis Alliance of Canada, the College of Family Physicians of Canada, and the Centre for Effective Practice. It includes specific recommendations on non-pharmacologic and pharmacologic therapies as well as resources to promote patient self-care.

The bilingual toolkit is available at *www.arthritisalliance.ca/en/osteoarthritis-toolbox*. By November 2017, the toolkit had been provided to over 30 AAC member organizations and their communities. Promotional efforts to widely disseminate the tool included an Internet, email and social media campaign. In the first three months, the toolkit was downloaded by more than 1,200 users and there have been thousands of webpage views and Twitter impressions.

Future dissemination efforts include conference exhibits and workshops, such as the Family Medicine Forum (*fmf.cfpc.ca*). We are also developing an OA-centred eLearning module for launch in summer 2018–visit *cfpc.ca/OATool/* for regular updates.

The College of Family Physicians of Canada, Mississauga, ON

2) Specialized Care Access: Coordinated Intake and Triage Benefits of Provincial Triage Initiatives

CreaTe Central Access and Triage Improves Access to Care for Albertans

By Dianne Mosher, MD, FRCPC

CreaTe central access and triage was instituted in Calgary in 2007 as part of an innovations grant through the government of Alberta. Central access and triage is a single intake point for rheumatology referrals at the University of Calgary serving a population of approximately 2 million people in Southern Alberta. Since its inception in 2007, over 65,000 patients have been triaged and we continue to meet the Canadian Wait Time Alliance benchmark for early inflammatory arthritis of 4 weeks.

Nineteen rheumatologists are part of this program. The triage nurse reviews all referrals, prioritizes the referral and facilitates appointments to the first available provider. All referrals are entered and tracked in a database. Specialized clinics were established to expedite the care of more urgent patients. Referrals that are not accepted or where the triage category is unclear are reviewed by a physician.

The objective is to manage our wait list more effectively by using one central intake, eliminating duplicate referrals and prioritizing the most urgent patients first.

A study by Hazlewood[1] showed that at two years, the variability of wait times for rheumatologists decreased, wait times for urgent and moderate referrals were reduced, the quality of referrals improved, and there were no duplicate referrals. At seven years follow up, wait times for urgent and moderate referrals were controlled despite a growing population.

Today we receive 500-600 referrals a month and we have a wait list of over 1,200 patients.

Capacity issues are being addressed by Stable Rheumatoid Arthritis clinics, a partnership with our primary care networks which provides telephone advice via a specialist link, and care pathways developed for gout and osteoarthritis (OA) incorporating the AAC-CFPC OA Tool. Key performance indicators have been developed for central intake to insure we are improving accessibility to rheumatology care for Albertans.[2]

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

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1. Hazlewood GS, Barr SG, Lopatina E, et al. Improving appropriate access to care with central referral and triage in rheumatology. Arthritis Care & Research 2016; 68(10):1547–53.
2. Barber CE, Patel JN, Woodhouse L, et al. Development of key performance indicators to evaluate centralized intake for patients with osteoarthritis and rheumatoid arthritis. Arthritis Res Ther 2015; 17:322.

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

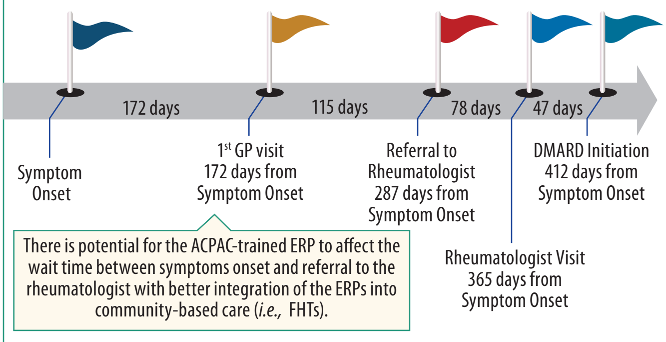
Since its inception in 2005, the Advanced Clinician Practitioner in Arthritis Care (ACPAC) Program[1] (*acpacprogram.ca*) has successfully graduated 69 extended-role practitioners (ERPs) practising across Canada. It is an Ontario-based, formal, post-licensure training program for appropriately chosen 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)

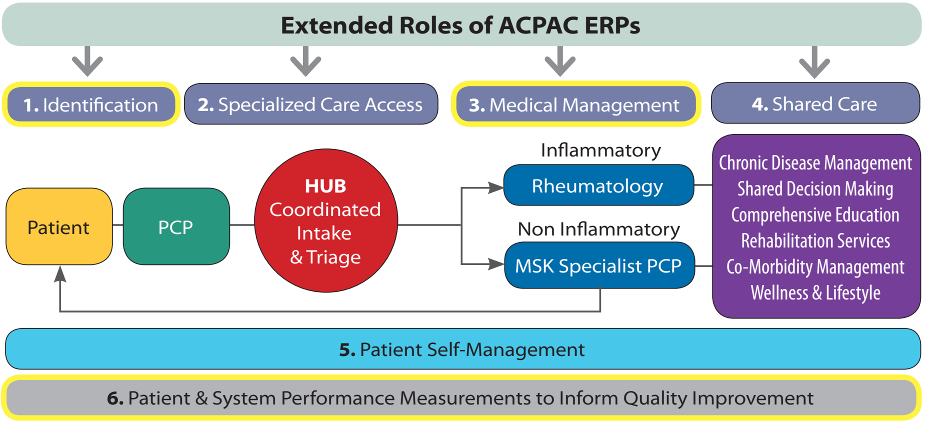


There is potential for the ACPAC-trained ERP to affect the wait time between symptoms onset and referral to the rheumatologist with better integration of the ERPs into community-based care (*i.e.,* FHTs).

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

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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

Family Physicians with Extended Scope of Practice Improve Access to Care in Nova Scotia

By Evelyn Sutton, MD, FRCPC, FACP

In response to an acute shortage of rheumatologists in Nova Scotia in 2011, an innovative new Collaborative Care Clinic was launched in Halifax to expand access and services for patients with inflammatory arthritis. The clinic was based on a multidisciplinary model of care tailored to meet regional needs. A local family physician completed a six-month training program in rheumatology and then worked alongside a team of experienced rheumatology nurses, physiotherapists and a rheumatologist in the Collaborative Care Clinic.

After the clinic had been operational for three years, an independent research firm was contracted to evaluate the strengths and weaknesses of the model. The most important lesson learned was that success relied on having buy-in from everyone involved in the clinic. Booking clerks had not been included in the initial discussions when setting up the clinic, and the result was that they tended to book stable inflammatory arthritis patients with the rheumatologist rather than with the collaborative care team, thinking this was 'preferred.' Once they understood the rationale for the triage model and were exposed to the positive ratings from patient satisfaction questionnaires, clinic bookings improved dramatically.

The model was expanded to Cape Breton in 2015, where two family physicians were trained to work alongside a rheumatologist and one continues in this role. A quality assessment conducted after just one year showed impressive improvements in wait times and better utilization of scarce rheumatology resources.

A prospective study is now underway to examine patient satisfaction, disease outcomes, and patient self-perception of pain management among patients cared for within the Collaborative Care Clinic compared to those followed in usual care (*i.e.*, by a rheumatologist who works in a hospital outpatient clinic).

Dr. Evelyn Sutton, Division of Rheumatology, Department of Medicine, Division of Medical Education, Halifax, NS

Reference:

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	2014	2015	Impact
Non-urgent wait list	12 months	2 months	243 new patient visits
Urgent referrals	Sent to Halifax - 5 hour travel time	Seen locally by Rheumatologist	Access to urgent care for remote communities
Follow-up care	12 months +	Every 6 months with GP	Stable HAQ scores

HAQ—Health Assessment Questionnaire

Videoconferencing and Interprofessional Support Can Improve Access to Care in Saskatchewan

By Regina Taylor-Gjevre, MSc, MD, FRCPC; Bindu Nair, MSc, MD, FRCPC; Brenna Bath, BScPT, MSc, PhD; Udoka Okpalauwaekwe, MD, MPH; Meenu Sharma, MSc; Erika Penz, MD, MSc, FRCPC; Catherine Trask, PhD; and Samuel Alan Stewart, PhD

A relatively high proportion of the Saskatchewan population resides in smaller communities and rural areas. Travel to access rheumatology follow-up and care for people with rheumatoid arthritis (RA) in these areas may be challenging. There have been several reports of utilization of telehealth in the provision of rheumatology consultation. Our group undertook a study supported with research funding from the Canadian Initiative for Outcomes in Rheumatology care (CIORA), to evaluate whether RA patients followed longitudinally, using videoconferencing and interprofessional care support, have comparable disease control to those followed in traditional in-person rheumatology clinics.

A total of 85 RA patients were allocated to either traditional in-person rheumatology follow-up or video-confer-

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- Risk of viral reactivation, including herpes zoster.
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- Risk of lymphopenia, neutropenia, anemia, and lipid elevations.
- XELJANZ should not be used in patients with severe hepatic impairment, or in patients with positive hepatitis B or C virus serology.
- Use with caution in patients with a risk or history of interstitial lung disease (ILD).
- XELJANZ can increase the risk of immunosuppression. Concurrent use with potent immunosuppressive drugs is not recommended.
- Concurrent use with live vaccines is not recommended.
- Use with caution in patients with impaired renal function (i.e., CrCl <40 mL/min).
- XELJANZ should not be used during pregnancy.
- Women should not breastfeed while being treated with XELJANZ.
- The safety and effectiveness of XELJANZ in pediatric patients have not been established.
- Caution should be used when treating the elderly and patients with diabetes because of an increased risk of serious infections.
- Use with caution in Asian patients because of an increased risk of events including: herpes zoster, opportunistic infections and ILD.
- Treatment with XELJANZ was associated with increases in creatine kinase.

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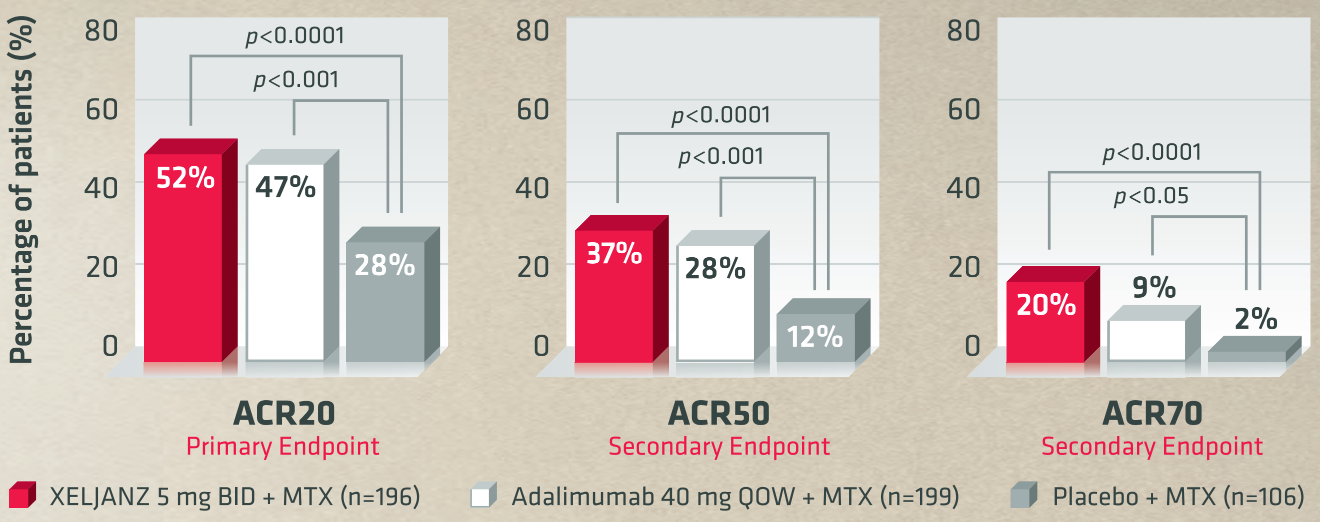
This study was not designed to compare XELJANZ to adalimumab.

ACR response rates at 6 months



Improvements from baseline in physical functioning were significantly greater in patients receiving XELJANZ + MTX vs. placebo + MTX at 3 months (as measured by decreases in HAQ-DI scores).[1*]

Mean HAQ-DI decrease from baseline at 3 months: -0.56 XELJANZ 5 mg BID or -0.51 adalimumab 40 mg QOW vs. -0.25 placebo ($p<0.0001$).
This study was not designed to compare XELJANZ to adalimumab.

- XELJANZ causes a decrease in heart rate and a prolongation of the PR interval. Caution should be observed in patients with a low heart rate at baseline (<60 beats per minute), a history of syncope or arrhythmia, sick sinus syndrome, sinoatrial block, atrioventricular (AV) block, ischemic heart disease, or congestive heart failure.
- Treatment with XELJANZ was associated with increased incidence of liver enzyme elevations.

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Reference: 1. Pfizer Canada Inc. XELJANZ Product Monograph. September 15, 2015. **2.** Arthritis Society. June 2014 Impact - Ease of Use. Available at http://www.arthritis.ca/page.aspx?pid~7650. Accessed July 22, 2014.

BID = Twice daily; QOW = Every other week; MTX-IR = Methotrexate Inadequate Responders

* Multicentre, randomized, double-blind, placebo-controlled study in patients ≥18 years with active RA according to ACR criteria. Patients received MTX and were randomized to receive XELJANZ 5 mg BID (n=196), adalimumab 40 mg QOW (n=199), or placebo (n=106). The primary endpoints were the proportion of patients who achieved an ACR20 response at month 6, mean change from baseline in HAQ-DI at month 3, and the proportion of patients who achieved DAS28-4 (ESR) <2.6 at month 6.

† The Arthritis Society's Ease-of-Use Commendation recognizes products, like the XELJANZ bottle cap, that have been independently tested for easy use and handling for people living with arthritis. The Arthritis Society does not determine the therapeutic value of products and the designation is not intended as a general product endorsement that are designed for ease of use in patients with arthritis.

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enced follow-up with urban-based rheumatologists and rural in-person physical therapist examiners. Follow-up was every three months for nine months. Outcome measures included disease activity metrics (DAS-28CRP, RA disease activity index (RADAI)), modified health assessment questionnaire (mHAQ), quality of life (EQ5D), and patient satisfaction (VSQ9).

We found no evidence of a difference in effectiveness between interprofessional videoconferencing care and traditional rheumatology clinic for both provision of effective follow-up care and patient satisfaction for established RA patients. High drop-out rates in both groups reinforced the need for consideration of patients' needs and preferences in developing models of care. While use of videoconferencing/telehealth technologies may be a distinct advantage for some patients, there may be loss of travel-related auxiliary benefits for others.

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Dr. Bindu Nair, Division of Rheumatology, College of Medicine, University of Saskatchewan, Saskatoon, SK

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Dr. Samuel Alan Stewart, Medical Informatics, Department of Community Health & Epidemiology, Dalhousie University, Halifax, NS

Reference:
Taylor-Gjevre R, Nair B, Bath B, et al. Addressing rural and remote access disparities for patients with inflammatory arthritis through video-conferencing and innovative inter-professional care models. Musculoskeletal Care 2018; 16(1):90-5.

3) Medical Management

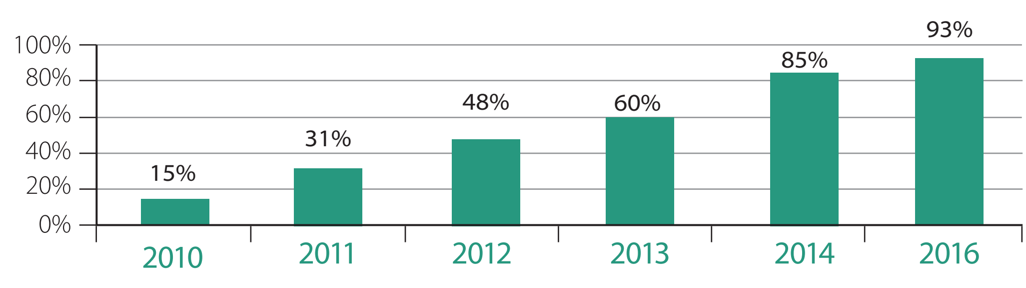
Integrating EMRs into Rheumatology Practices

By Vandana Ahluwalia, MD, FRCPC; and Sandra Couto, BSc, BSc Pharm

Physicians continue to implement electronic medical records (EMR) into their practice with the aim of improving the quality of care delivered and work flow efficiency. The integration of EMR solutions into clinical practices has been supported by several provincial agencies. In Ontario, OntarioMD was established to help community physicians select, implement and adopt EMRs.

EMRs continue to revolutionize patient care. Canada Health Infoway reports that 79% of Canadian specialists are currently using EMRs.[1] Rheumatology adoption is slightly lower at 70% with the majority of adoption in Ontario.

It was a daunting task when Ontario physicians were encouraged to transition to EMRs. The certified EMR platforms were created to support primary care physicians and were not fully prepared to support specialists' needs. In the absence of essential tools and functionality for the rheumatology community, the Ontario Rheumatology Association (ORA) established an EMR subcommittee to identify the needs of the rheumatology community and implement rheumatology-specific tools within existing EMR platforms. The tools that were created included clinical documentation Smart forms (with embedded joint counters, disease activity calculators, PROs and labs), HAQ, BASDAI and BASFI questionnaires, and OBRI Registry Data collection forms.



EMRs continue to revolutionize patient care. Canada Health Infoway reports that 79% of Canadian specialists are currently using EMRs.[1] Rheumatology adoption is slightly lower at 70% with the majority of adoption in Ontario.

Figure 1: Increasing use of EMRs by Ontario community rheumatologists: 2010 to 2016.

These forms are available to rheumatologists in other provinces if they are using one of the Ontario specialty-specific EMR platforms (Accuro, Telus-PS or Oscar).

Many physicians report that EMRs have increased their workload, that they are doing more data entry, and that they feel more physician burnout due to increasing requirements for documentation. Some even say that the EMR has altered the physician-patient encounter by reducing eye contact and not sensing the patient's body language. However, these challenges may be overcome by optimizing the office digital space and making the EMR part of routine practice in a way that enhances the patient-physician relationship. Rheumatologists have integrated kiosks to capture patient-reported outcomes in waiting rooms, and others have developed new EMR tools to facilitate documentation of patient care treatment plans that can be shared jointly with their patients. The ORA recently developed a customized Inflammatory Arthritis Care Plan to support patient self-management. The tool is being integrated into the Accuro EMR platform and will be piloted in a few Ontario rheumatology sites.

With the increased availability and adoption of EMR platforms, data is more readily available to users than ever before. Patients are accessing their personal healthcare information more easily–they can look up their blood work results online, engage in virtual visits through rheumatology telehealth, and in some areas, book their own appointments. Physicians can record and organize key clinical information, they can retrieve and edit it more easily, and with the emergence of individual dashboards, display and interpret data during patient encounters to help them make informed decisions that deliver improved patient care. To support this, the Arthritis Alliance of Canada[2] has developed a standardized rheumatology core dataset to be used in the EMR. With standardized data collection, measurement of comparative outcomes across users can be easily performed and collectively shared.

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

Ms. Sandra Couto, OBRI, Director Partnerships & Stakeholder Relations, Toronto General Hospital Research Institute, Toronto, ON

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2. Development of a Canadian Core Clinical Dataset to Support High-quality Care for Canadian Patients with Rheumatoid Arthritis. J Rheumatol 2017; 44;1813-22.

4) Shared Care

Ontario MedsCheck Program Integrates Pharmacists into Patient Care

By Carolyn Whiskin, RPh, BScPharm, NCMP

The Ontario Ministry of Health and Long-term Care funds a medication review for any Ontario resident who is taking three or more chronic disease medications. Known as the "MedsCheck Program," this consists of a one-on-one interview between the pharmacist and patient to review all prescription and non-prescription medications. A lifestyle assessment is also conducted to address smoking, alcohol, illicit drug use and exercise routine. At the end of the appointment, a complete list of all medications is provided to the patient and shared with their family physician, and any drug-therapy problems that are uncovered are shared with the prescribing physician.

Recognizing the opportunity of MedsCheck for arthritis patients, a joint committee of the Ontario Pharmacists Association and the Ontario Rheumatology Association was established. The goal was to identify how the MedsCheck program could help provide an accurate medication profile for patients to share with their rheumatologist. One of the committee recommendations was to have the intake person at the rheumatologist's office request that patients book a MedsCheck appointment with their community pharmacist prior to their clinic appointment. The resulting medication list could then be faxed to the rheumatologist's office directly by the community pharmacy, and copies provided to the patient for distribution to any of their other health care providers.

A communication was subsequently distributed to every Ontario pharmacist and rheumatologist through their respective associations in an effort to maximize uptake of the MedsCheck program in rheumatology.

Ms. Carolyn Whiskin, Pharmacy Manager for Charlton Health, Hamilton, ON

Reference:
Ontario Ministry of Health and Long-Term Care. MedsCheck. Available at *www.health.gov.on.ca/en/pro/programs/drugs/medscheck/medscheck_original.aspx*

Patient Self-Care and Self-Management Resources

By Ms. Anne Lyddiatt

Searching for and finding reliable sources of information on how to live with and manage arthritis can be a daunting task. This is especially true for newly or relatively newly diagnosed patients who are not yet familiar with terminology, treatments, what constitutes reasonable expectations, and how to recognize a "get rich quick" scheme with a "cure" for a disease still waiting for a cure to be discovered. With over 100 types of arthritis, how can a patient find the information pertinent to their condition?

Most Canadians are unable or unwilling to commit to the educational program on arthritis based on the Stanford model consisting of six weekly two-hour sessions. The need for accurate information is as great as ever, but the preference is for less structured and more easily available information.

There can be differences in interpretation of self-care and self-management. Some patients and professionals regard self-care as looking after oneself and one's arthritis, while others feel self-management is how they manage their disease on a daily basis and self-care is a separate issue. When searching for resources, it is a good idea to search both terms.

Some excellent resources are available online including RheumInfo, Joint Health, the Canadian Arthritis Patient Alliance (CAPA) website and newsletters, and The Arthritis Society website, to name a few. The challenge is finding a way to reach people when they are newly diagnosed and desperate for the answers and help they can find on these reliable sites. It remains an ongoing challenge to ensure that people can access information to understand their arthritis and the need to follow their treatment plan to enjoy the best possible quality of life.

Ms. Anne Lyddiatt, National Trainer, Patient Partners, Ingersoll, ON

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5) Performance Measurement

The First Canadian System-level Performance Measures for Inflammatory Arthritis

By Claire Barber, MD, PhD, FRCPC

When the Arthritis Alliance of Canada (AAC) developed an approach to Models of Care for inflammatory arthritis (IA) in 2014, a critical component of implementing this approach was evaluation. At the time, there were no existing system-level performance measures for IA care. We therefore embarked on a study to develop a set of performance measures to evaluate models of care for IA at a system level.

Through multiple rounds of an online modified-Delphi process, we gained broad input from 50 arthritis stakeholders including rheumatologists, allied health professionals, persons living with arthritis, and researchers. Participants rated the validity, feasibility, relevance and likelihood of using a proposed set of performance measures, which were identified based on a systematic review of the literature.

Six performance measures emerged for evaluating inflammatory arthritis care:

1) wait times for rheumatology consultation for patients with new onset IA;
2) percentage of IA patients seen by a rheumatologist;
3) percentage of IA patients seen in yearly follow-up by a rheumatologist;
4) percentage of rheumatoid arthritis patients treated with a disease-modifying anti-rheumatic drug (DMARD);
5) time to DMARD therapy in patients with rheumatoid arthritis;
6) number of rheumatologists per capita.

This constitutes the first set of system-level performance measures for evaluating models of care in IA. These can serve as an aid for health care decision-makers to identify and prioritize areas for improvement, and to measure outcomes of health system changes whose goals are to improve the care of patients with IA.

Dr. Claire Barber, Assistant Professor, Rheumatologist, University of Calgary, Calgary, AB

Reference:

Barber CE, et al. Development of system-level performance measures for evaluation of models of care for inflammatory arthritis. J Rheumatol 2016; 43:530-40.

Core Clinical Data Set Supports High-quality Care for RA Patients in Canada

By Claire Barber, MD, PhD, FRCPC

Variability in clinical data collection has been identified as a barrier to quality measurement, since it creates challenges in terms of maintenance of complete patient records and monitoring the provision of care. The Arthritis Alliance of Canada (AAC) partnered with the Canadian Rheumatology Association (CRA) and individual investigators to develop a Canadian Rheumatoid Arthritis Core Clinical Dataset (CAN-RACCD) to encourage best practices and to facilitate future quality measurement efforts.

The CAN-RACCD was developed through a three-phase program that included an environmental scan to identify a candidate set of core data elements, stakeholder meetings to prioritize elements for inclusion, and a modified-Delphi process to finalize the core clinical dataset. Broad input was gained from 47 rheumatologists, people living with arthritis, and allied health providers from across Canada.

The CAN-RACCD includes 49 individual data elements across nine categories: (1) demographic; (2) timing - including dates of symptom onset, referral, first visit and diagnosis; (3) clinical data; (4) disease activity; (5) comorbidities; (6) smoking status; (7) patient-reported outcomes; (8) medications; and (9) laboratory and radiographic data

This is an important first step in standardizing measurement that will help improve the quality of care of people living with rheumatoid arthritis.

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Reference:
Barber CEH, et al. Development of a Canadian core clinical dataset to support high quality care for rheumatoid arthritis patients in Canada. J Rheumatol 2017 Dec; 44(12):1813-22.

Knowledge Translation and Implementation

By Alexander Lo, MD, FRCPC; Shirley Chow, MD, FRCPC; Natasha Gakhal, MD, FRCPC; and Linda Li, BSc(PT), MSc, PhD

Knowledge Translation (KT) is of critical importance to health research, as it has become clear that the creation of new knowledge often does not, on its own, lead to widespread implementation or impacts on health. KT is important in bridging the gap between research and practice so that patients can benefit optimally from advances in research evidence.

There exist various theories, approaches and models of KT. The Knowledge-to-Action Process Framework[1] is one model. Knowledge application is an important component that represents the ″action″ phase of the framework, which involves tailoring the knowledge product/tool for implementation, dissemination and quality improvement (QI).

The Model for Improvement is a practical QI approach that can be used to implement the Inflammatory Arthritis or Osteoarthritis Models of Care (MOCs) at the front line of clinical care. According to this model, sequential Plan-Do-Study-Act (PDSA) cycles are executed to guide specific improvement activities. By following a few step-by-step principles, health care providers can apply a QI assessment in their own clinical setting. These steps include performing a gap analysis of the current state to identify ways an individual's practice could be improved to better reflect a MOC.

The second step is to engage stakeholders and conduct a root cause analysis to understand the reasons for the gap in practice and the barriers to implementing the MOC in an individual setting. To understand the nature of the problem and identify the key drivers of the quality gap, such tools as fishbone diagrams, process maps and Pareto charts can be used. These root causes will be the targets of the QI intervention.

The third step is to implement a change to improve practice and to evaluate the effects of the change to identify what adjustments may be required to refine the process further. Multiple small-scale PDSA cycles are usually necessary to achieve gradual improvements over time.

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Dr. Shirley Chow, Assistant Professor, Department of Medicine, University of Toronto, Toronto, ON

Dr. Natasha Gakhal, Rheumatologist, Women's College Hospital, Toronto, ON

Dr. Linda Li, Professor, University of British Columbia; Senior Scientist, Arthritis Research Canada, Vancouver, BC

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Rheumatology Workforce in Canada

By Claire Barber, MD, PhD, FRCPC

The Arthritis Alliance of Canada's System Level Performance Measures were designed to evaluate models of care to ensure patients with inflammatory arthritis receive timely diagnosis and treatment. Central to ensuring timely care is making sure there are adequate numbers of rheumatologists for making an early diagnosis and starting appropriate treatment.

In 2015, the Canadian Rheumatology Association launched "Stand Up and Be Counted," a national workforce survey of rheumatologists across Canada. The results highlighted that there is a current shortage of rheumatologists across the country that may worsen over the next 10 years because a third of the workforce reported plans to retire in the near future.

Further analysis of the results of the survey will be published imminently in *The Journal of Clinical Rheumatology* and will describe factors associated with rheumatologists' clinical work hours and patient volumes.

Dr. Claire Barber, Assistant Professor, Rheumatologist, University of Calgary, Calgary, AB

Reference:
Barber CEH, et al. Stand Up and Be Counted: Measuring and Mapping the Rheumatology Workforce in Canada. J Rheumatol 2017; 44(2):248-57.

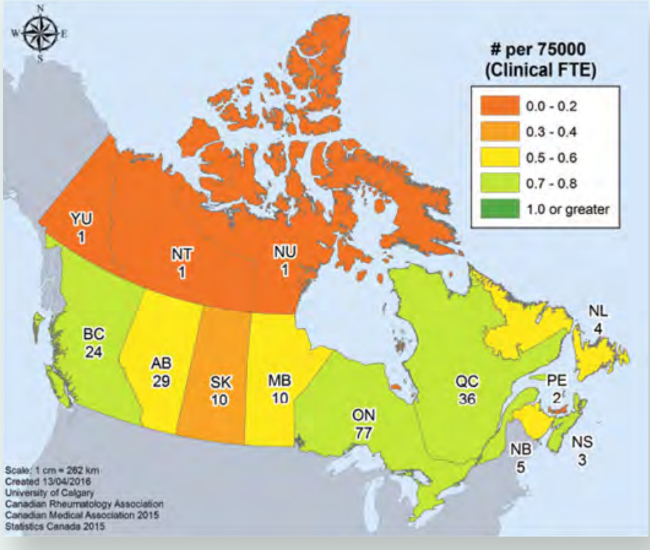

Figure 1. Distribution of Rheumatologists Across Canada

Map of Canada showing the number of FTE-practicing rheumatologists per 75,000 population and the number of FTE rheumatologists required to meet the target of 1:75,000 benchmark (superimposed provincial count). FTE were estimated based on the national median reported time allocated to clinics from all respondents of the 2015 Stand Up and Be Counted survey and used to adjust the 2015 Canadian Medical Association numbers of rheumatologists in each province.

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Economic Perspectives

By Elena Lopatina, MD, MSc; Deborah A. Marshall, PhD; Vandana Ahluwalia, MD, FRCPC; Stephanie Garner, MD, MSc; Hani El-Gabalawy, MD, FRCPC, FCAHS; Dianne Mosher, MD, FRCPC; and Carter Thorne, MD, FRCPC

The devastating consequences of inflammatory arthritis (IA) to individual patients and the healthcare system burden associated with the treatment of IA and productivity losses[1,2] highlight the need to provide the right care to the right patient at the right time.[3]

Given the scarcity of healthcare resources and financial constraints,[4] the efficiency of care (*i.e.*, optimal use of resources in achieving desired outcomes[5]) is an important aspect to consider.[5-7] Models of care (MOCs) are one approach that is expected to improve accessibility, appropriateness, effectiveness, and safety of care for IA patients[8] and, consequently, to improve patient outcomes and increase likelihood of remission[9] and reduce the associated medical costs.[10-13]

From an economic perspective, there may be costs associated with the implementation and operation of MOCs (*e.g.*, education and training of staff, ongoing funding for staff salaries), but this must be balanced against the benefits to patients in terms of improved outcomes and reduced health care costs associated with the management of patients with IA with lower disease activity. MOCs for IA patients thus have the potential to be cost-effective and possibly cost-saving.

The current evidence regarding the efficiency of MOCs for IA patients is limited, especially in local Canadian settings. To draw decision-makers' attention to and improve uptake of MOCs for arthritis patients, evidence on their efficiency is required. The Arthritis Alliance of Canada (AAC) is currently undertaking a cost consequences analysis of MOCs for IA patients with a specific focus on the access to care element of MOCs for IA patients to demonstrate the benefits of implementing MOCs and explore their efficiency.

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Dr. Carter Thorne, Rheumatologist/Medical Director, The Arthritis Program, Southlake Regional Health Centre, Newmarket, ON

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Advocating for Change

By Kelly Lendvoy; and Janet Yale

This special issue of *The Canadian Rheumatology Association Journal* has been dedicated to highlighting the many projects and initiatives that have been undertaken by the Arthritis Alliance of Canada (AAC) and the rheumatology community in the last five years. These initiatives have also formed the basis for our advocacy efforts with policymakers across the country whose decisions today will impact patients' access to quality arthritis care in the years to come.

Our advocacy and awareness goals are to ensure arthritis is fully understood by our key external audiences, such as health care providers, government, employers and private health insurers, and compel them to engage and invest in our community's initiatives. To accomplish these goals, the AAC mobilizes and activates our members, providing them the tools and data to tell the arthritis story.

The AAC has developed guidelines to ensure our advocacy activities are effective and sustainable:

- Integrated with AAC awareness raising;
- Scaled to its capacity and resources;
- Opportunistic and leveraging the current political or policy environment;
- Appealing and relevant to its supporters and members; and
- Offering an opportunity to build government relations capacity of the organization and advocacy interest of AAC supporters and members.

As we move forward, the AAC will continue to leverage the wide range of expertise, capabilities and networks of its members from across Canada to provide evidence-based information to inform and support policies that improve the delivery of care to people with arthritis. Their ongoing work, both as individual organizations and in collaboration with other arthritis stakeholders, is essential to achieving the overall goals of mitigating the personal and societal burden of the more than 100 types of arthritis–the leading cause of pain and disability in Canada.

Mr. Kelly Lendvoy, Vice President, Communications and Public Affairs, Arthritis Consumer Experts, Vancouver, BC

Ms. Janet Yale, Chair of Board, Arthritis Alliance of Canada; President & Chief Executive Officer, Arthritis Society, Toronto, ON

JOINT COMMUNIQUÉ

Looking Ahead: The Future of Models of Care

By Vandana Ahluwalia, MD, FRCPC; Dianne Mosher, MD, FRCPC; Michel Zummer, MD, FRCPC; Michelle Teo, MD, FRCPC; Claire Barber, MD, PhD FRCPC; Cheryl Barnabe, MD, FRCPC; and Carter Thorne, MD, FRCPC

As a collaborative, the Arthritis Alliance of Canada and the Canadian Rheumatology Association are proposing innovations in models of care to respond to historical human health shortages, and to anticipate the next crisis that will impact accessibility to rheumatology care. By 2025, it is estimated that one third of Canadian rheumatologists will retire,[1] coupled with an anticipated growth in patient volume driven by an aging population.[2] With the knowledge of the impact of early diagnosis and treatment on outcomes in rheumatologic diseases, we must find alternative approaches to patient care.

Team-based models of care are a natural option for a specialty with a long history of collaborating with allied health professionals including physiotherapists, occupational therapists and more recently, nurses. These models increase patient access, improve quality of care, and invigorate the clinic environment. These models take time and energy to develop, highlighting the need for peer-to-peer mentorship, opportunities to share experiences, and new/continued provincial and national support.

As highlighted in this edition of *CRAJ*, a diverse array of models of care has been successfully implemented throughout Canada. There is no "one size fits all" solution, and in the end, the most appropriate model is determined by the rheumatologist's style of practice, availability of allied health professionals and resources to support the model of care, and ultimately, the needs of the local community. Regardless of which model is utilized, patient and system outcome measures need to be collected, studied and analysed, to verify that patient needs are being met, and that a positive change occurs in our care delivery systems.

The adoption of quality of care measurement and monitoring of adherence to performance measures is in its infancy in rheumatology, but the future is bright with a new robust generation of rheumatologists in Canada. The awareness of the need to revolutionize patient care will drive this positive change.

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Acknowledgments

This section of the *CRAJ* on healthcare delivery and models of care, prepared by the Arthritis Alliance of Canada (AAC), undoubtedly showcases the tremendous work that has taken place in the development and implementation of models of care in Canada. The published work would not be possible without the efforts and support of many individuals and organizations across the country. The AAC Board Chair, Co-chairs of all pillar committees and its members wish to express their great appreciation to all who contributed to the models of care work over the years and to this publication in the *CRAJ*.

New Collaborative Cardio-Rheumatology Program – Improving Cardiac Outcomes in Rheumatology

By Lihi Eder, MD, PhD; Shadi Akhtari, MD, FRCPC; and Paula Harvey, BMBS, PhD

The notion that inflammation is bad for the arteries and that our rheumatic patients are at high risk for developing cardiovascular events is now well accepted in the rheumatology community. However, there are many gaps in knowledge regarding the underlying mechanisms of cardiovascular diseases in rheumatic patients, which lead to varying and conflicting recommendations for the management of cardiovascular risk in these patients. Standard clinical risk-assessment tools which take into account traditional cardiovascular risk factors underestimate cardiovascular risk in patients with inflammatory rheumatic conditions.There is a need for development of more accurate tools to assess cardiovascular risk in this population.

Additionally, significant gaps in care exist in the management of cardiovascular risk factors in patients with rheumatic diseases. Awareness of the increased cardiovascular risk among rheumatologists has not translated into adherence to treatment recommendations. A significant proportion of patients have undiagnosed and undertreated cardiovascular risk factors. These gaps in care may be explained by the fact that, understandably, visits with rheumatologists are spent addressing the management of the actual rheumatic condition, leaving little time and attention to primary prevention of cardiovascular events. This is potentially compounded by the fact that many family physicians and even cardiologists may not be aware of the increased cardiovascular risk in these patients. Limited knowledge about cardiovascular prevention strategies and disagreement in the rheumatology community about the role of specialists versus family doctors in the management of cardiovascular risk factors are some of the potential additional reasons for this gap in care.

The Women's College Hospital Cardio-Rheumatology Program was established in July 2017 as part of a wider collaborative network within the University of Toronto that also involves physicians from Mount Sinai Hospital led by Dr Bindee Kuriya.

The program is led by Dr. Lihi Eder, staff rheumatologist and scientist at Women's College Research Institute and Dr. Paula Harvey, cardiologist and Chief of Medicine at Women's College Hospital. Together with Dr. Shadi Akhtari, a cardiologist, who runs the weekly cardio-rheum clinic, the team has set a goal to improve the management of cardiovascular risk in patients with rheumatic diseases.

Paula Harvey has been involved in the field of cardio-rheumatology since coming to Canada in 1999 from Australia to do her post-doctoral research, which evolved from her special interest in studying cardiovascular dis-

Dr. Lihi Eder

Dr. Shadi Akhtari

Dr. Paula Harvey

ease in women. This interest led to a close clinical and research collaboration with the University of Toronto Lupus Program. Lihi Eder's interest in cardiovascular morbidity in rheumatic diseases evolved during her post-doctoral fellowship at the University of Toronto Psoriatic Arthritis Program, where she investigated the effect of biologic medications on atherosclerosis progression in patients with psoriatic disease. Their shared interest in cardiovascular medicine in rheumatic patients led to the establishment of this collaborative program.

The program aims to improve the primary prevention of cardiovascular events in rheumatic patients by developing novel approaches to cardiovascular risk stratification using traditional risk factors, laboratory biomarkers and cardiovascular imaging. The clinic runs once a week and accepts referrals of patients with rheumatoid arthritis, psoriatic arthritis and ankylosing spondylitis, aged 40 years and older, who do not have a history of cardiovascular disease. Patients undergo a comprehensive evaluation including a cardiologist assessment, laboratory testing, non-invasive stress testing where appropriate, calcium score coronary CT and carotid ultrasound to quantify the carotid plaque burden. Based on the results of this detailed assessment, the patients are stratified according to their predicted future cardiovascular risk and recommendations are made regarding medication and lifestyle interventions required to reduce cardiovascular risk. The team plans to follow the clinic patients in a longitudinal study to determine the long-term outcomes of these interventions and to inform the development of evidence-based guidelines.

This collaborative model is one approach that could potentially improve co-morbidities in rheumatic patients. Similar models of care already exist for patients with diabetes and chronic kidney disease. However, such models require local resources and may not be available outside of academic centres. Raising physician awareness of the increased cardiovascular risk in patients with inflammatory rheumatic disorders while developing alternative models of shared care between family physicians, rheumatologists and cardiologists are also long-term core objectives of this novel collaborative program. Finally, educating our rheumatic patients about their increased cardiovascular risk and encouraging them to adhere to heart-healthy lifestyle recommendations is a critical component of any strategy aimed at improving cardiovascular outcomes in this cohort.

Through a coordinated care program involving the patient, rheumatologist, cardiologist and family physician, we hope to address the unmet clinical and research needs, to identify early atherosclerosis in patients with rheumatic disease, and to improve the health outcomes of this patient population.

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CPD for the Busy Rheumatologist

Practice Reflection: Can I Improve My Patient Outcomes with MOC Section 3 Credits?

By Raheem B. Kherani, BSc (Pharm), MD, FRCPC, MHPE; Jerry M. Maniate, MD, M.Ed, FRCPC; and Craig M. Campbell, MD, FRCPC

"I recently finished my review and reflection on my Continuing Professional Development (CPD) activities," exclaimed Dr. AKI Joint, a rheumatologist member of the CRA. "I realized that I don't have much in section 3, despite all of my CPD activities for last year. I faithfully reviewed the Summer and Fall 2017 *CRAJ* CPD articles. I went to rounds and the 2017 CRA Annual Scientific Meeting (ASM) in Ottawa for maintenance of certification (MOC) section 1 credits. After reading the last article, I downloaded the MAINPORT app for iPhone and Android users (*www.royalcollege.ca/rcsite/resources/access-royal-college-apps-e*) which enabled me to capture MOC section 2 credits, in real time, for the learning I was already doing while looking after my patients."

"I read on The Royal College of Physicians and Surgeons of Canada (RCPSC) website that all new MOC program cycles beginning on or after January 1, 2014, require program participants to complete a minimum of 25 credits in each section during their five-year cycle. That means I need to complete MOC section 3 credits, too. I have never done this before."

"Interestingly, the Royal College website states, 'The CPD research literature[1,2] has clearly demonstrated that physician's self-assessment compared to external measures of performance is inaccurate, and assessment strategies that provide data with feedback have a higher likelihood of changing performance and improving patient outcomes compared to other forms of continuing professional development.' Even though I am a busy clinician, I certainly want to improve my practice and do an even better job looking after my patients. This sounds like an approach that really could work. I do look after many patients with rheumatoid arthritis that require assessment of tuberculosis (TB) and vaccination status," reported Dr. Joint. "I think I am consistently assessing these aspects of care before commencing treatment, but how would I know for sure?"

"The Royal College website had a number of potential ideas for Performance Assessment, including multi-source feedback, feedback on teaching and direct observation. I certainly used the first two in training. I remember a poster at the 2017 CRA ASM about video review (Abstract 201 [page 81] in *The Journal of Rheumatology* [*jrheum.org/content/jrheum/early/2017/04/22/jrheum.170256.full.pdf*], that was discussed further in an MOC Tip of the Month in the RCPSC Dialogue) (*royalcollege.ca/rcsite/publications/dialogue/dialogue-july-2017-e*). However, the approach that seems like it will work for me is a Chart Audit. At the 2016 CRA ASM in Lake Louise, some of my colleagues went to a Chart Audit Workshop by Dr. Henry Averns and learned about how to analyze their patient medical records to improve the quality of their patient care. On the CRA website members' section (Figure 1) there was great information from this workshop (*rheum.ca/en/members/chart_audit*). This was really useful! I also found step-by-step instructions on 'How to do a Chart Audit', links to Chart Audit tools and examples of Clinical Audits of Infection and Vaccination Status and Scleroderma. There is even a link to a fellow CRA member's article on publication of practice audits (*ncbi.nlm.nih.gov/pmc/articles/PMC5283566/*)."

Table 1:
Steps To Take Using Resources and Patient Charts

Steps		Example
1	Select a topic.	Infection and vaccination status
2	Determine what you will measure and your benchmarks.	2012 CRA guidelines (Reference 3)
3	Collect your data.	Chart review revealed: • 100% had pre-biologic TB screening • 90% had influenza vaccine • 77% had pneumococcal vaccine • 25% of eligible patients had shingles vaccine
4	Compare your data against your measures.	Compare to the 2012 CRA guidelines recommendations (Table 3; Recommendations 2 through 9)
5	Obtain feedback.	Review with a colleague: • Good TB screening and influenza vaccine rates • Consider strategies to improve pneumococcal and shingles vaccination rates in appropriate patients, like the approach my colleague and her nurse took. They put together pamphlets about local availability of the vaccines for their patients that patients found helpful.
6	Identify outcomes and apply results.	My colleague provided a copy of the patient education document for adaption for my local practice. I have begun to distribute these pamphlets and am collecting further feedback from patients
7	Document the chart audit in the MAINPORT ePortfolio.	I used the MAINPORT app to document the 6 hours (= 18 credits) I spent on this project.

"Using the above resources and my patient charts (either paper or EMR) I tried the steps outlined in Table 1."

"Since I have been following the series on CPD for the busy rheumatologist, I have an advanced understanding of MOC sections 1, 2 and 3. As a result, I am now more precise with my choice of learning opportunities, I am able to document my patient-based learning on the MAINPORT app, in real time, and also improve my practice and care for my patients through chart audits," reflected Dr. Joint. I plan to review similar data next year to see if my analysis changes for the better. Hopefully, my colleague will review this again and we can learn from each other. At the recent 2018 CRA ASM in Vancouver, there were many interesting sessions, such as immunotherapy, using digital technology in arthritis care, cybersecurity, building cultural competence, and even navigating conflict of interest. Hopefully I can build on what I learned in 2017 to continue to improve my skills as a rheumatologist."

Before you started reading this series, you might have raised a question on how to make your learning more effective. Reading these articles, the time you spent reading and reflecting on these articles and coming to some conclusions on results that you would like to implement, would qualify for a Personal Learning Project (MOC section 2).

Our lives as rheumatologists are busy with the balance of many competing personal and professional interests. Optimizing learning, implementing helpful tools and reflecting on practice, like Dr. AKI Joint did, can make learning more efficient and enjoyable while also impacting our ability to provide care!

If you have your own CPD stories or tips to share, please email Claire McGowan at *claire@rheum.ca*.

Acknowledgement to Dr. Barry Koehler (a CRA Past-President), for the initial discussion that lead to this article series, immediately following the 2017 CRA Annual Scientific Meeting (ASM).

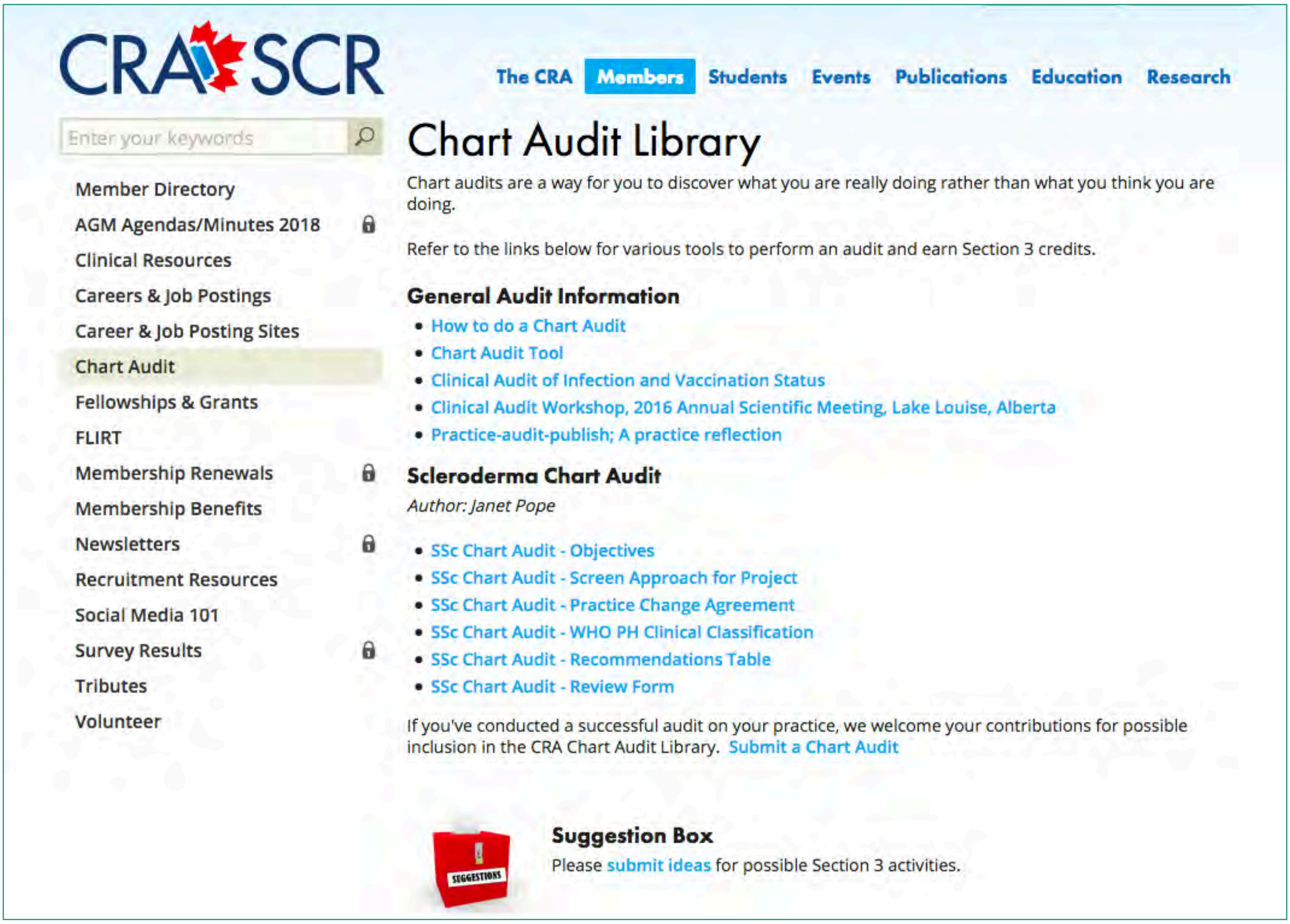

Chart Audit Library

Chart audits are a way for you to discover what you are really doing rather than what you think you are doing.

Refer to the links below for various tools to perform an audit and earn Section 3 credits.

General Audit Information

- How to do a Chart Audit
- Chart Audit Tool
- Clinical Audit of Infection and Vaccination Status
- Clinical Audit Workshop, 2016 Annual Scientific Meeting, Lake Louise, Alberta
- Practice-audit-publish; A practice reflection

Scleroderma Chart Audit

Author: Janet Pope

- SSc Chart Audit - Objectives
- SSc Chart Audit - Screen Approach for Project
- SSc Chart Audit - Practice Change Agreement
- SSc Chart Audit - WHO PH Clinical Classification
- SSc Chart Audit - Recommendations Table
- SSc Chart Audit - Review Form

If you've conducted a successful audit on your practice, we welcome your contributions for possible inclusion in the CRA Chart Audit Library. Submit a Chart Audit

Suggestion Box

Please submit ideas for possible Section 3 activities.

Figure 1. CRA website, members' section

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Medical Lead, Arthritis Program, GF Strong Rehabilitation Centre
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Rheumatologist, West Coast Rheumatology Associates
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References:

1. Davis DA, Mazmanian PE, Fordis, et al. Accuracy of physician self-assessment compared with observed measures of competence: a systematic review. JAMA. 2006; 296(9):1094–02. doi:10.1001/jama.296.9.1094

2. Eva, K. W. and Regehr, G. "I'll never play professional football" and other fallacies of self-assessment. J Contin Educ Health Prof 2008; 28: 14–9. doi:10.1002/chp.150

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REGIONAL NEWS AB

Updates from Calgary

Grant Funding Success for Calgary

Eminent pediatric and adult rheumatologists from Calgary, including Drs. Susa Benseler, Marvin Fritzler, Marinka Twilt and Dianne Mosher, and scientist Dr. Deborah Marshall, were successful in securing a $10 million grant from Genome Canada in partnership with the Canadian Institutes of Health Research (CIHR) to transform the treatment of juvenile idiopathic arthritis through better identification of the right drug for the right patient.

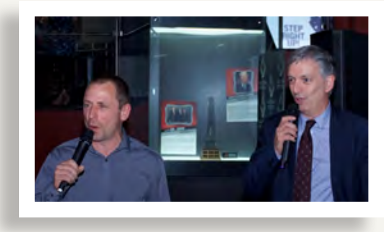
Retirement of Nurse Extraordinaire Terri Lupton

Terri Lupton and Dr. Dianne Mosher

On a lovely spring evening in 2017, we celebrated the career of Terri Lupton, who put Calgary on the map for developing a city-wide Central Triage Unit, while also mentoring countless nurses joining the Division of Rheumatology since 2006. In her honor, an annual "Terri Lupton Lecture" has been established.

Rheumatologist Featured on CBC

Dr. Paul MacMullan, infamous for covering city-wide call at four hospitals and one outpatient clinic site from the back of a bike (roundtrip of over 100 km), was recently featured on the local CBC news for persisting through the series of large snow dumps Calgary has seen this winter. He added to his notoriety by getting fellow Irishman Dr. Liam Martin up to sing "Ring of Fire," a local anthem for the Calgary Flames, at our Division Christmas party, held at the Canadian Sports Hall of Fame.

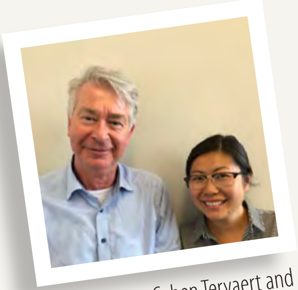


Dr. Paul MacMullan and Dr. Liam Martin

– Cheryl Barnabe, MD, FRCPC, MSc

Updates from Northern Alberta

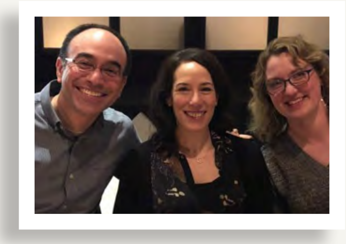
News from the University of Alberta



Dr. Jan Willem Cohen Tervaert and Dr. Carrie Ye

The Division of Rheumatology at the University of Alberta welcomed their new Division Director, Dr. Jan Willem Cohen Tervaert in the fall of 2017. He received his MD and PhD in the Netherlands with his thesis on ANCA autoantibodies. He brings with him a fresh Dutch perspective and a large body of work in the field of vasculitis and immunology. He is also a former Chair of the Scientific Advisory Board of the Dutch Arthritis Foundation. The division is eager to see where he takes us!

Filling the position of Program Director for the Division is Dr. Carrie Ye, a University-of-Alberta-trained rheumatologist. She has also started a multidisciplinary clinic for the management of glucocorticoid-induced osteoporosis. She replaces Dr. Steven Katz who has moved into the role of Program Director for the Core Internal Medicine Program.



Dr. Steven Katz, Dr. Sarah Troster, and Tobi Leder

Also at the University of Alberta, we are delighted to have two recent rheumatology resident graduates pursue extra training to further enrich our division. Dr. Sarah Troster is excited to embark on her Master's in Education while also collaborating with other rheumatologists in Western Canada to create a pregnancy and rheumatic disease registry. Dr. Natalie Maclean is currently working on her Master's in Epidemiology at the School of Public Health and will explore patient-related outcomes in inflammatory arthritis as part of her thesis. Dr. Mohamed Osman continues the second year of his research fellowship in immunology and has started a clinical immunology clinic, collaborating with a multi-specialty group to create expertise in clinical immunology.

News from Recent Graduates

With the recent surge of rheumatology applicants, we are thrilled to send our recent graduates into the real world. Dr. Evelyn Kwok has moved to Kelowna to join Dr. Stuart Seigel while Dr. Norm Madsen is madly scanning joints and seeing patients in northwest Edmonton, as well as expanding his own family. Drs. Jason Soo and Tharindri Dissanayake have opened up a new office across the street from the University of Alberta – Garneau Rheumatology. We are thrilled to work with our new rheumatology colleagues.

– Joanne Homik, MD, MSc, FRCPC;
and Stephanie Keeling, MD, MSc, FRCPC

The first and only anti-TNF indicated in nr-Ax SpA[1*†]

NOT ALL TYPES OF AXIAL SPA CAN BE SEEN WITH AN X-RAY[2]

Indications and clinical use which have not been discussed elsewhere in the piece:

SIMPONI® is also indicated:

- For reducing signs and symptoms in adult patients with active ankylosing spondylitis (AS) who have had an inadequate response to conventional therapies
- In combination with methotrexate (MTX): for reducing signs and symptoms and improving physical function in adult patients with moderately to severely active rheumatoid arthritis and inhibiting the progression of structural damage in adult patients with moderately to severely active rheumatoid arthritis who had not previously been treated with MTX.
- For reducing signs and symptoms, inhibiting the progression of structural damage and improving physical function in adult patients with moderately to severely active psoriatic arthritis. SIMPONI® can be used in combination with MTX in patients who do not respond adequately to MTX alone.
- In adult patients with moderately to severely active ulcerative colitis who have had an inadequate response to, or have medical contraindications for, conventional therapy including corticosteroids, amino salicylates, azathioprine (AZA), or 6-mercaptopurine (6-MP), for inducing and maintaining clinical response (reduction in signs and symptoms); inducing clinical remission; achieving sustained clinical remission in induction responders; improving endoscopic appearance of the mucosa during induction.

- No studies have been performed in pediatric patients
- Caution should be used when treating the elderly, as there is a higher incidence of infections in this population. There were no patients ≥65 years in the nr-Ax SpA study

Contraindications:

- Severe infections such as sepsis, tuberculosis and opportunistic infections
- Moderate or severe (NYHA class III/IV) congestive heart failure
- Patients who are hypersensitive to golimumab, or any other ingredient in the formulation or component of the container

Most serious warnings and precautions:

Infections:

- Serious infections leading to hospitalization or death, including sepsis, tuberculosis (TB), invasive fungal, and other opportunistic infections have been observed with the use of TNF antagonists including golimumab. Administration of SIMPONI® should be discontinued if a patient develops a serious infection or sepsis. Treatment with SIMPONI® should not be initiated in patients with active infections including chronic or localized infections.
- Physicians should exercise caution when considering the use of SIMPONI® in patients with a history of recurring or latent infections, including TB, or with underlying conditions, which may predispose patients to infections, who have resided in regions where TB and invasive fungal infections such as histoplasmosis, coccidioidomycosis, or blastomycosis are endemic.
- Tuberculosis (frequently disseminated or extrapulmonary at clinical presentation) has been observed in patients receiving TNF-blocking agents, including golimumab. Tuberculosis may be due to reactivation of latent tuberculosis infection or to new infection.
- Before starting treatment with SIMPONI®, all patients should be evaluated for both active and latent tuberculosis.
- If latent tuberculosis is diagnosed, treatment for latent tuberculosis should be started with anti-tuberculosis therapy before initiation of SIMPONI®
- Physicians should monitor patients receiving SIMPONI® for signs and symptoms of active tuberculosis, including patients who tested negative for latent tuberculosis infection.

Malignancy:

- Lymphoma and other malignancies, some fatal, have been reported in children and adolescent patients treated with TNF blockers, of which golimumab is a member.

For patients with severe active nr-Ax SpA* with objective signs of inflammation (OSI)

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INDICATION

Treatment of adults with severe active non-radiographic axial spondyloarthritis (nr-Ax SpA) with objective signs of inflammation as indicated by elevated C-reactive protein (CRP) and/or magnetic resonance imaging (MRI) evidence who have had an inadequate response to, or are intolerant to nonsteroidal anti-inflammatory drugs (NSAIDs).

Other relevant warnings and precautions:

- Geriatrics (65 years of age or older): Caution should be used in treating the elderly
- Risk of hepatitis B virus reactivation
- Risk of worsening or new onset of congestive heart failure
- Risk of infection with concurrent use of anakinra, abatacept or other biologics; concurrent use is not recommended
- Risk of hematologic reactions
- Risk of hypersensitivity reactions
- Risk of latex sensitivity
- Risk of clinical infections, including disseminated infections, with live vaccines and therapeutic infectious agents; concurrent use is not recommended
- Risk of autoimmunity
- May cause immunosuppression; may affect host defences against infections and malignancies
- Potential for medication errors
- Risk of new onset or exacerbation of CNS demyelinating disorders
- Risk of infection in peri-operative patients
- Adequate contraception must be used to prevent pregnancy in women of childbearing potential for at least 6 months after last treatment
- Not to breast-feed during and for at least 6 months after treatment with SIMPONI®
- Use with caution in patients with impaired hepatic function
- May have a minor influence on the ability to drive due to dizziness following administration

For more information

Please consult the Product Monograph at http://www.janssen.com/canada/products#prod-425 for important information relating to adverse reactions, drug interactions, and dosing information which has not been discussed in this piece.

The Product Monograph is also available by calling 1-800-567-3331.

* Non-radiographic axial spondyloarthritis

† Comparative clinical significance has not been established.

References: **1.** SIMPONI® Product Monograph, Janssen Inc., August 21, 2017. **2.** Hochberg, MC, Silman, AJ, Smolen, JS, *et al.* (2015). Rheumatology. Philadelphia: Mosby/Elsevier.

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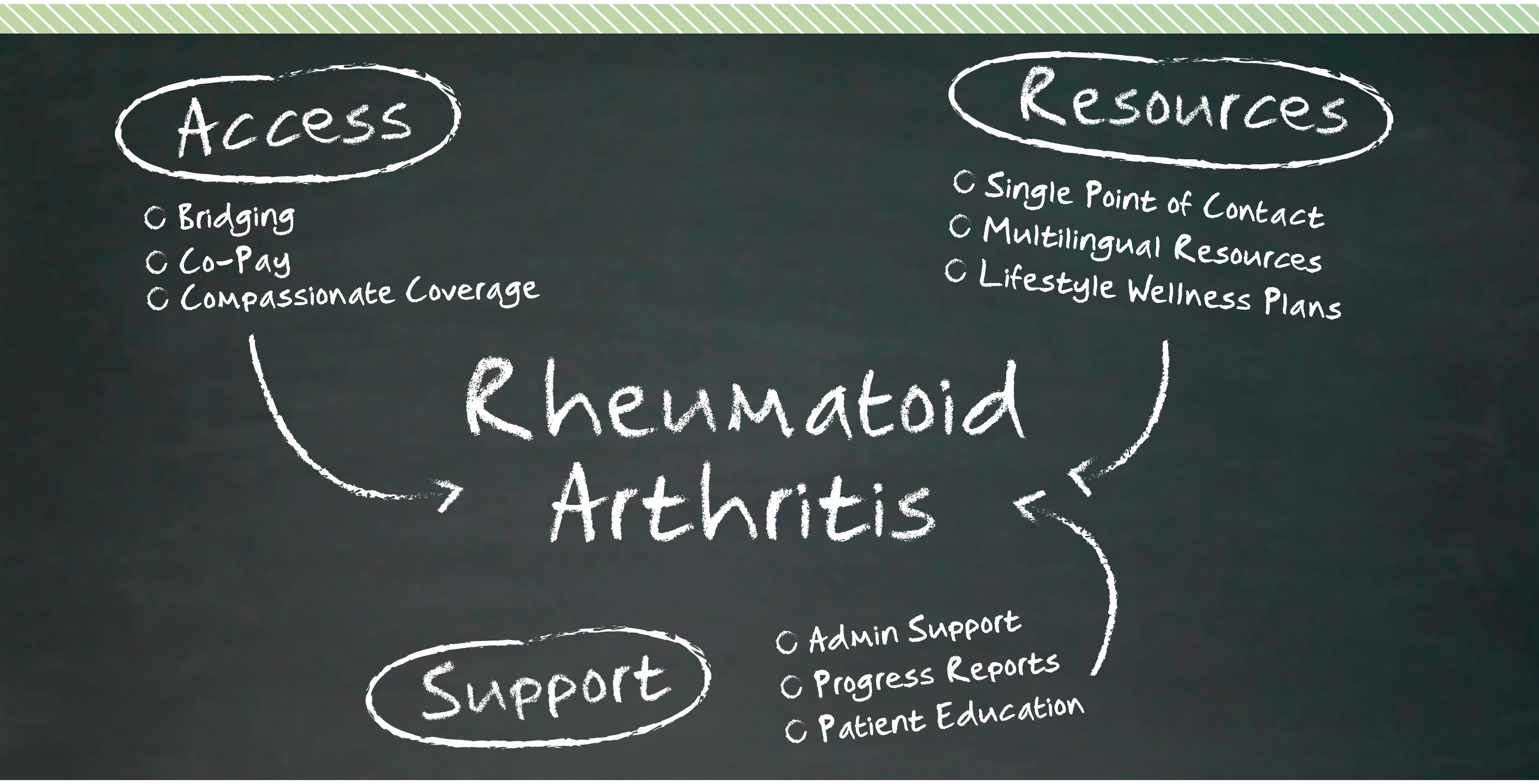

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XELJANZ (tofacitinib) in combination with methotrexate (MTX) is indicated for reducing the signs and symptoms of rheumatoid arthritis (RA) in adult patients with moderately-to-severely active RA who have had an inadequate response to MTX. In cases of intolerance to MTX, physicians may consider the use of XELJANZ as monotherapy.

Use of XELJANZ in combination with biological disease-modifying anti-rheumatic drugs (DMARDs) or potent immunosuppressants such as azathioprine and cyclosporine is not recommended.

Please consult the product monograph at http://pfizer.ca/pm/en/XELJANZ.pdf for contraindications, warnings, precautions, adverse reactions, interactions, dosing information and conditions of clinical use. The product monograph is also available by calling us at 1-800-463-6001.

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