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).

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Reference:
1. Hickcox S. Rheumatology Care Re-designed, Models of Care in Action: You can do it too! Workshop held at the 2017 Canadian Rheumatology Association annual meeting. Ottawa. 2017.

	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-

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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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.

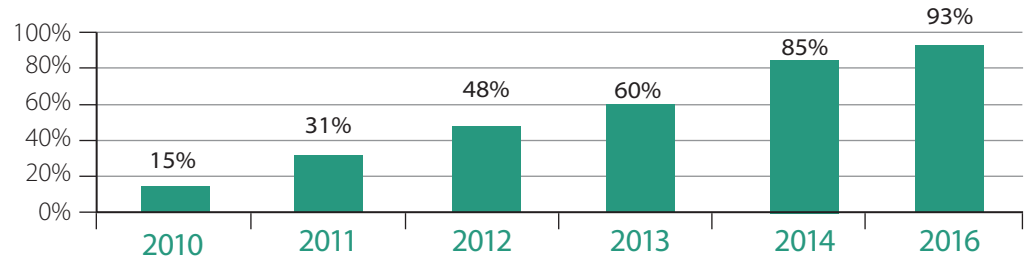

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Figure 1: Increasing use of EMRs by Ontario community rheumatologists: 2010 to 2016.