

CRA SCR

The Journal of the Canadian Rheumatology Association



Spotlight on:

Interprofessional Models of Care in Rheumatology

Editorial

Data for Good: Evaluating the EMR

What's the CRA Doing For You?

Who's in the Rheum? Dr. Patrick Donio

News from CIORA

2024 CIORA Grant Award Recipients Announced

Awards, Appointments, and Accolades

Celebrating Drs. Nigil Haroon, Allan Kagal and Suzanne Morin

Joint Communiqué

CPD for the Busy Rheumatologist — Raising the Bar of the Clinical Audit Spectrum: A Comparison Between the Mini-Practice Audit Model (mPAM) and Other Types of Clinical Audits

The CRA's 2024 Distinguished Rheumatologist: Dr. John Esdaile

Mapping the Journey to Rheumatology Team Care in BC (2010-2024)

Joint Count

Survey Results: Digital Quality Improvement

Hallway Consult

More Than Skin Deep: Thinking Below the Surface

Northern (High)lights

Patient Perspective: Donna Neal

Patient Perspective: Carrie Barnes

Stronger Together: The Opportunities of Interdisciplinary Models of Rheumatology Care
Implementing Interprofessional Rapid Assessment Clinic Models for Rheumatology to Support Equitable and Timely Access to Care

Interprofessional Shared Decision Making to Achieve Health Equity

In Memoriam

Tribute to Dr. Raymond M. Lewkonja

When your patient presents
with active psoriatic arthritis,
SAY TREMFYA^{®1}

**TREMFYA[®] and TREMFYA ONE-PRESS[®]:
Provincial and federal funding are now
available in most provinces for adult
patients with PsA.^{1-10*}**

Restrictions may apply. Refer to your respective
provincial and federal listings for full coverage
details and restrictions.^{2-10*}



TREMFYA[®]/TREMFYA ONE-PRESS[®] (guselkumab injection)
is indicated for the treatment of adult patients with active
psoriatic arthritis. TREMFYA[®]/TREMFYA ONE-PRESS[®] can be used
alone or in combination with a conventional disease-modifying
antirheumatic drug (cDMARD) (e.g., methotrexate).¹

TREMFYA[®]/TREMFYA ONE-PRESS[®] is also indicated for the treatment of adult
patients with moderate-to-severe plaque psoriasis who are candidates for
systemic therapy or phototherapy.¹



**ONE dedicated BioAdvance[®] Coordinator supports your
patients with reimbursement assistance so they can get
started on TREMFYA[®]/TREMFYA ONE-PRESS[®].**

Learn more at [Janssenpro.ca](https://www.janssenpro.ca)

Please consult the Product Monograph at www.janssen.com/canada/our-medicines for important
information relating to warnings, precautions, adverse reactions, interactions, dosing, and conditions
of clinical use that has not been discussed in this piece.

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

PsA=psoriatic arthritis.

* Alberta, Saskatchewan, Manitoba, New Brunswick, Newfoundland and Labrador, Nova Scotia, Ontario (EAP), Prince Edward Island, and Non-Insured
Health Benefits (NIHB). Please refer to the respective listings for coverage information and restrictions.

References: **1.** TREMFYA[®]/TREMFYA ONE-PRESS[®] (guselkumab injection) Product Monograph. Janssen Inc. January 17, 2024. **2.** Alberta Health. Drug
benefit list. Formulary Search Results. October 13, 2023. **3.** Manitoba Pharmacare. Manitoba Drug Benefits Formulary Bulletin #129. December 21, 2023.
4. New Brunswick (NB) Drug Plans Formulary Update. Bulletin #1122. December 18, 2023. **5.** Newfoundland and Labrador Prescription Drug Program
Bulletin #234. December 13, 2023. **6.** Nova Scotia Formulary November 16, 2023. **7.** Ontario Ministry of Health. Exceptional Access Program Reimbursement
Criteria for Frequently Requested Drugs. December 18, 2023. **8.** Health PEI. PEI Pharmacare Formulary. November 2023. **9.** Saskatchewan Drug Plan.
Formulary Search Results. November 16, 2023. **10.** Non-Insured Health Benefits (NIHB) Program. Drug Benefit List. November 30, 2023.



The image depicted contains models and is being used for illustrative purposes only.

Janssen Inc. 19 Green Belt Drive | Toronto, Ontario | M3C 1L9 | www.janssen.com/canada

© 2024 Janssen Inc. | All trademarks used under licence. | CP-429532E



Data for Good¹: Evaluating the EMR

By Philip A. Baer, MDCM, FRCPC, FACR

The Great Debate at the Canadian Rheumatology Association (CRA) Annual Scientific Meeting (ASM) 2024 centred on the proposition: “Be it Resolved That Electronic Medical Records (EMRs) Save Time for Healthcare Providers & Improve Quality of Care.” As you read in the writeup of this session in the *Canadian Rheumatology Association Journal's* summer 2024 issue, the “For” side dominated the voting and were crowned the winners for 2024.

Of course, the “Against” side in the debate made many valid points. The benefits versus downsides of EMRs and electronic health records (EHRs) are by no means a settled issue. Let’s explore a few recent articles on the subject.

One has been sitting on my desktop since 2019, with the file name “EHR versus true work done.” The actual title is “Concordance Between Electronic Clinical Documentation and Physicians’ Observed Behavior,” published in the *Journal of the American Medical Association (JAMA) Network Open*.² The key question of the study was: “How closely does documentation in electronic health records match the review of systems and physical examination performed by emergency physicians?” This study was conducted in the United States (US) where, for the last 30 years, policies have been introduced tying physician reimbursement to documentation. The study focused on emergency medicine residents. They were initially told that this was a time-motion study aiming to understand how they performed histories and physical examinations. However, the real purpose was to assess the accuracy of documentation of the review of systems and the physical examination in EHRs, based on direct physical observation, review of audio recordings, and an analysis of the EHR records for emergency room visits. Twelve physicians participated, but three later withdrew when the true purpose of the study was revealed. Overall, 180 physician-patient encounters were reviewed, with the median encounter lasting 6.6 minutes. Major inconsistencies were observed between the number of systems documented and the number of systems observed, both for the review of systems and the physical examinations. The tendency skewed towards documenting more than what had been directly observed. Of 14 possible systems that could be reviewed and examined, the median observed number of systems reviewed was five and the median examined was eight. Only 38.5% of the review of systems groups and 53.2% of the physical examination

systems documented in the electronic health record were corroborated by direct audiovisual or reviewed audio observation. The conclusion of the study was that EHR documentation may not accurately represent physician actions, and that payers should consider removing financial incentives to generate lengthy documentation. In other words, “you get what you pay for,” and if you're paying for excessive documentation, it will be generated.

The second article is also from *JAMA Network Open* and was published earlier this year. This is another American study, entitled “Vacation Days Taken, Work During Vacation, and Burnout Among US Physicians.”³ The key question was “Are vacation days taken and working while on vacation associated with physician burnout?” This cross-sectional study evaluated vacation patterns, magnitude of work while on vacation, and levels of burnout and personal fulfillment among over 3,000 US physicians. Sixty percent of respondents took 15 or fewer vacation days per year, and 20% took five or fewer. Seventy percent performed patient-care-related tasks during their vacation, and 33% worked at least 30 minutes on a typical vacation day. Only 49% had full EHR inbox coverage while on vacation. Reported barriers to taking vacation included finding someone to cover clinical responsibilities, the financial impact on clinical compensation, and the volume of EHR inbox work faced upon return. Physicians who took more vacation days, had full EHR inbox coverage, and worked less during vacation reported significantly reduced emotional exhaustion, depersonalization, and overall burnout. These individuals also reported better professional fulfillment. Study conclusion: the reported vacation behaviours reflect chronic work overload, which heightens the risk of future physician burnout. The inability of physicians to disengage from patient care is a health system failure in terms of teamwork, clinical staffing, and cross-coverage options. Complete EHR inbox coverage is desirable and would allow predictable patient care to continue while physicians take much-needed vacation time.

Previously, I frequently accessed my EMR and work-related emails while on vacation. This was based in part on a 2011 article in the *Journal of the Ontario Medical Association*, authored by Dr. Perry Celzuz,⁴ promoting the benefits of logging in while on vacation: “I can now take time

Continued on page 5

CRAJ EDITORIAL BOARD

Mission Statement. The mission of the *CRAJ* is to encourage discourse among the Canadian rheumatology community for the exchange of opinions and information.

EDITOR-IN-CHIEF

Philip A. Baer, MD, MDCM, FRCPC, FACP
Past-President,
Ontario Rheumatology Association
Past-Chair, Section of Rheumatology,
Ontario Medical Association
Scarborough, Ontario

CRA EXECUTIVE

Trudy Taylor, MD, FRCPC
President,
Canadian Rheumatology Association
Associate Professor,
Dalhousie University
Halifax, Nova Scotia

Stephanie Tom, MD, FRCPC
Vice-President,
Canadian Rheumatology Association
Division Head of Rheumatology,
Trillium Health Partners
Mississauga, Ontario

Nigil Haroon, MD, PhD, DM, FRCPC
Past-President,
Canadian Rheumatology Association
Co-Director, Spondylitis Program, UHN
Clinician Scientist, UHN
Scientist, Krembil Research Institute
Associate Professor,
University of Toronto
Toronto, Ontario

MEMBERS

Vandana Ahluwalia, MD, FRCPC
Former Corporate Chief of
Rheumatology,
William Osler Health System
Brampton, Ontario

Cory Baillie, MD, FRCPC
Assistant Professor,
University of Manitoba
Winnipeg, Manitoba

Louis Bessette, MD, MSc, FRCPC
Associate Professor,
Université Laval
Rheumatologist,
Centre hospitalier universitaire
de Québec
Québec City, Quebec

May Y. Choi, MD, MPH, FRCPC
Associate Professor,
Cumming School of Medicine
University of Calgary and
Alberta Health Services
Calgary, Alberta

Joanne Homik, MD, MSc, FRCPC
Associate Professor
of Medicine,
University of Alberta
Edmonton, Alberta



Stephanie Keeling, MD, MSc, FRCPC
Professor of Medicine,
University of Alberta
Edmonton, Alberta

Shirley Lake, MD, FRCPC, MSc (QIPS)
Assistant Professor,
Division of Rheumatology,
University of Toronto,
Toronto, Ontario

Deborah Levy, MD, MS, FRCPC
Associate Professor,
University of Toronto,
Team Investigator,
Child Health Evaluative
Sciences Research Institute
Toronto, Ontario

Bindu Nair, MD, MSc, FRCPC
Professor of Medicine,
Division of Rheumatology
University of Saskatchewan
Saskatoon, Saskatchewan

Jacqueline C. Stewart, BSc (Hons), B ED, MD, FRCPC
Clinical Assistant Professor,
Department of Medicine,
University of British Columbia,
Rheumatologist,
Penticton Regional Hospital
Penticton, British Columbia

Evelyn Sutton, MD, FRCPC, FACP
Associate Dean,
Undergraduate
Medical Education
Professor of Medicine,
Dalhousie University
Halifax, Nova Scotia

Carter Thorne, MD, FRCPC, FACP
Medical Director,
The Arthritis Program &
Chief Division of
Rheumatology,
Southlake Regional
Health Centre
Newmarket, Ontario

The editorial board has complete independence in reviewing the articles appearing in this publication and is responsible for their accuracy. The advertisers exert no influence on the selection or the content of material published.

PUBLISHING STAFF

Mark Kislingbury
Executive Editor

Jyoti Patel
Managing Editor

Catherine de Grandmont
Senior Medical Editor
(French)

Virginie Desautels
Junior Editor
(French)

Donna Graham
Production Manager

Dan Oldfield
Design Director

Mark Kislingbury
Publisher

The **CRAJ** is online!
You can find us at:
www.craj.ca

Access code: **craj**

Copyright©2024 STA HealthCare Communications Inc. All rights reserved. THE JOURNAL OF THE CANADIAN RHEUMATOLOGY ASSOCIATION is published by STA Communications Inc. in Pointe Claire, Quebec. None of the contents of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means (electronic, mechanical, photocopying, recording or otherwise) without the prior written permission of the publisher. Published every three months. Publication Mail Registration No. 40063348. Postage paid at Saint-Laurent, Quebec. Date of Publication: September 2024.

The opinions expressed herein are those of the editors and authors and do not necessarily reflect the views of STA Communications or the Canadian Rheumatology Association. THE JOURNAL OF THE CANADIAN RHEUMATOLOGY ASSOCIATION selects authors who are knowledgeable in their fields. THE JOURNAL OF THE CANADIAN RHEUMATOLOGY ASSOCIATION does not guarantee the expertise of any author in a particular field, nor is it responsible for any statements by such authors. Physicians should take into account the patient's individual condition and consult officially approved product monographs before making any diagnosis or treatment, or following any procedure based on suggestions made in this document.

Please address requests for subscriptions and correspondence to: THE JOURNAL OF THE CANADIAN RHEUMATOLOGY ASSOCIATION, 6500 Trans-Canada Highway, Suite 310, Pointe-Claire, Quebec, H9R 0A5.

Data for Good¹: Evaluating the EMR

(continued from page 3)

off while still keeping in touch with critical issues. With Internet access virtually worldwide, I am able to read and respond to my e-mails and log into my EMR to retrieve lab reports, etc., while away from the office... I'm not applying for any continuing medical education (CME) credits for reading the *JAMA* article cited above, but I plan to consign Dr. Celzus' advice to the digital garbage can going forward.

The final article was published in *JAMA Internal Medicine* also earlier this year. The title is "The Day the Electronic Medical Records System Went Down."⁵ In the article, Dr. Sofia Mettler, a Harvard internal medicine resident, describes her medical centre's experience when the Epic EHR system experienced a fatal error one night. Initially, there was uncertainty and panic, as scheduled blood tests would not be drawn, and test results could not be entered into the EHR system and reviewed by the residents. Quickly, the team recognized that they could evaluate patients directly, and consult with nursing and other staff to assess patients properly. Tests were ordered using legacy systems, and results still became available in a timely manner. Unnecessary investigations and documentation were avoided, rounds were completed earlier than usual, and care plans did not change once the Epic system had been restored later that day. What might have been a terrible day ended up being a professionally fulfilling, collaborative and patient-centred day, and patient care was not jeopardized.

While all of these studies were conducted in the US, efforts are underway in Canada at both the national and provincial levels to improve the EMR/EHR experience. The CRA board has identified practice and EMR inefficiencies as a top priority for the CRA to address, based on a series of member consultations in 2022. The CRA is working with experts in digital health and clinical informatics to identify the features of a next generation pan-Canadian rheumatology informatics platform, code-named Project Athena. In Ontario, the Ontario Rheumatology Association has launched RheumView,⁶ an intuitive interface added to existing EMRs, where information is better organized, more accessible and customized to rheumatologists' practice, supporting more efficient delivery of care. RheumView is a workflow solution for inflammatory arthritis with a focus on better patient outcomes. It is designed to save clinician time, make life easier, and improve the clinician experience. Let's hope that the promise of Project Athena and of RheumView can be realized to the benefit of all Canadian rheumatologists and their patients. Then we will truly be using our EMR/EHR data for good.

References:

1. Data for Good. Available at <https://dataforgood.ca>. Accessed August 11, 2024. (Data For Good is a collective of do gooders, who want to use their powers for good, and not evil, to help make our communities better through data. We are a national not for profit organization, with chapters across the country, that help other not for profit, and non-governmental, organizations harness the power of their data to make more informed and better decisions in their quest to make their communities flourish.)
2. Berdahl CT, et al. *JAMA Network Open*. 2019;2(9):e1911390. doi:10.1001/jamanetworkopen.2019.11390
3. Sinsky CA, et al. *JAMA Network Open*. 2024;7(1):e2351635. doi:10.1001/jamanetworkopen.2023.51635
4. Celzus P. Confessions of an EMR Luddite: On Vacation, but Never Far Away. *Ontario Medical Review* April 2011.
5. Mettler SK. *JAMA Internal Medicine*. Published Online: April 29, 2024. doi:10.1001/jamainternmed.2024.1066
6. Ontario Rheumatology Association. RheumView. Available at <https://ontariorheum.ca/rheumview>. Accessed August 12, 2024.

Philip A. Baer, MDCM, FRCPC, FACR
 Editor-in-chief, CRAJ
 Scarborough, Ontario

Who's in the Rheum? Dr. Patrick Donio



In this edition of *Who's in the Rheum?* the Canadian Rheumatology Association (CRA) would like to introduce you to Dr. Patrick Donio, who is a rheumatology fellow at Queen's University. Dr. Donio completed medical school at the Northern Ontario School of Medicine (NOSM) in 2020, and Internal Medicine at NOSM in 2023. Dr. Donio is Ojibway and is on-track to become Canada's first First Nations rheumatologist. He recently presented at the Ontario Rheumatology Association's Annual Scientific Meeting, discussing Indigenous Perspectives in Health Care. After training, he plans to return home to Thunder Bay, Ontario, as a community rheumatologist. While serving his home community and the surrounding region, he hopes to focus on helping to address barriers to care, health inequity, and inflammatory arthritis amongst Indigenous populations. Dr. Donio dreams of getting his pilot's license so he can fly up to remote Northern communities to provide specialty care . . . and possibly to catch some fish!



We're happy to share more fun and interesting facts about Dr. Donio below!

What made you want to become as involved with the CRA as early as you did?

I joined the CRA Therapeutics Committee to qualify for a travel bursary to the 2024 CRA Annual Scientific Meeting (ASM). While I expected a good learning experience, I did not realize I would be working with some of the current leaders in Canadian rheumatology. The CRA as a focal point for Canada's best was reinforced at the annual meeting, a highly impactful educational and networking experience. It felt like a great environment in which to grow my knowledge and career, while gaining friends and mentors along the way.

What is the best thing to do in your community?

Thunder Bay is located on the shores of Lake Superior, in the heart of Northern Ontario. It is surrounded by vast forests with innumerable lakes and trails to explore. If you are up for adventure, pristine nature, and the peace that comes with it, it is one of the greatest things our community has to offer. It is an endless source of wonder and humility.

If you could think of one rheumatologist or professor who influenced you to get into your field of work, who would it be?

My first exposure to rheumatology was during Internal Medicine training, with Dr. Wesley Fidler. He is the figurative Atlas of rheumatology in Northwestern Ontario. Despite decades of grinding to keep up with an overwhelming demand for care, he maintains an enthusiasm for rheumatology that I found inspiring and contagious. Dr. Fidler is also a dedicated teacher. He helped me conceptualize the spectrum of rheumatic disease, and what we do as a specialty — which can be a hard thing to understand. By the end of my rotation, I realized rheumatology encompassed what I love most about medicine. He has been instrumental in helping shape my future career.

The second *one* rheumatologist who played a role would be Dr. Sindhu Johnson. She truly opened the door for me, providing opportunities to grow and to explore the field and academia. She has been a constant source of direction and encouragement for me.

What is your favourite activity outside of work?

I have developed a taste for delayed gratification and have been slowly planting a food forest on the land where I hope to one day raise my family.

It will be satisfying, in time.

2024 CIORA Grant Award Recipients Announced



The Canadian Rheumatology Association Foundation (CRAF) is pleased to announce that its research granting division, the Canadian Initiative for Outcomes in Rheumatology cAre (CIORA), will be funding 1 two-year grant, 1 one-year grant and 1 community grant for a total of \$221,318 CDN to projects that will enhance access and innovation for rheumatology care.

Since 2006, CIORA has funded 122 projects and provided over \$9 million CDN in research funding.

CIORA's research grant program supports sustainable projects related to:

- Academic clinical research initiatives related to all rheumatic diseases
- Clinical research initiatives for community rheumatologists related to all rheumatic diseases

Principal Investigator(s)	Title	Award
Janet Pope	A pragmatic trial to compare differences in retention in first-line advanced therapy in RA: A comparison between TNF inhibitors (TNFi) and JAK inhibitors (JAKi)	\$120,000
Ngai Chow Vinod Chandran Dafna D. Gladman	Early detection of psoriatic arthritis: Implementing an interdisciplinary triage clinic	\$54,628
Sabrina Lue Yan Yeung Cassandra Schulz	Comorbidity Management in Rheumatic Disease: Assessing a Potential Care Gap in Patients with Rheumatoid Arthritis	\$46,690

A listing of all current and previous recipients is available at crafoundation.ca/ciora.

A special thanks to our sponsors for their continued support:



CIORA is issuing another call for grants!

CIORA Online Grant Application System opens on **January 27, 2025**.

Letter of Intent must be submitted by **March 7, 2025**.

CIORA Online Grant Application submission deadline is **April 4, 2025, at 17:00 (Pacific Time)**.

Grant notifications will be sent out in **July 2025**.

Patient Perspective: Donna Neal

My name is Donna Neal, and I have rheumatoid arthritis. A health descriptive that not only sounds scary and intimidating, but also one that I was not ready to hear at the age of 51.

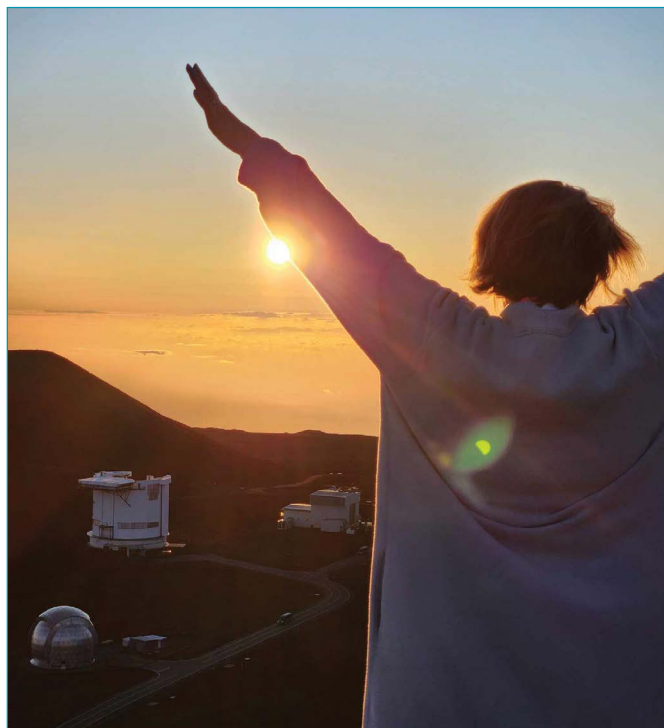
I am positive that my story would be very different if I had not had a healthcare provider who recognized the value of a collaborative approach when dealing with a patient's situation and care. Mine was as simple, and to me as benign, as a swollen finger. At the time of diagnosis, I was an accident-prone mother of two very active teenagers, and I saw my swollen finger as an annoyance. I figured that at some point I had jammed and broken it, so after a few months, it probably was a good time to get it taken care of, as I was unable to close my hand. My general practitioner (GP) looked at it and immediately determined that it was not broken but inflamed. Off I was sent for bloodwork, and I never gave it a second thought.

In the days that followed, I received a call from my GP's office saying my results were in, and I was being referred to an arthritis clinic, The Arthritis Program (TAP), for an assessment the following week. My journey to remission began on that day when Dr. Carter Thorne revealed that my rheumatoid markers were extremely high and outlined the plan for how I was going to take my life back.

Being a part of the TAP program allows access to a resource-rich environment. Their holistic approach tended to not only meet my emotional needs, but all the firsts that were about to come. It wasn't only about me, but the importance of what this meant to my husband and family. We were now a team.

Feeling like I had to take back a piece that I felt I had lost control of, I attended TAP's Inflammatory Workshop, which was a game changer. I was presented with knowledge and resources such as pharmacists, physiotherapists and mental health specialists who would help guide me through my journey, in addition to providing my family with the understanding of what I was facing and the tools to help me succeed.

It was a long road but after six years, in June of 2022, I got the news I was fighting for. You are in remission. I am not naïve to think this is forever; however, I have the tools, the medical team and the confidence to conquer whatever I am faced with to get back on track.



Donna Neal at the top of Mauna Kea volcano in Hawaii. She says of her expedition: "I felt this symbolized my journey to remission. There were some very hard days but my fight allowed me to witness such beauty on my own terms."

When asked how I would define interprofessional care, I look at my path to remission for the answer:

1. A collaborative physician network
2. Patient knowledge and literature in a form the patient can understand
3. Patient support for all phases of the journey
4. Empathy. Life altering news doesn't always "sink in" the first time it's heard. Deliver information with kindness and patience in order to create that safe space where a patient can ask the questions that they fear the most and/or be given time to regain composure after a moment of weakness.

*Donna Neal, Patient Advocate
Newmarket, Ontario*

Stronger Together: The Opportunities of Interdisciplinary Models of Rheumatology Care

By Lauren King, MD, PhD, FRCPC

The value of teamwork was on full display at this summer's Olympic Games in Paris. Summer McIntosh's journey to winning three gold medals in swimming showcased the collective effort of a "village" supporting her success. The Canadian women's soccer team overcame numerous challenges, together, to advance to the quarterfinals. In athletics, the men's 4x100-metre relay team's gold medal performance illustrated how a team's performance can exceed the sum of its parts. Not a single one of the runners even made the final in their individual events but, with their complementary strengths, they won the relay! Now, with the Games behind us (yes, I am experiencing Olympic withdrawal), it is an opportune time to reflect on some parallels we can apply to rheumatology as we strive for the best care and outcomes for people living with rheumatic disease.

As rheumatologists, we face key challenges in care delivery. First, there are not enough of us relative to the rapid rise in prevalence of rheumatic diseases in our growing population, and the workforce is not evenly distributed across all regions in Canada. As a result, patients often face long wait times to be seen. Second, we assess and treat people with complex chronic diseases that seem to be increasingly intricate. We know that people with rheumatic diseases (even those with osteoarthritis) are at higher risk of adverse health outcomes, including all-cause mortality. They require comprehensive care to ensure the best health outcomes. Yet, given the demands of care required, it sometimes feels like we're settling for "good enough."

Enter the interdisciplinary model of rheumatology care. This is broadly defined as a collaborative team involving a rheumatologist working alongside one or more interdisciplinary health professionals (such as physical therapists, nurses, occupational therapists, pharmacists, etc.) within a rheumatology practice to support various aspects of care. We can think of this not only as adding more hands to expand our workforce (reducing wait times), but as an opportunity to leverage the skills of interdisciplinary health professionals to broaden the care we provide and ensure we can fully meet care needs. As different team members work together, this approach may enable, for example, longer patient visits to meaningfully address patient concerns, provide more detailed disease education to support self-management and self-efficacy,



Dr. Lauren King, Gareth Sneath (PT, ACPAC), Balraj Singh (RN), and Angelo Papachristos (PT, ACPAC) working together in the Interdisciplinary Rheumatology Osteoarthritis Program at St. Michael's Hospital in June 2024.

and more thorough medication counselling. This is not a novel concept. A Canadian Rheumatology Association position statement on "Priority Areas to Support the Sustainability of the Canadian Rheumatology Workforce", published in 2022, recommends drawing on interdisciplinary health professionals to promote and enhance the rheumatology workforce. I see these benefits for care delivery firsthand, working in Toronto and Thunder Bay with physical therapists, occupational therapists, and nurses.

The concept of interdisciplinary team-based rheumatology care sounds like a winner, right? So, why are these models not broadly implemented? What will it take to do so? What kind of funding is required to feasibly support these models for rheumatologists to adopt them? These are among the key questions that need to be answered to put team-based models into mainstream practice. The Canadian Rheumatology Implementation Science Team (CAN-RIST) is a large, pan-Canadian team working to generate actionable evidence to support the broad implementation, spread, and scaling of interdisciplinary care. Our hope is to provide the blueprint for highly effective team-based care, and the evidence to support the health-economic rationale behind it that is critical to policymakers. Our vision is to facilitate team-based care becoming part of mainstream rheumatology practice, ultimately leading to improved care experiences and outcomes for people with rheumatic diseases, reducing healthcare costs, improving health equity, and optimizing workforce well-being and sustainability. By the time the next Summer Olympic Games in Los Angeles roll around, we aim to have advanced, evidence-informed solutions in place.

*Lauren King, MD, PhD, FRCPC
Rheumatologist and Clinician Scientist,
St. Michael's Hospital, Unity Health Toronto
Assistant Professor, Department of Medicine,
University of Toronto
Toronto, Ontario*

Implementing Interprofessional Rapid Assessment Clinic Models for Rheumatology to Support Equitable and Timely Access to Care

By Shawn Brady, Vice President, Arthritis Rehabilitation and Education Program and Innovation, Arthritis Society Canada

The best chance a patient with inflammatory arthritis has to achieve optimal outcomes and quality of life is to receive an accurate diagnosis and medical/pharmaceutical management from a rheumatology specialist, through the referral of a family physician. However, there exists a physician crisis in Canada that prevents those suffering from receiving timely referrals from primary care and assessment from specialists. About 6.5 million Canadian adults (more than one in five) report having no family physician.¹ Patients who do not have a primary care physician are at greater risk of developing serious health complications, placing additional pressure on other areas of our overworked healthcare system, including hospitals, emergency departments and long-term care homes. For those with arthritis, this challenge is further compounded with difficulties in accessing timely specialist care. A 2022 article noted a deficit ranging from 1–78 full-time equivalent (FTE) rheumatologists per province/territory and 194 FTE rheumatologists nationally to meet the CRA's workforce benchmark. The current shortage of rheumatologists is expected to intensify with roughly 28% of the rheumatology workforce planning to retire between 2025–2030.²

The development of Rheumatology Rapid Access Clinics (Rheum-RAC) is an innovative way to provide those suffering from arthritis fast and accurate triaging and referrals to rheumatologists, by leveraging existing but underutilized healthcare providers.

The Rheum-RAC is an upstream, shared-care model of practice in which patients receive rapid joint assessment and triage, education, and evidence-based self-management plans, which may include referral to local services. It is designed so that patients with active inflammatory arthritis can be fast-tracked to specialists and diagnostic services when indicated, to commence earlier treatment for better disease control, preventing irreversible joint damage and disability. Patients are assessed by an Extended Role Practitioner (ERP) in Arthritis Care (physiotherapist or occupational therapist) who will work with them to determine the appropriate care pathway and facilitate streamlined access.

The Rheum-RAC supports family physicians by providing in-person rheumatological care, triaging and/or virtual consultation in partnership with associated rheu-

matologists either locally or across each province. This shortens the wait time to see a specialist rheumatologist. It also frees time for physicians to see more patients in a more efficient manner. Additional benefits of this model include a reduction in emergency room visits, a reduction in unnecessary diagnostic imaging as well as unnecessary specialist referrals, improved patient satisfaction, and an improved doctor-patient relationship with effective holistic care. Studies have demonstrated that a well-trained and experienced ERP can shorten the time-to-rheumatologist-assessment and time-to-treatment-decision for patients with suspected inflammatory arthritis (IA) with a very high agreement in diagnostic accuracy between the rheumatologist and the ERP.³ Arthritis Society Canada's Ontario based Arthritis Rehabilitation and Education Program (AREP) has implemented this model in key geographies where there is a lack of specialist support, and a recent article published in the *Journal of Rheumatology* demonstrated the success of this model in decreasing days to access rheumatologist, decreasing travel costs for patients and improving patient experience.⁴ A gap currently exists in terms of government support for these types of care models, making advocacy efforts essential to enabling and expanding implementation. With a looming physician crisis in both primary care and specialist care, the time is now to introduce and implement more interprofessional models of care. The Rheum-RAC model provides a viable solution to bring effective, timely and equitable care to the 6 million Canadians suffering with arthritis.

References:

1. Kiran T, Daneshvarfard M, Wang R, et al. Public Experiences and Perspectives of Primary Care in Canada: Results from a Cross-Sectional Survey. *CMAJ*. 2024; 196(19):E646-E656.
2. Kulhavy-Wibe SC, Widdfield J, Lee JY, et al. Results From the 2020 Canadian Rheumatology Association's Workforce and Wellness Survey. *J Rheumatol*. 2022; 49(6):635-643.
3. Ahluwalia V, Larsen TLH, Kennedy CA, et al. An Advanced Clinician Practitioner in Arthritis Care Can Improve Access to Rheumatology Care in Community-based Practice. *J Multidiscip Healthc*. 2019; 12: 63-71.
4. Steiman A, Inrig T, London K, et al. Telerheumatology Shared-Care Model: Leveraging the Expertise of an Advanced Clinician Practitioner in Arthritis Care (ACPAC)-Trained Extended Role Practitioner in Rural-Remote Ontario. *J Rheumatol*. Sep 2024; 51(9):913-919.

Shawn Brady
Vice-President, Arthritis Rehabilitation and Education Program and Innovation
Arthritis Society Canada

Patient Perspective: Carrie Barnes

At the age of 32, I became unable to care for myself or my family. Every aspect of my life was affected by swollen, painful joints. Simple tasks like preparing food and getting dressed were no longer possible without help from others, even my ability to chew was unpredictable. I felt lost and scared, having trouble recognizing the person staring back at me in the mirror.

At the time my symptoms started, we had recently moved across the province, leaving me without a family doctor. Relying exclusively on walk-in clinics made it nearly impossible to have any continuity or consistency to my care. My body continued to change at an alarming rate, leaving me more and more incapable by the day, and after struggling to keep up with the demands at work, I was connected to a local interdisciplinary rheumatic disease clinic. From that point on, things started to change for me.

It is quite an experience to be diagnosed with a chronic illness. I'll never forget the day I was given mine. In some ways it's a relief to give symptoms a name instead of just "pain" or "illness," but all I heard was, "chronic, injections, medication, appointments . . ." I went from, "Finally! A diagnosis!" to "Please no. I can't do this." I was overwhelmed and felt alone and truly incapable of taking a step in the direction I needed to (pun intended).

At the clinic, I was assessed, triaged, and seen in a timely manner by several of the healthcare team members. I was never asked to repeat the same test, scan, examination, or assessment, never asked the same set of questions, and was always included in the dialogue about my care. A welcome change after the revolving door I had experienced previously and the broken record I felt I had become.

I remember sitting in a room surrounded by a variety of healthcare professionals; social worker, occupational therapist, pharmacist, physiotherapist, and rheumatologist, all discussing my care, all reading off one chart, my chart. I could tell they respected each other's roles and input by the way they communicated and interacted. Witnessing a group of providers come together, bring their professional best, share their expertise, and



then create a plan as a unified whole, gave me the confidence I desperately needed to do MY part...the follow through.

Soon after diagnosis, I attended an education session at the clinic, delivered by the various healthcare disciplines. I was provided with knowledge about my illness, my medications and how to begin to understand what was going on in my body. I was taught to recognize subtle changes and symptoms before they became bigger issues; skills I use to this very day, skills that have kept me out of the emergency room for nearly a decade and a half. And lastly, I was shown how to

contact and access the various team members when I needed assistance.

My care didn't end at diagnosis. There have been ups and downs along the way, but I have been able to access the specific care I've needed with the appropriate team member each time. Everything from tweaking my orthotics, ordering specific medications for travel, addressing a joint before it flared, injections and everything in between, my team is available and ready to assist as needed.

I have remained employed, been on many grand adventures and engage in life to the fullest of my abilities. I would not be where I am today if it weren't for the interdisciplinary care I received and continue to have access to.

Carrie Barnes, Patient Advocate Ontario



The author on the Lake Superior Coastal Trail.

Interprofessional Shared Decision Making to Achieve Health Equity

By Karine Toupin-April, PhD; and Cheryl Barnabe, MD, MSc, FRCPC

On behalf of Natasha Trehan, Founder, Take a Pain Check; Elizabeth Stringer, MD, MSc, FRCPC; Laurie Proulx, Canadian Arthritis Patient Alliance; Linda Li, PT, PhD; Glen Hazlewood, MD, PhD, FRCPC; Claire Barber, MD, PhD, FRCPC; and Chance McDougall, MD, FRCPC

Interprofessional Shared Decision Making

Shared decision making (SDM) is supported by evidence as an optimal way to make complex medical decisions. It is a collaborative process between patients (and/or their proxies) and healthcare providers, informed by the best evidence available and the patient's values and preferences.^{1,2} There are various models of SDM, some of which include interprofessional team members,³ thus having high relevance to rheumatology. SDM is not always used in clinical practice, primarily due to health care providers' perspectives — they often perceive it takes too much time to implement, that it is not applicable to their patients, or that the decision taken by the patient is not consistent with clinical practice guidelines' recommendations.^{4,5} However, SDM may be more efficient for chronic conditions. Choices aligning with patient values and preferences are more likely to result in adherence to the selected treatment plan.

Important Elements of SDM

SDM is not “one size fits all” and must be centred on each patient's needs. Patients emphasize the need for health professionals to listen to their questions and concerns, and provide them with the information required to make autonomous decisions (see infographic with tips provided by patients: choiceresearchlab.ca/tools-and-resources-to-facilitate-the-use-of-shared-decision-making-sdm/). A video also highlights the elements critical for high quality SDM implementation: www.youtube.com/watch?v=4OxXIXMfJAo). Patient decision aids (PDAs) and decision coaching are interventions to help facilitate SDM (decisionaid.ohri.ca/). They lead to increased knowledge and a more active role in decision-making.^{6,7} However, further efforts in knowledge mobilization are required for health professionals to become familiar with the unique roles of PDAs as compared to other patient education materials used in clinical practice.⁸

SDM Use in Rheumatology Practice

A scoping review on applications of SDM in rheumatology is available.⁹ There are various PDAs in adult and pediatric rheumatology (choiceresearchlab.ca/tools-and-resources-to-facilitate-the-use-of-shared-decision-making-sdm/). SDM is especially important for preference-sensitive decisions, meaning when there is no single best treatment option based on the available evidence and the decision will depend on patient values and preferences, as is common in rheumatology.

SDM is included in rheumatology clinical practice guidelines such as the Canadian Rheumatology Association (CRA) Living Guidelines for Rheumatoid Arthritis (RA) (rheum.ca/resources/publications) and a decision tool has been developed for COVID-19 Vaccination in patients with autoimmune rheumatic diseases (rheum.ca/decision-tool/). In a recent example of applying SDM in practice, a CRA decision aid on tapering biologic/targeted synthetic disease-modifying anti-rheumatic drugs (DMARDs) in RA was sent to patients one month ahead of their annual visit.¹⁰ The decision aid was well received, prompted discussions around tapering medication, and resulted in many people choosing to try tapering their medication after discussion with their rheumatologist. This research provides preliminary evidence that using a decision aid that is consistent with clinical practice guidelines, in combination with patient reflection and discussions with rheumatologists, may support cost-effective patient-centered decision-making about tapering.

Health Equity and SDM

Health equity is a fundamental human right. As described by the World Health Organization, “Equity is the absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality . . .” (who.int/health-topics/health-equity#tab=tab_1). Engaging patients in their health decisions through SDM in the context of their



A few of the members of the panel from the 2024 CRA ASM workshop, "Clinical Practice Guidelines and Interprofessional Shared Decision Making: A Journey Towards Health Equity." Pictured from left to right: Dr. Karine Toupin-April, Dr. Cheryl Barnabe, Dr. Chance McDougall, Natasha Trehan, and Dr. Elizabeth Stringer.

own circumstances can help them attain their full potential for health and well-being and enhance health equity. SDM rebalances power between patients and healthcare providers, increasing autonomy, reducing paternalism, and improving trust in healthcare providers. It can also reduce unwarranted variations in care by reducing biases, as provider assumptions about patient values may influence the treatment options presented.^{11,12,13}

SDM for Indigenous Women

SDM can be particularly helpful for Indigenous populations. Culturally safe and empathic care that incorporates all aspects of health, and that respects knowledge and experience from Indigenous worldviews, are a requirement for establishing trust with Indigenous patients. Decision-making should be collaborative with active involvement of the patient. Professionals should be knowledgeable, honest and use effective communication, including active listening skills. According to a study of Indigenous women with RA in urban Calgary, priorities were to use treatment decisions informed by Indigenous population data, including traditional and cultural treatment options in care plans, and reflecting available medication cost coverage options.^{14,15} In addition to adapted PDAs, decision coaching may be preferred, with nurses, family members or an Elder serving as the trusted source of information and support, with the emphasis placed on dialogue and community-based decision support and consultation.^{14,15}

Implications

SDM has a strong potential to improve engagement and self-determination in decision-making, which could reduce barriers to health equity. Adaptations to SDM tools and approaches may be required to be effective in diverse populations.

References:

1. Makoul G, Clayman ML. An Integrative Model of Shared Decision Making in Medical Encounters. *Patient Educ Couns*. 2006 Mar; 60(3):301-12.
2. Hoffmann TC, Montori VM, Del Mar C. The Connection Between Evidence-based Medicine and Shared Decision Making. *JAMA*. 2014 Oct 1; 312:1295-6.
3. Légaré F, Stacey D, Gagnon S, et al. Validating a Conceptual Model for an Inter-Professional Approach to Shared Decision Making: A Mixed Methods Study. *J Eval Clin Pract*. 2011; 17(4):554-64.
4. Légaré F, Ratté S, Gravel K, et al. Barriers and Facilitators to Implementing Shared Decision-making in Clinical Practice: Update of a Systematic Review of Health Professionals' Perceptions. *Patient Educ Couns*. 2008 Dec; 73(3):526-35.
5. Légaré F, Thompson-Leduc P. Twelve Myths About Shared Decision Making. *Patient Educ Couns*. 2014; 96(3):281-6. doi: 10.1016/j.pec.2014.06.014.
6. Stacey D, Lewis KB, Smith M, et al. Decision Aids for People Facing Health Treatment or Screening Decisions. *Cochrane Database Syst Rev*. 2024 Jan 29; 1(1):CD001431.
7. Jull J, Köpke S, Smith M, et al. Decision Coaching for People Making Healthcare Decisions. *Cochrane Database Syst Rev*. 2021 Nov 8; 11(11):CD013385.
8. Zong JY, Leese J, Klemm A, et al. Rheumatologists' Views and Perceived Barriers to Using Patient Decision Aids in Clinical Practice. *Arthritis Care Res*. 2015; 67(10):1463-1470.
9. Morrison T, Foster E, Dougherty J, et al. Shared Decision Making in Rheumatology: A Scoping Review. *Semin Arthritis Rheum*. 2022 Oct; 56:152041. doi: 10.1016/j.semarthrit.2022.152041.
10. Lee J, Barber C, Jung M, et al. Decision Aid-led Tapering of Biologic and Targeted Synthetic DMARDs in Rheumatoid Arthritis: A Qualitative Study. *J Rheumatol*. 2024 Aug 15;jrheum.2024-0383.
11. Pianarosa E, Hazlewood GS, Thomas M, et al. Supporting Equity in Rheumatoid Arthritis Outcomes in Canada: Population-specific Factors in Patient-centered Care. *J Rheumatol*. 2021 Dec; 48(12):1793-1802.
12. Barnabe C. Towards Attainment of Indigenous Health Through Empowerment: Resetting Health Systems, Services and Provider Approaches. *BMJ Glob Health*. 2021 Feb; 6(2):e004052.
13. Grabinski VF, Myckatyn TM, Lee CN, et al. Importance of Shared Decision-making for Vulnerable Populations: Examples from Postmastectomy Breast Reconstruction. *Health Equity*. 2018 Sep 1; 2(1):234-238.
14. Umaefulam V, Fox T, Barnabe C. Decision Needs and Preferred Strategies for Shared Decision Making in Rheumatoid Arthritis: Perspectives of Canadian Urban Indigenous Women. *Arthritis Care Res (Hoboken)*. 2021; 20:10-13.
15. Umaefulam V, Fox TL, Hazlewood G, et al. Adaptation of a Shared Decision-Making Tool for Early Rheumatoid Arthritis Treatment Decisions with Indigenous Patients. *Patient*. 2022 Mar; 15(2):233-243.

Karine Toupin-April, PhD

School of Rehabilitation Sciences, Faculty of Health Sciences
Department of Pediatrics, Faculty of Medicine
University of Ottawa
Children's Hospital of Eastern Ontario Research Institute
Institut du savoir Montfort

Cheryl Barnabe, MD, FRCPC, MSc

Professor, Cumming School of Medicine
McCaig Institute for Bone and Joint Health
University of Calgary
Calgary, Alberta

Welcome to the Rheum

Welcome to the following new CRA members:

Anwar Alkandri, Toronto, ON	Hsin Yen Liu, Toronto, ON
Wafaa Alsamadani, Vancouver, BC	Zechen Ma, Burlington, ON
Rana Alsulami, Toronto, ON	Sonali Mitra, Toronto, ON
Abdullah Azab, Kingston, ON	Patricia Morassut, Ottawa, ON
Madelaine Beckett, Vancouver, BC	Njood Nazer, Toronto, ON
Frederik Bouchard, Québec, QC	Minh-Duc Ngo, Montréal, QC
Ricardo Cartagena, Brandon, MB	Nam Nguyen, Toronto, ON
Chelsea Cheng, Toronto, ON	Christopher Otu, Penticton, BC
Kayla Chubbs, Halifax, NS	Sagar Patel, Brampton, ON
Gleice Clemente Souza Russo, Toronto, ON	Amy Qi, Montreal, QC
Jean Jacques De Bruycker, Montreal, QC	Rebecca Quilty, Toronto, ON
Henrique De Sa Ellwanger, Vancouver, BC	Emma Reesor, London, ON
Ait ouarab Djamil, Longueuil, QC	Ian Reinhorn, Montreal, QC
Ciarán Duffy, Ottawa, ON	Shreya Sathaye, Saskatoon, SK
Cathy Flanagan, New Westminster, BC	Walter Silecky, Oshawa, ON
Nathan Hitchman, London, ON	Vivian Szeto, Mississauga, ON
Whitney Hung, Edmonton, AB	Julia Tan, Victoria, BC
Ahmed Ibrahim, Calgary, AB	Sirikarn Tangcheewinsirikul, Bangkok (Thailand)
Darya Jalaledin, Saint-Lambert, QC	Hyman Tannenbaum, Montreal, QC
Kaitlyn Kaltenberger, Calgary, AB	Michal Vinker Shuster, Toronto, ON
Natasha Le Blanc, Montreal, QC	Jagdeep Walia, Saskatoon, SK
Frederique Lefrancois, Amherstview, ON	Nikola Wilk, Ottawa, ON
Felix Lessard, Sherbrooke, QC	Chu Ming Yu, Vancouver, BC

CRA SCR

2025
ANNUAL
SCIENTIFIC
MEETING



2025
ASSEMBLÉE
SCIENTIFIQUE
ANNUELLE

26 FEB - 1 MAR CALGARY, AB 26 FÉV - 1 MARS

CRA ANNUAL SCIENTIFIC MEETING

FEB. 26 – MAR. 1, 2025



Registration Opens Nov. 1, 2024 | IN PERSON ONLY

Join us for the **2025 CRA Annual Scientific Meeting**,
hosted **IN PERSON** in Calgary, Feb. 26 – Mar. 1, 2025!

Exceptional education, innovative science, interactive programming, and opportunities to connect with Canada's largest rheumatology community.

This year's theme, **Ascending to New Heights: Peaks of Innovation in Rheumatology**, celebrates the latest advancements and breakthroughs in rheumatology with a community who pushes the boundaries of what is possible in the diagnosis, treatment, and management of rheumatic diseases.

Learn more and register at asm.rheum.ca

Early Bird registration deadline: Dec. 13, 2024
Registration deadline: Jan. 31, 2025, at 11:59 p.m. ET



VIRTUAL | VIRTUELLE

RheumReview



Feb. 21, 2025

Registration Opens Nov. 1, 2024

Refresh your knowledge with a high-yield educational program on clinically relevant topics!

CRA RheumReview: Canadian Clinical Updates is a full-day virtual event designed for practicing rheumatologists interested in updating their knowledge on hot topics within the rheumatology world.

Patient Support Program

PfizerFlex

Experienced, Dedicated Team

Enrol your patients by calling **1-855-935-3539**
or direct them to visit PfizerFlex.ca for more
information on the program services.



RHEUMATOID ARTHRITIS

^{Pr}XELJANZ[®]/^{Pr}XELJANZ[®] XR (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 and to one or more disease-modifying anti-rheumatic drugs (DMARDs). In cases of intolerance to MTX and other DMARDs, physicians may consider the use of XELJANZ/XELJANZ XR (tofacitinib) as monotherapy.

LIMITATIONS OF USE

XELJANZ should not be used in combination with other Janus kinase (JAK) inhibitors, immunomodulating biologics (e.g., biologic DMARDs), or with potent immunosuppressants such as azathioprine and cyclosporine.



XELJANZ[®] / XELJANZ[®] XR PF Prism C.V., owner/Pfizer Canada ULC, Licensee.
PFIZERFLEX[™], Pfizer Inc., owner/Pfizer Canada ULC, Licensee.
© 2023 Pfizer Canada ULC, Kirkland, Quebec H9J 2M5





For your RA patients on
XELJANZ/XELJANZ XR,

THE PFIZERFLEX PROGRAM
REMAINS AT THEIR SIDE*

For more information:

Please consult the Product Monograph at <https://www.pfizer.ca/en/our-products/xeljanz-tofacitinib> and an Important Safety Information Advisory available at <https://recalls-rappels.canada.ca/en/alert-recall/xeljanzxeljanz-xr-tofacitinib-risk-major-adverse-cardiovascular-events-malignancy> for important information relating to contraindications, warnings, precautions, adverse reactions, interactions, dosing and conditions of clinical use. The Product Monograph is also available by calling 1-800-463-6001.

* May not be available in Quebec.

Pr **XELJANZ**[®] 
[tofacitinib citrate]

Pr **XELJANZ**[®] **XR** 
[tofacitinib citrate]

More Than Skin Deep: Thinking Below the Surface

By Nadia Luca, MD, FRCPC, MSc

Case Presentation

A 4-year-old girl originally from Jordan was referred to the pediatric rheumatology clinic with a 2-month history of progressive thickening and tightening of her skin, generalized joint stiffness and painful bilateral swelling of her hands and feet. A few weeks prior to onset of symptoms, she had fever, diarrhea and oral ulcers and was treated with amoxicillin. Her history was significant for expressive language delay, polydactyly of the hands and feet, and syndactyly of the toes. She took no regular medications. On physical examination she had diffuse induration of the skin, more pronounced on the extremities than the trunk, with sparing of her face. She also had a linear hyperpigmented lesion extending down the posterior right lower extremity (Figure 1). She did not have any digital pitting or ulcers, telangiectasia or abnormal nailfold capillaries. She had swelling of several joints, including bilateral proximal interphalangeal joints, metacarpophalangeal joints, elbows, wrists, knees, and ankles. Many of the joints were held in fixed contracture resulting in very limited mobility. Her laboratory testing revealed a normal complete blood count apart from eosinophils of $0.9 \times 10^9/L$ ($0.0-0.6 \times 10^9/L$). Erythrocyte sedimentation rate (ESR) was 62 mm/Hr (normal <37 mm/Hr) and C-reactive protein was 54 mg/L (normal <10.0 mg/L). Creatine kinase and immunoglobulin G were elevated at 436 U/L (normal 35-180 U/L) and 19.2 g/L (normal 6.4-14.4 g/L), respectively. Rheumatoid factor was negative, anti-nuclear antibody was positive at a titre of 1:160, and anti-RNP/Sm antibody was also positive. Magnetic resonance imaging (MRI) of the extremities demonstrated increased T2 signal in the subcutaneous and deep fascia with gadolinium enhancement. Biopsy of the deep muscular fascia of the right lower leg revealed patchy perimysial and endomysial inflammation composed of lymphocytes and plasma cells with no eosinophils. The fascia showed diffuse inflammation composed of lymphocytes and plasma cells with a patchy increase in eosinophils.

Epidemiology

Eosinophilic fasciitis (EF) was first recognized by Shulman in 1975 as a diffuse scleroderma-like illness characterized by firm bound-down skin associated with peripheral eosinophilia and hypergammaglobulinemia.¹ Since then, approximately 300 cases have been reported, and one study cites a prevalence of 14 per million.² EF primarily affects adults in the fourth or fifth decades, but all ages may be affected. Most reported patients are Caucasian.³

The etiology and pathogenesis of EF remain unknown. Reported potential triggers include intense physical exertion or trauma (more so in adult versus pediatric patients), various drugs (e.g. natalizumab, influenza vaccine, simvastatin, phenytoin, ramipril), radiation therapy, and *Borrelia burgdorferi* infection.⁴ Co-existing autoimmune

diseases and hematologic disorders (e.g. aplastic anemia, less frequently malignancies) may be present. Notably, approximately 29-50% of patients with EF simultaneously present with localized scleroderma (LS).^{5,6} EF has been described along the spectrum of scleroderma-like disease, perhaps at the more severe end; however, its association with LS remains to be elucidated. Most types of LS have superficial, discontinuous asymmetric cutaneous sclerosis. However, deep variants of LS may be difficult to distinguish from EF. Fortunately, the treatment regimens for both entities are quite similar, making absolute distinction nonessential.

Clinical Features

EF is characterized by symmetrical, painful edema of the extremities followed by progressive sclerosis of the

mid and deep dermis, subcutaneous fat and fascia. The epidermis and superficial dermis are largely spared. The characteristic *peau d'orange* appearance occurs as a result of the deep dermis becoming tethered to the fascial and muscle layers. The groove sign is characterized by linear depressions traversing along the course of superficial veins and is best seen with limb elevation (Figure 2). In addition to the characteristic cutaneous features, up to 50% of patients with EF may also develop an inflammatory and occasionally erosive arthritis, most commonly involving the hands, knees and wrists. Progressive induration in EF can lead to joint contractures (e.g. prayer sign in 50-67% of cases), decreased mobility and nerve entrapment.⁴ Constitutional symptoms such as fatigue, arthralgia, myalgia and weight loss may also be present. Internal organ involvement is generally absent in EF, distinguishing it from systemic scleroderma.

Diagnosis

Diagnostic criteria have been proposed by Pinal-Fernandez⁷ but have not been validated (Table 1). The gold standard for diagnosis remains a full-thickness wedge biopsy demonstrating thickened fascia including lymphocytes and macrophages, with or without eosinophils. MRI may identify hyperintense fascia on T2-weighted images and is increasingly used for diagnosis and monitoring. Supportive laboratory features include peripheral eosinophilia present in 63-93% of patients (not mandatory for diagnosis), hypergammaglobulinemia and elevated ESR. While skin biopsy is not necessary in a majority of LS cases, histopathologic studies of a full-thickness skin biopsy with fascia and muscle tissues are required for the diagnosis of EF.

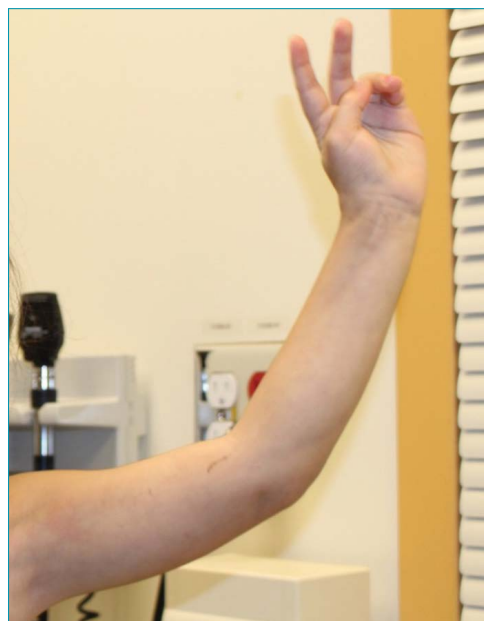
Therapeutic Approach

Given the rarity of EF, there are no randomized controlled studies regarding treatment, and current treatment recommendations are based on observational studies. In his original report, Shulman reported clinical response of fasciitis to prednisone therapy over 15 months in one affected patient¹, and several subsequent studies describe EF as steroid-responsive. Oral prednisone at a dose of 1 mg/kg/day tapered over weeks or months is typically used. Intravenous methylprednisolone (IV MP) pulses may be used at induction for more severe cases. Complete response is more likely with the addition of a second



Photograph courtesy of Dr. Nadia Luca/Dr. Vimal H. Prajapati.

Figure 1. Index patient, demonstrating linear localized scleroderma lesion at posterior right lower limb.



Photograph courtesy of Dr. Nadia Luca/Dr. Vimal H. Prajapati.

Figure 2. Index patient, demonstrating "groove sign" in left upper extremity.

Table 1: Proposed Criteria for the Diagnosis of Eosinophilic Fasciitis⁷

Major Criteria	Minor Criteria
1. Swelling, induration, and thickening of skin and subcutaneous tissue that is symmetrical or non-symmetrical, diffuse (extremities, trunk, abdomen) or localized (extremities)	1. Eosinophilia >0.5 x 10 ⁹ /L
2. Fascial thickening with accumulation of lymphocytes and macrophages with or without eosinophilic infiltration (full-thickness wedge biopsy of clinically affected skin)	2. Hypergammaglobulinemia >1.5 g/L
	3. Muscle weakness and/or elevated aldolase levels
<i>Exclusion criteria: diagnosis of systemic sclerosis</i>	4. Groove sign and/or <i>peau d'orange</i>
	5. Hyperintense fascia on MR T2-weighted images

Both major criteria, or 1 major plus 2 minor criteria, establish the diagnosis of eosinophilic fasciitis.

immunosuppressive drug, the preferred agent being methotrexate 15-25 mg weekly.⁸ Other alternatives include mycophenolate mofetil (MMF) or hydroxychloroquine. Success has also been reported with IV immunoglobulin (IVIG).⁹ In refractory cases of EF, various biologic agents have been tried, with IL-6 inhibitors having the greatest frequency of cases with improvement, followed by anti-TNF α agents.¹⁰ Recent case reports of response to Janus kinase inhibitors have been published.

The index patient was treated with systemic steroids (initially IV MP pulses followed by oral prednisone taper), monthly IVIG, and subcutaneous methotrexate. She experienced reduction in pain, skin and joint swelling and improved mobility. However, as she still had significant tightening of skin and contracture in the extremities, MMF was added. She had difficulty with adherence to MMF and repeat MRI demonstrated some ongoing fascial inflammation, thus tocilizumab was tried. After several months there was no clinical improvement and she was switched to tofacitinib, which resulted in modest additional improvement.

Nadia Luca, MD, FRCPC, MSc
 Pediatric Rheumatologist and Associate Professor,
 University of Ottawa
 Ottawa, Ontario

References:

- Shulman LE. Diffuse Fasciitis with Hypergammaglobulinemia and Eosinophilia: A New Syndrome? *J Rheumatol*. 1984 Oct; 11(5):569-70. PMID: 6542592.
- Spielmann L, Arnaud L, Severac F, et al. Population-based Prevalence of Eosinophilic Fasciitis (Shulman Syndrome): A Capture-recapture Study. *Br J Dermatol*. 2018 Aug; 179(2):516-517. doi: 10.1111/bjd.16535. Epub 2018 Jun 7. PMID: 29526049.
- Bischoff L, Derk CT. Eosinophilic Fasciitis: Demographics, Disease Pattern and Response to Treatment: Report of 12 Cases and Review of the Literature. *Int J Dermatology*. 2008; 47:29-35. <https://doi.org/10.1111/j.1365-4632.2007.03544.x>
- Fett N, Arthur M. Eosinophilic Fasciitis: Current Concepts. *Clin Dermatol*. 2018 Jul-Aug; 36(4):487-497. doi: 10.1016/j.clindermatol.2018.04.006. Epub 2018 Apr 10. PMID: 30047432.
- Mazilu D, Boltasiu Tataru LA, et al. Eosinophilic Fasciitis: Current and Remaining Challenges. *Int J Mol Sci*. 2023 Jan 19; 24(3):1982. doi: 10.3390/ijms24031982. PMID: 36768300; PMCID: PMC9916848.
- Stubbs LA, Ogunbona O, Beil E, et al. Juvenile Eosinophilic Fasciitis: A Single Center Case Series. *Pediatr Rheumatol*. 2024; 22(29). <https://doi-org.ezproxy.lib.ualgary.ca/10.1186/s12969-024-00960-w>.
- Pinal-Fernandez I, Selva-O'Callaghan A, Grau JM. Diagnosis and Classification of Eosinophilic Fasciitis. *Autoimmun Rev*. 2014 Apr-May; 13(4-5):379-82. doi: 10.1016/j.autrev.2014.01.019. Epub 2014 Jan 11. PMID: 24424187.
- Wright NA, Mazori DR, Patel M, et al. Epidemiology and Treatment of Eosinophilic Fasciitis: An Analysis of 63 Patients From 3 Tertiary Care Centers. *JAMA Dermatol*. 2016 Jan; 152(1):97-9. doi: 10.1001/jamadermatol.2015.3648. PMID: 26559760.
- Obiakor B, Fan W, Jacobson R, et al. Functional and Cutaneous Treatment Outcomes With Intravenous Immunoglobulin for Eosinophilic Fasciitis: A Retrospective Study. *J Drugs Dermatol*. 2024 Apr 1; 23(4):e107-e109. doi: 10.36849/JDD.8017. PMID: 38564381.
- Mufti A, Kashetsky N, Abdulmulla A, et al. Biologic Treatment Outcomes in Refractory Eosinophilic Fasciitis: A Systematic Review of Published Reports. *J Am Acad Dermatol*. 2022 Apr; 86(4):951-953. doi: 10.1016/j.jaad.2021.03.089. Epub 2021 Apr 2. PMID: 33812957.



Dr. Nigil Haroon – Schroeder Arthritis Institute Collaborative Pilot Grant

Dr. Nigil Haroon is the Head of the Division of Rheumatology, University Health Network and Sinai Health, Senior Scientist at the Schroeder Arthritis Institute and Associate Professor at the Department of Medicine, Institute of Medical Sciences, University of Toronto.

Dr. Haroon has been awarded the Schroeder Arthritis Institute Collaborative Pilot Grant, alongside Dr. Jason Rockel. The primary objective of this grant is to support innovative and collaborative arthritis-related research. The proposed study will help identify biomarkers that predict the probability of response to IL-17A inhibitors in patients with spondyloarthritis that could guide an informed choice for personalized targeted therapeutic strategies and improved patient care.



Dr. Allan Kagal – GTA Community Rheumatologist Excellence Award

Dr. Kagal was awarded the GTA Community Rheumatologist Excellence Award from the University of Toronto.

As the current Division Director of Rheumatology at Mackenzie Health, Dr. Kagal has recruited talented young rheumatologists to make Mackenzie Health a community hospital with a strong rheumatology presence. He is also the co-founder of the Early Arthritis Program at Mackenzie Health (formerly known as York Central Hospital). He was also the winner of the Kiani Compassionate Care Award, given to hospital staff and physicians who show exemplary compassion to patients.

Throughout his career, he has received accolades for his excellent teaching skills from rheumatology fellows. He is also the founder of the York Region Rheumatology Journal Club, the largest community rheumatology journal club in the GTA. In addition to having a busy practice in Vaughan, Dr. Kagal works closely with the Arthritis Society in Sudbury to help provide rheumatology care in northern Ontario. In his spare time, Dr. Kagal enjoys travelling with his family and training for the upcoming New York Marathon.



Dr. Suzanne Morin – 2024 Jeffrey Shiroky Award

I was deeply honoured to receive the 2024 Jeffrey Shiroky Award at the most recent *Conférence Laurentienne de rhumatologie* in beautiful l'Estérel, Québec.

I knew Dr. Shiroky early in my career while he was still at McGill, where he honed his expertise and made outstanding contributions in clinical research in rheumatology. Over the years, I have had the great privilege of working closely with stellar rheumatologists; these collaborations have shaped my clinical and research work and led to favorable cross-pollination between medical specialties. Thank you.

CPD for the Busy Rheumatologist

Raising the Bar of the Clinical Audit Spectrum: A Comparison Between the Mini-Practice Audit Model (mPAM) and Other Types of Clinical Audits

By Douglas L. Wooster, MD, FRCSC, FACS, DFSVS, FSVU, RVT, RPVI; Elizabeth M. Wooster, M.Ed, PhD(c); and Raheem B. Kherani, BSc (Pharm), MD, FRCPC, MHPE

“The Royal College said clinical chart audits are important for mandatory Section 3 Credits. . . I looked this up and there are different kinds . . . some look easier than others!” exclaims Dr. AKI Joint, a rheumatologist member of the Canadian Rheumatology Association (CRA). “I know there have been recent changes to the Maintenance of Certification Guidelines — what do I do?”

A clinical audit is a systematic review of an individual’s or group’s practice with comparison to established “best practice” standards. The audit cycle identifies gaps, promotes change and confirms practice improvement. It should be direct and focus on actual practice in a manner that allows for discrete intervention and change. It is not a practice inventory or a research project to identify “best practice.” It is an audit designed to lead to quality improvement of actual practice. Ideally, gaps should be identified and feedback given to address remedies that can be established in practice. A follow-up re-audit can be done to confirm change in practice.

Although administrative and authority-driven audits and 360° reviews have been promoted to identify strengths and weaknesses in physicians’ use of practice guidelines, these are frequently large and expensive and done only occasionally. The chosen guidelines may not be relevant to actual practice. Patient selection may lack specificity and relevance and often demands large numbers of patients or “blind” audits of extensive databases. The information is usually diffuse and not specific to an individual’s practice. Analysis may be done by “experts” and feedback given as a committee’s “action plan”. This may lead to irrelevant comparisons and, hence, impractical conclusions and recommendations for change. As such, implementation and re-audit may not be practical.

In contrast, the mini-Practice Audit Model (mPAM) (Table 1) uses specific domains and elements directly related to individual practice guidelines, standards or protocols. A limited number of patients (10-20) is often adequate to sample practice patterns. The data can be

correlated directly to guidelines and gaps can be readily identified. It has been shown to directly inform feedback to individual physicians for improvement strategies and specific implementation. It is reliable and relates clearly to actionable interventions, including education and re-audit, and implementation of practice improvement (Wooster 2007).

The cycle of audit, analysis, education/intervention, application, re-audit and re-application used in the mPAM can be used for personal improvement or in a group strategy. It can be documented as a personal learning project or otherwise as a quality improvement activity for recognized CPD credits. The findings and process can also be used for group learning and focused education rounds or courses, or literature review or to search for appropriate definitions and guidelines. Identified deficiencies can also inform further clinical and standards investigation and quality improvement strategies in related areas.

“The mPAM format is one that I could actually do...” says Dr. AKI Joint. “I will be able to select the best approach every six months to actively monitor my own patient charts in my practice (and to get MOC Section 3 credits).”

References:

- Rose N, Pang SJ. A Practical Guide to Implementing Clinical Audit. *Can Vet J*. 2021; 62:145-156.
- Pasquale E, Dal Canton A. “Clinical Audit, a Valuable Tool to Improve Quality of Care: General Methodology and Applications in Nephrology.” *World J Nephrol*. 2014 Nov 6; 3(4):249-55. doi:10.5527/wjn.v3.i4.249
- Wooster D. A Structured Audit Tool of Vascular Ultrasound Interpretation Reports: A Quality Initiative. *JVU*. 2007; 31(4):207-10. doi: 10.1177/154431670703100404.
- Fasih N, Mason A. The Canadian Association of Radiologists. A Step by Step Guide: Maximizing The Effectiveness Of Clinical Audits. 2011. Available at <https://car.ca/wp-content/uploads/CAR-Guide-Clinical-Audit.pdf>. Accessed September 7, 2024.
- Pereira VC, Silva SN, Carvalho VKS, et al. Strategies for the Implementation of Clinical Practice Guidelines in Public Health: An Overview of Systematic Reviews. *Health Res Policy Syst* [Internet]. 2022; 20(1). Available at <http://dx.doi.org/10.1186/s12961-022-00815-4>. Accessed August 13.
- Kherani RB, Wooster EM, Wooster DL. CPD for the Busy Rheumatologist: MOC Section 3 Credits: These Can Be Easy. *CRAJ*. Fall 2023; 33(3):20.
- Kherani RB, Wooster EM, Wooster DL. CPD for the Busy Rheumatologist: Knowledge Translation: What’s in It for Me? *CRAJ*. Winter 2023; 33(4):22-23.
- Kherani RB, Wooster EM, Wooster DL. CPD for the Busy Rheumatologist: Mini-Practice Audit Model (mPAM): Overcoming the “Fear” of Chart Audits. *CRAJ*. Spring 2024; 34(3): 26-27.

Table 1: Pros and Cons: Clinical Practice Audits (CPA) and mPAM Process

	CPA	mPAM
Administrative Considerations	Large, diffuse	Individual
	Time consuming	Time efficient
	Complex governance	Local ethics and governance
	Authorities, costly	Specific, cost effective
Guideline Selection	Standard selection	Specific to individual practice
Patient Population	Large sized	Focused, limited
	General group	Specific to practice
Data Analysis	Remote authority	Self-directed
		Peer to Peer
Gap Identification	Comparison to "standard"	Relevant to practice
Change Recommendation	Unavailable or costly resources	Modelled to practice
	System based	Process and system based
Implementation	Time consuming	Time efficient
	Costly	Cost effective
Re-audit	General	Specific, focused
	Time consuming	Time efficient
	Costly	Cost efficient
	Costly	Cost efficient

Douglas L. Wooster, MD, FRCSC, FACS,
DFSVS, FSVU, RVT, RPVI
Professor of Surgery,
Temerty Faculty of Medicine,
University of Toronto

Elizabeth M. Wooster, B.Comm, M.Ed, PhD(c)
OISE/University of Toronto
Research Associate,
School of Medicine,
Toronto Metropolitan University

Raheem B. Kherani, BSc (Pharm), MD, FRCPC, MHPE
CRA Education Committee Past Chair,
Program Director and Clinical Associate Professor,
University of British Columbia
Director, Intensive Collaborative Arthritis Program,
Mary Pack Arthritis Program
Clinician Investigator, Arthritis Research Canada
Division Head, Rheumatology, Richmond Hospital
Rheumatologist, West Coast Rheumatology Associates
Richmond, British Columbia

The CRA's 2024 Distinguished Rheumatologist: Dr. John Esdaile

Why did you become a rheumatologist? What or who influenced you along the way to do so? How did your time working at McGill and at Yale mold your career?

I was fortunate to have a great education that permitted me to be admitted to McGill Medical School from high school. Early on in medical school I was mentored by the premier immunology group at the time — Samuel O. Freedman, Phil Gold, Joe Shuster and David Hawkins. All were research leaders (one was nominated for a Nobel Prize) and outstanding clinicians. The Immunology Division was expanded to include rheumatology. Based on the cases I found most interesting as a trainee they felt I would enjoy that aspect of the field.

At Yale University I was involved with the Robert Wood Johnson Clinical Scholars Program run by the grandfather of clinical epidemiology, Dr. Alvan R. Feinstein. In my second year at Yale, Alvan appointed me to the faculty while I obtained a Masters of Public Health degree and continued to work with him. I was honoured to be allowed to give some of Alvan's lectures. He turned me into a clinical epidemiologist.

Dedicated to expanding Canada's role in patient-focused arthritis research, you have been involved in establishing Arthritis Research Canada/Arthrite-recherche Canada and were named the founding Scientific Director.

You have prioritized investing in people and created a culture dedicated to supervising trainees and mentoring young scientists in a wide variety of disciplines. Over twenty-three years, the organization has grown to more than 100 scientists and staff, located at seven universities across Canada: University of British Columbia (UBC), Simon Fraser, Calgary, McGill, Laval, Dalhousie and the University of Montreal.

What motivated you to establish Arthritis Research Canada/Arthrite-recherche Canada?

I had informed the search committee looking for a new Division Head at UBC that I intended to establish a research centre. The Dean at the time noted that neither the Medical School nor the University as a whole had a major interest in rheumatology research and that I should proceed independently. Fortunately, a pioneering group (Don Elkington, John Hurst, Jack Kowarsky [chair], Peter-Paul Saunders) volunteered to form a Board of Directors of Arthritis Research Canada/Arthrite-recherche Canada and bring on new members. Over the years the board



has included giants from the fields of manufacturing, marketing, finance, law, accounting, and provincial and national politics, including Colin Hansen and Joy McPhail provincially, and two senators, Pat Carney and Nancy Greene Raine. The first chair, Jack Kowarsky, asked that a national perspective be taken from the start.

I was able to raise money for the first ever Chair in Biostatistics related to arthritis and musculoskeletal disease. There were major contributions from philanthropists Maureen and Milan Ilich, Merck Frosst Canada, the Lohn Foundation and from Simon Fraser University itself (Michael Stevenson, President). With the chair at Simon Fraser there were suddenly two Centres. The third and fourth centres followed; with the support of the McCaig family, the University of Calgary;

and l'Université Laval.

The new Scientific Director, Dr. Diane Lacaille, has been responsible for bringing in the most recent new centres at McGill University, Dalhousie University and l'Université de Montréal.

Arthritis Research Canada/Arthrite-recherche Canada benefits from huge expertise in many different domains related to arthritis research in different centres across the country. This has supported a national collaborative research approach and an incredible training program for what is now more than three dozen graduate students at all levels through post-doctoral.

What is the greatest professional and organizational challenge you have faced, and how did you address/overcome this challenge?

There really has only been one major challenge. A national arthritis organization tried to arrest the development of Arthritis Research Canada/Arthrite-recherche Canada. Fortunately, this was averted thanks to the legal involvement of a board member and their colleagues. Like many challenges in life, if you survive the challenge, you turn out to be stronger and wiser going forward.

You have authored more than 280 publications in refereed journals. Your major areas of research interest include systemic lupus erythematosus, rheumatoid arthritis and osteoarthritis. Your focus has been on early diagnosis and early intervention as key elements to reduce disability and to save lives. Can you tell us more about your research and its implications?

As what would now be called a PGY2, my colleagues were aghast that I was interested in arthritis. They felt that there was next to nothing that could be done for patients with arthritic diseases



Dr. John Esdaile receiving his award from outgoing CRA President Dr. Nigil Haroon at the CRA Annual Scientific Meeting in Winnipeg, which took place in February 2024.

and that I ran the risk of wasting my life. It seemed to me that the huge knowledge gaps that existed were fertile ground for research. Indeed, as you suggest, early diagnosis, more accurate diagnosis, and early aggressive intervention, particularly for the many types of inflammatory arthritis, have been a major goal of my research.

It is important to note that my research has been supported by an ever-increasing number of younger bright hardworking scientists. I do believe that only research is going to improve the lives of people with arthritis. The future will be different and the scientists of Arthritis Research Canada/Arthrite-recherche Canada are now including preventing arthritis in their research palette, something that was hard to imagine 45 years ago.

What do you foresee as challenges to Canadian rheumatologists in the future and what can individual rheumatologists and the CRA do to meet these challenges?

The Canadian Rheumatology Association has been hugely successful. All of the universities where we have centres have outstanding clinicians who are active in supporting and guiding the activities of the Canadian Rheumatology Association. I believe it was Niels Bohr who said “prediction is very difficult, especially if it is about the future!” I could not have predicted the growth of Arthritis Research Canada/Arthrite-recherche Canada in 1999, and I hesitate to predict the future challenges for the Canadian Rheumatology Association. I am sure it will meet and deal successfully with the inevitable challenges as they arise.

You are the recipient of numerous awards and accolades including being named the Kirkland Scholar by the Kirkland Foundation in New York, NY. In 2007, you were elected a Fellow of the Canadian Academy of Health Sciences and, in 2012, you received the American College of Rheumatology Masters award. What is your proudest accomplishment to date?

Undoubtedly the creation of Arthritis Research Canada/Arthrite-recherche Canada, and being able to encourage outstanding trainees to commit to a life as researchers and supporting faculty as they start their careers. I think everyone that I have personally hired is smarter than I am and that has worked out very well for me as they give me undue credit.

What do you believe are the qualities of a distinguished rheumatologist?

One could come up with an extensive list. If there was a single one, I would suggest always trying to put the patient first. In the current healthcare system, one does not always get the feeling that the patient is indeed the most important aspect of the system, but I do believe that rheumatologists and those interested in musculoskeletal disease stand out as a group who believe this. It should apply to the clinical and the research world.

In your acceptance video for this award, you jokingly referred to it as the Extinguished Rheumatologist Award. You are well known for your facility with words and wordplay. How did you hone this talent?

My parents encouraged public speaking from an early age, and in high school I was very involved in debating. Words and word play can make ideas interesting. Also, entertaining an audience helps people stay awake.

What are some of your other passions outside of rheumatology and medical education?

I am incredibly proud of James, William and Tara, my children, and their ability to develop into extremely successful individuals with different interests. They are doing a sterling job of improving the world. I have three grandchildren who are simply adorable. Now that I am retired, I can do all sorts of things that I never had time to do, like cooking, reading non-medical books, playing tennis, and bicycling. My wife, Jane Bern, tolerates all of my bad habits — well almost all. I am passionate about her.

You are marooned on a desert island? What book would you like to have on hand with you?

A book on boat building.

What is your favourite food or cuisine?

I don't know that I have a favourite. A perfectly cooked dish is all that I ask for!

You are handed a plane ticket to anywhere in the world. Where do you go?

I might turn in the plane ticket in exchange for a caravan and drive around to some places in North America that I have never visited.

How many cups of coffee does it take to make a productive day?

It depends on how you define a cup of coffee. One shot of espresso is 50-70 mg of caffeine, and one cup of filtered coffee is at least 200 mg. I simply cannot function in the morning without a latte with at least two shots of espresso. I used to drink more, but I am totally unwilling to give up my morning primer of espresso.

*John M. Esdaile, MD, MPH, FRCPC, FCAHS, MACR
Professor of Medicine Emeritus,
University of British Columbia
Scientific Director Emeritus,
Arthritis Research Canada/Arthrite-recherche Canada*

Mapping the Journey to Rheumatology Team Care in BC (2010-2024)

By Jason Kur, MD, FRCPC

In the early 2000s, rheumatology in British Columbia (BC) was facing a crisis — access to rheumatology care was challenging, there were very few rheumatologists per capita in the province, and the physician workforce was dwindling. The situation was so critical the BC Medical Journal's cover story, in April 2011, cheekily asked if rheumatologists were an “endangered species”. That stark conclusion came from the work that the BC Society of Rheumatologists (BCSR) undertook to determine the status of the BC rheumatology workforce.

Around the same time, the Specialists Services Committee (SSC), a collaborative committee between the Doctors of BC and the BC Ministry of Health, allocated funding as part of a Labour Market Adjustment (LMA). This funding was agreed to, as part of the 2011 Physician Master Agreement. A 10-million-dollar fund was established for the SSC to distribute to specialities who suffered from the most significant recruitment and retention challenges. I realized it was important for rheumatology to access these funds to help reduce disparity and increase retention.

In my fellowship training at the University of British Columbia (UBC), I was impressed by the collaborative nature of pediatric rheumatology at BC Children's Hospital. The pediatric rheumatologists worked seamlessly with clinic nurses to help with methotrexate teaching, and these nurses also assisted with patient and parent counselling. At the same time, I also noticed that, in endocrinology, diabetes clinics had the benefit of allied health professionals helping patients manage the complications of chronic disease. At that point, I asked myself, why could/should this not be the case in rheumatology?

On behalf of our section and in dialogue with other rheumatologists, I set about to create a proposal for a change to care delivery in the province. This consisted of several key initiatives, the cornerstone of which was changing the model of care, and the development of a fee code to support the use of nurses in outpatient fee-for-service practice. This code, billable every six months, was characterized as follows: “Multidisciplinary Conference for community-based patients: To consist of assessment, written treatment plan and any other counselling the patient needs for management of their particular diagnosis.”

The other successful changes as part of this process were the creation of (i) a time-based complex care code, as well as (ii) the annual immunosuppressant review checklist for patients on advanced therapies.

The ensuing years saw rheumatologists in BC incorporating nurses in their practices, usually on a part-time basis to assist in the management of patients with inflammatory diseases. It didn't take long for the BCSR to demonstrate that this model of care had many benefits — including increased access in terms of patient visits, as well as improved provider and patient satisfaction. In addition, the uptake for this model of care was remarkable with 80% of the rheumatologists accessing the fee code. The appetite for system change, even in a traditional fee-for-service model, was evident. Of course, these changes were instigated to improve recruitment and retention. To that end, rheumatology in BC has seen growth in full-time equivalent (FTE) practitioners, with the onboarding of newer physicians now matching with the number of retirements. Moreover, specific studies reflecting on the timeframe (2010-2018) demonstrated that, after the implementation of the LMA codes in 2010, there was an increase in the number of FTE rheumatologists providing outpatient services in BC, rising from 30.0 FTEs in 2010, to 58.4 FTEs in 2018.

Other specialists have taken note of the successes that BC rheumatology has had. Indeed, the SSC has successfully completed a broader project, which supported nine different specialties (medical and surgical), to expand their out-patient specialist team care with the addition of allied health professionals (including nurses, dietitians, and therapists). Drs. Tommy Gerschman and Michelle Teo, both CRA members, led this initial expansion towards a transformative model of team care for specialists in BC. By way of their leadership, a step-by-step toolkit was created to advance specialist success. The first cohort of specialist team care leaders was completed in 2024. The SSC has taken on a second, larger cohort to further build on this success. As the current co-chair of the SSC, it is heartening for me to see this progression of team care gain momentum.

Such a significant change in practice has not surprisingly been associated with some issues along the way. Some of these concerns relate to the time needed to train nurses in rheumatology, finding health care professionals

Timeline of BC Rheumatology Team Care:

BCSR identifies rheumatology workforce crisis	2009-2010
SSC creates LMA fund	2011
BCSR creates Multidisciplinary Fee Code	2011
Impact of Fee Code published	2014, 2020
LMA Review Paper completed	2019
SSC launches first cohort for Team Care for Multiple Specialties	2022
BCSR Multidisciplinary Fee Code provisional status removed	2024
SSC launches second cohort for Team Care for Multiple Specialties	2024 and onwards

in a limited workforce, office logistics, and even having the clinical space to allow this team model of care to flourish. None of these challenges are insurmountable, but they all need ongoing physician support and attention.

Since the inception of the multidisciplinary team care fee code in BC, years of financial monitoring have occurred. The BCSR has been at the forefront of helping create this sustainable model of care. In 2024 the fee code was finally transferred to the Medical Services Plan general pot and no longer has a provisional code designation. The nursing team model of care has, over the past 14 years in BC, become an established standard of care for patients with inflammatory diseases.

*Jason Kur, MD, FRCPC
President, BC Society of Rheumatologists
Co-Chair, BC Specialist Services Committee
Summerland, British Columbia*

References:

1. Kur J. and Koehler B. Rheumatologist Demographics in British Columbia: A Looming Crisis. *BCMJ* 2011; 53(3).
2. Sun M, Jamal S, Kur J. Analysis of Rheumatology Nursing Interventions in Out-patient Practice Settings. *CRAJ*. 2014; 24,3:18-22.
3. Duncan R, Cheng L, Law MR, et al. The Impact of Introducing Multidisciplinary Care Assessments on Access to Rheumatology Care in British Columbia: An Interrupted Time Series Analysis. *BMC Health Serv Res*. 2022; 22(1):327.
4. Connell J, Kur J, Gurmin JH. Assessing the Impact of a Nursing Model of Care on Rheumatology Practice Patterns and Patient Satisfaction in British Columbia. *BCMJ*. 2020; 62(3):98-102.
5. Specialist Services Committee. "Consultant Specialist Team Care Toolkit". May 2024. Available at <https://sscbc.ca/sites/default/files/DoBC%20CSTC%20Toolkit%20V3.pdf>. Accessed September 2, 2024.

Survey Results: Digital Quality Improvement

This edition’s Joint Count survey focused on asking CRA members their perspectives on digital quality improvement. There were 47 surveys completed, equating to a response rate of 12%.

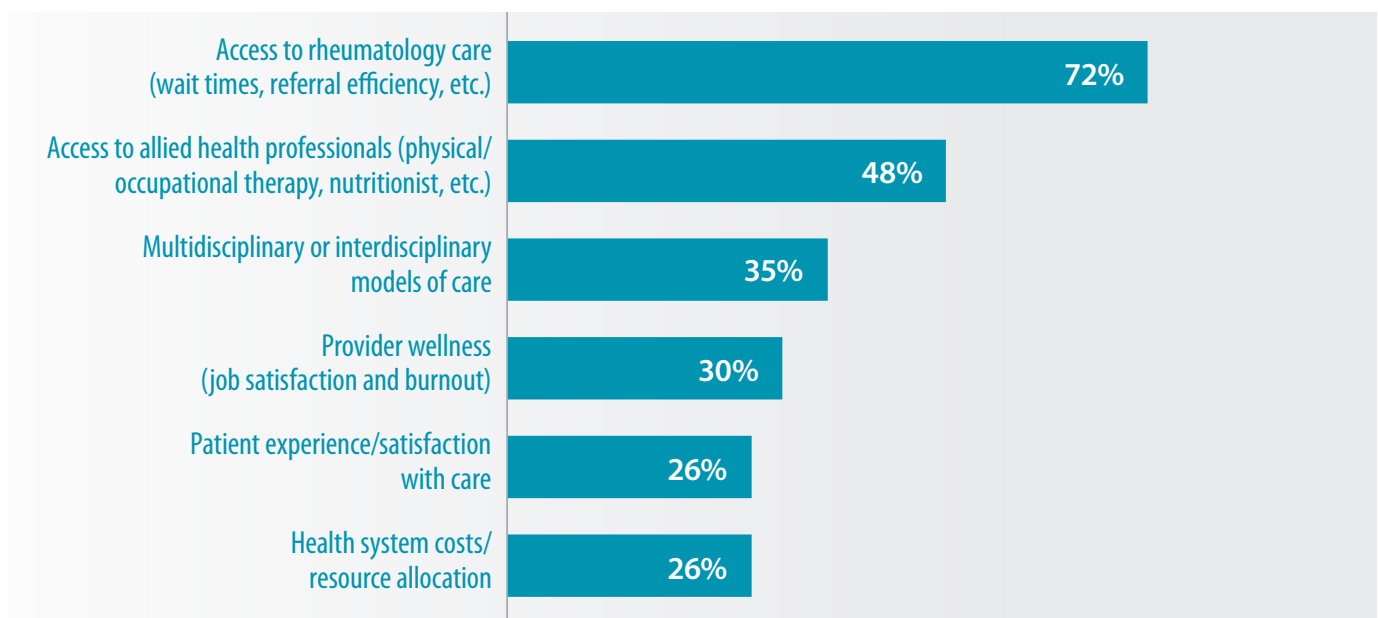
The first question regarding rheumatic diseases/conditions asked “Which of the following should be prioritized for quality measure development, endorsement, and implementation in Canadian Rheumatology Care? Select up to 3 choices.” The top 5 overall were (1) rheumatoid arthritis (54%); (2) systemic lupus erythematosus (52%); (3) spondyloarthritis (including psoriatic arthritis and ankylosing spondylitis) (30%); (4) osteoporosis (26%); and (5) vasculitis (20%).

The second query focused on diagnostic, therapeutic or preventive interventions, and asked survey takers “Which of the following should be prioritized for quality measure development, endorsement, and implementation in Canadian rheumatology care? Select up to 3 choices.” Here, the top 5 results were (1) comorbidity screening & management in rheumatology care (cardiovascular disease, diabetes, interstitial lung disease, osteo-

porosis, etc.) with 52% of votes; (2) tied for second place, vaccinations and appropriate use or overuse of imaging and laboratory testing (with 44% of votes each); (3) reducing and/or appropriate use of glucocorticoids (35%); (4) appropriate use of disease-modifying treatments (30%); and (5) patient-reported outcome measures (e.g., functional status, pain, fatigue assessment, etc.) (20%).

The topic of the final question was optimizing health-care service delivery, and the question was similar to the previous ones: “Which of the following should be prioritized for quality measure development, endorsement, and implementation in Canadian Rheumatology Care? Select up to 3 choices.” The top 5 here were (1) access to rheumatology care (wait times, referral efficiency, etc.) (72%); (2) access to allied health professionals (physical/occupational therapy, dietitian, etc.) (48%); (3) multidisciplinary or interdisciplinary models of care (35%); (4) provider wellness (job satisfaction and burnout) (30%); and (5) tied for fifth place both patient experience/satisfaction with care and health system costs/resource allocation (with 26% of votes each).

Chart 1. Optimizing Healthcare Service Delivery: Which of the following should be prioritized for quality measure development, endorsement, and implementation in Canadian rheumatology care? (Select up to 3 choices)



The Digital Quality Improvement Subcommittee is evaluating these results and is working on building resources

for CRA members. For any questions or feedback, please reach out to info@rheum.ca.

Tribute to Dr. Raymond M. Lewkonja

By Gary Morris, MD, PhD, FRCPC

Dr. Lewkonja of Calgary passed away on October 3, 2023, at the age of 80 years.

Dr. Lewkonja was born in 1944 in England. After graduating with his medical degree from the University of Liverpool in 1966, he studied immunology, rheumatology, and medical genetics in Edinburgh and London. Dr. Lewkonja moved to Canada and started his rheumatology career in Calgary in 1976, achieving the rank of professor in 1995.

Dr. Lewkonja was instrumental in setting up the medical school at the University of Calgary. He served as the chairman, clerkship coordinator, or manager of many medical school committees throughout the 1980s and 1990s and established the Medical Skills Center in 1991. He remained a passionate advocate for medical education throughout his entire career.

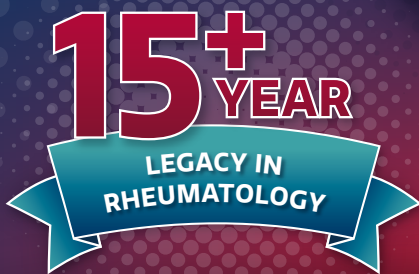
Dr. Lewkonja published throughout his career and combined his knowledge of medical genetics with his expertise in heritable disorders of connective tissues to become a leading expert in this area.

Dr. Lewkonja is survived by his wife Angela Jane, and his sons Peter and Michael. Services were held for family only. In lieu of flowers, the family requests donations be made to the CNIB, an organization Dr. Lewkonja felt strongly about. Dr. Lewkonja will be sorely missed by his colleagues in Calgary.

*Gary Morris, MD, PhD, FRCPC
Clinical Associate Professor,
Division of Rheumatology
Cumming School of Medicine
University of Calgary
Calgary, Alberta*



THE #1 DISPENSED BIOLOGIC DMARD IN CANADA PRESCRIBED BY RHEUMATOLOGISTS*



COMMITTED TO SUPPORTING YOUR
PATIENT'S TREATMENT JOURNEY.



RA



AS



PsA



nr-Ax
SpA

AVAILABLE
SINCE

2009

2016

SIMPONI[®], in combination with MTX, is indicated for: 1) Reducing signs and symptoms and improving physical function in adult patients with moderately to severely active RA; 2) Inhibiting the progression of structural damage in adult patients with moderately to severely active RA who had not previously been treated with MTX.

SIMPONI[®] is indicated for: 1) Reducing signs and symptoms in adult patients with active AS who have had an inadequate response to conventional therapies; 2) The treatment of adults with severe active nr-Ax SpA with objective signs of inflammation as indicated by elevated CRP and/or MRI evidence who have had an inadequate response to, or are intolerant to NSAIDs; 3) Reducing signs and symptoms, inhibiting the progression of structural damage and improving physical function in adult patients with moderately to severely active PsA. SIMPONI[®] can be used in combination with MTX in patients who do not respond adequately to MTX alone.

Please consult the Product Monograph at janssen.com/canada/our-medicines for contraindications, warnings, precautions, adverse reactions, interactions, dosing, and conditions of clinical use. The Product Monograph is also available by calling 1-800-387-8781.

* Comparative clinical significance unknown.
AS=ankylosing spondylitis; CRP=C-reactive protein; DMARD=disease modifying anti-rheumatic drug; MRI=magnetic resonance imaging; MTX=methotrexate;
nr-Ax SpA=non-radiographic axial spondyloarthritis; NSAID=nonsteroidal anti-inflammatory drug; PsA=psoriatic arthritis; RA=rheumatoid arthritis.

Reference: SIMPONI[®] Product Monograph. Janssen Inc., January 5, 2024.

© 2024 Janssen Inc. | All trademarks used under license.
Janssen Inc. | 19 Green Belt Drive | Toronto, ON M3C 1L9 | janssen.com/canada
CP-431662E



ONE POINT OF CONTACT.

SUPPORT YOU CAN COUNT ON.

ONE dedicated BioAdvance[®] Coordinator supports both you and your patients with:

- Help securing reimbursement and financial assistance
- Support getting access to the drug as quickly as possible
- A simple enrolment process, initiated by a single call or email from you



Visit [BioAdvanceSupport.ca](https://www.bioadvancesupport.ca)

The image depicted contains models and is being used for illustrative purposes only.

Janssen Inc. 19 Green Belt Drive | Toronto, Ontario | M3C 1L9 | www.janssen.com/canada

© 2022 Janssen Inc. | All trademarks used under license. | CP-340708E

60,000+
PATIENTS
ENROLLED IN
PFIZERFLEX



Patient Support Program
PfizerFlex
Experienced, Dedicated Team

Count on Pfizer's commitment to patients with PfizerFlex*

PfizerFlex is the Patient Support Program for your patients taking:

XELJANZ
[tofacitinib citrate]

XELJANZ XR
[tofacitinib citrate]

Abrilada
adalimumab

Inflectra
infliximab

Ruxience
rituximab



For more information,
visit PfizerFlex.ca

* May not be available in Quebec.



ABRILADA® Registered trademark of Pfizer Inc. Used under licence. | INFLECTRA® Registered trademark of Pfizer Inc. Used under licence.
RUXIENCE® Registered trademark of Pfizer Inc. Used under licence. | XELJANZ® / XELJANZ® XR PF Prism C.V., owner/Pfizer Canada ULC, Licensee
PFIZERFLEX™ Pfizer Inc., owner/Pfizer Canada ULC, Licensee | © 2024 Pfizer Canada ULC, Kirkland, Quebec H9J 2M5



PP-XEL-CAN-1014-EN