Please Don't Let Me Be Misunderstood[1]

By Philip A. Baer, MDCM, FRCPC, FACR

After six years away, I recently returned to a prior role as Chair of the Section on Rheumatology at the Ontario Medical Association. Much has happened during that time, including a pandemic, high inflation, and increases in administrative burden and physician burnout. However, some things never change: as physicians, we are always confronting our single payer, the provincial Ministry of Health, in an effort to maintain and improve the healthcare system, including funding rheumatology services at a reasonable level.

For several years, we have been advocating for a new fee code as an add-on to visits that involve initiating or switching of a biologic (biologic disease modifying antirheumatic drug [bDMARD]) or oral small molecule advanced therapy (targeted synthetic [ts]DMARD). Unfortunately, the bilateral medical association/Ministry of Health committee has consistently indicated it does not support our proposal, stating that "the elements described for this new code are already compensated with existing visit codes. The committee lacks evidence of the provision of care which is not already compensated."

The committee apparently feels that the components of these advanced therapy initiation/switching visits are analogous to standard follow-up visits. Anyone who understands the front lines of rheumatology care must be shaking their head in disbelief. A patient with rheumatoid arthritis who is doing well and coming in for a scheduled every six months follow-up visit is very different from a patient whose disease activity is not controlled, and thus may require the initiation or switching of an advanced therapy.

What is our rationale? When a patient is stable, we might schedule a visit length of 15-20 minutes, whilst knowing that some patients will require longer. This time is absolutely filled with a targeted history, a physical examination including joint counts, the determination of composite disease activity measures incorporating patient questionnaires, review of interim lab work and imaging, and ultimately decisions about future care and appointments. For a well-controlled patient, the visit conclusion may consist of simply refilling their medications, or we might attempt to taper their therapy. On the occasional day when the visit is uncomplicated, there may even be time to deal with all the disease comorbidities rheumatologists feel increasingly responsible for managing, including mood disorders, cardiovascular risk factors, bone health, and immunizations, among others. The patient-facing activities might be completed during the actual appointment time, though it is not uncommon to have to finish documentation tasks after the patient leaves, and sometimes at the end of the day after the office has been completed.

In contrast, we may be faced with a patient who is flaring, potentially requiring the initiation or switching of an advanced therapeutic. The patient may have made an impromptu appointment because of a flare. Many of these patients have to be added at the end of an office or during a lunch break. Alternatively, the patient may not be doing well, but may not recognize that they need a change in therapy. For such a patient who feels that their symptoms are in a "patient acceptable symptom state", the rheumatologist will have work to do to convince them that a change in therapy is needed to prevent joint damage, deformity, disability, and premature mortality.

The time required for these visits is far greater than that normally allotted to a follow-up visit. This puts the physician behind for the rest of the day and adds to the pressure felt in the office. Furthermore, once a decision is made to initiate or switch an advanced therapy in a patient with rheumatoid arthritis, we have more than 20 choices of therapies, counting originator and biosimilar drugs. The decision on which therapy to use is nuanced, and adequate time is required to consider individual patient factors and preferences, employing shared decision-making as much as possible. The patient could take a pill, receive an injection therapy or an infusion therapy. Patient support programs are often involved, requiring enrollment through a lengthy form. As well, all of these therapies remain expensive, ranging from $5,000-$20,000 per year, with public and private payers often demanding additional forms to be filled out for special authorization. Naturally, all of these tasks demand extra time after the visit. Not infrequently, after we mutually decide on a therapy with a patient, we later find out that the patient's insurance does not cover that therapy first-line due to tiering (a major issue with private payers whose criteria are not transparent). This engenders further currently unremunerated work.

Our non-rheumatologist colleagues have told us that they cannot understand how a biologic initiation or switching visit can be equated to a standard follow-up visit. In addition, before starting an advanced therapy, there is a biologic safety checklist which must be completed. Patients may require immunization updates, attention to other risk factors, and informed consent regarding potential adverse events must be documented.

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We are trying to get some traction by analogy to inpatient visit codes. In the past in Ontario, there was a single billing code for all internal medicine inpatient visits for the first five weeks of a patient's admission to hospital. Eventually, it was recognized that there was greater intensity associated with visits on the first day in hospital, the second day in hospital, and the last day in hospital when a patient is discharged. New codes have been added for these days, with a higher value than the standard daily visit fee. This is the same discrepancy that we face when we conduct a biologic initiation/switching visit versus a standard follow-up visit, and we think this should be recognized in the fee schedule.

What is a rheumatologist? Judging from some of the referrals we receive, and the blank look of many lay people when hearing the term "rheumatologist," we are certainly one of the most misunderstood specialties. We need to reassure payers that our intentions are good, and that with proper funding there is no limit to what we can achieve in helping our patients obtain better outcomes. Maybe then rheumatology can be restored to its former status as "the happiest specialty."[2,3]

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Selected References:
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3. James R. O'Dell, MD. The Happiest Specialty: Rheumatology Is #1! July 2012. Available at *www.the-rheumatologist.org/article/the-happiest-specialty-rheumatology-is-1/*. Accessed November 12, 2024.

Arthritis Society Canada and Creative Destruction Lab Announce Four Innovators Poised to Advance Arthritis Innovations

Ahead of World Arthritis Day on October 12th, Arthritis Society Canada, in partnership with Creative Destruction Lab (CDL), announced four arthritis-focused companies selected to join CDL's world-class program for massively scalable, seed-stage, science- and technology-based companies. They will spend the next nine months developing and bringing their innovations to market to improve the quality of life of people living with arthritis.

The selected innovators are:

1. **Canurta Therapeutics** – a biotechnology company addressing unmet needs in neurodegenerative diseases, including ALS, dementia, rheumatoid and juvenile arthritis, by developing rare botanical drugs.
2. **Interface Biosciences** – using a novel discovery platform that integrates artificial intelligence to develop therapies for autoimmune diseases, including rheumatoid arthritis and cancer.
3. **SereNeuro Therapeutics** – spearheading non-opioid pain therapies for long-term pain relief, using advanced cell and gene therapy for chronic pain, including applications for juvenile arthritis and other types of arthritis.
4. **A new company** (yet to be public) – advancing precision therapeutics targeting the root causes of inflammation in antibody-mediated diseases like rheumatoid and psoriatic arthritis.

These companies, along with 15 other seed-stage ventures, will gain mentorship and resources to launch their innovations. In Spring 2025, Arthritis Society Canada and CDL will celebrate their contributions to the future of arthritis care at an inaugural showcase event.

Learn more about Arthritis Society Canada's leadership in driving innovative solutions at *arthritis.ca*.