2016 Winter Newsletter

Dr Henry Averns

PRESIDENT'S MESSAGE

DR. HENRY AVERNS
President, Ontario Rheumatology Association

Our Winter Newsletter is all about membership engagement and involvement. This is your organization. We want you and need you to get involved in our work. We promised in the Summer to reach out to members by talking to groups representing various parts of the Province, all of whom have different needs and challenges. We are reviewing what we have learned from these meetings and this will underpin much of our mission in 2017 where we ensure that the Association is truly representing the members.

We are encouraging more members to take an active role in our work to ensure that we continue to represent all of our members, wherever they live and work. To this end you will be seeing an email flyer asking for expressions of interest in bringing a vision for an informatics platform to fruition over the next 3-4 years. The objective is to develop and implement an informatics platform that allows us to collect clinical and administrative data to demonstrate best practices, improved outcomes and accountability to the health care system. We believe we should be able to demonstrate practice efficiency and appropriate use of limited resources, and have a tool for clinical practice audit and research. We are well aware that there is a spectrum of enthusiasm for IT developments, with emotions ranging from huge excitement at the potential through to boredom and negativity, with a perceived threat where data are exported. We respect all of these pointe of view. But let's make sure that when this happens, which it will with or without our involvement, we have a clear seat at the table and we take control. I am anticipating an "early enthusiast" team, some later adopters, and a group who are happy just as they are. That is fine. I look forward to hearing from anybody who sees themselves in the first group and we will build the vision. We are planning a Winter workshop to further develop this framework – much of the feasibility testing has been completed already by OBRI who are partners in the venture.

We continue to work closely with the Exceptional Access Committee (EAP). For a number of reasons this has been a challenging year for the EAP in terms of processing applications for initial and repeat biologic medications for our patients, with processing times unacceptably long. At our most recent meeting we achieved an outcome which addressed the concerns in terms of wait times, and in the longer term the reasons behind the delays are being addressed with several new staff employed. Turnaround times for biologics are down to just a few days.

In addition to wait times we discuss other relevant areas related to appropriate access to medication for patients, and specifically discuss new drugs and indications. We are pleased that the uveitis criteria were approved and published in 2016. Is there something else you would like us to take to these meetings? If so you must let us know (write to me).

As always I hope you see that the ORA is working hard on your behalf. Enjoy the Winter!

In This Issue …

COMMITTEE UPDATES

Dr Philip Baer

OMA UPDATE

DR. PHILIP A. BAER MDCM, FRCPC, FACR
Chair, OMA Section of Rheumatology

Relations between the OMA and the Ministry of Health remain very acrimonious, as all our members who follow mainstream and social media are well aware. With the defeat of the tentative Physicians Services Agreement (tPSA), the OMA Board, Executive and Council have engaged in considerable soul-searching. A new Strategic Working Group has delivered 114 recommendations to move forward, divided into short, medium, and long-term goals. These were presented at OMA Fall Council and provide a sensible roadmap going forward. Members of the Concerned Ontario Doctors (COD) group have become engaged in this effort as well. We are trying to heal the internal divisions at the OMA in order to move forward. Our Charter challenge continues, aiming to achieve binding arbitration in future negotiations. Bill 41 has been passed and members should follow the OMA website for more information.

On the weekend of Nov. 25-27, I attended the OMA Fall Council as the Delegate for the Section on Rheumatology. The meeting was heated, included apologies from the OMA President for what transpired over the summer, and provided some direction going forward for a renewed, revitalized and more effective OMA in the area of negotiations, government relations, and member advocacy. On December 8, 2016 I presented a live CME webcast in Toronto to update our members on OMA matters. If you were unable to participate, a link to the recorded webcast will be available soon and shared with our membership.

I continue as an OMA representative on a Ministry of Health task force looking at modernizing the OPDP EAP program for drug access, using a web portal and eventually direct links to physicians' EMRs, codenamed SADIE. Dr. Jane Purvis has also recently joined this committee.

We continue to be represented, either by myself or our Section Vice-Chair, Dr. Nikhil Chopra, or our Section Secretary, Dr. Julie Kovacs, at all regular and special meetings of OMA Council, at all Medical Assembly meetings and teleconferences, and at all meetings and teleconferences related to OMA initiatives.

The Section on Rheumatology has moved to conform to the new OMA governance structure, including term limits. There is now a single election period in February-March of each year, in coordination with all other OMA Sections, with a nominating period extending from November 15th to January each year. The current Section officers have all expressed an interest in running in the 2017 Section election, and have been nominated through the new process to be reelected to their current positions. Anyone else who wants to run should consult emails from the OMA Elections department, or review the process outlined at the OMA website, www.oma.org , and can then apply to be nominated.

Please monitor the MOHLTC website under the Health Professionals tab for new developments (http://www.health.gov.on.ca/en/pro/). There are links there to OHIP Physician Bulletins

(http://www.health.gov.on.ca/en/pro/programs/ohip/bulletins/4000/bulletin 4000 mn.aspx), and to updates regarding the OPDP formulary, including new EAP listings

(http://www.health.gov.on.ca/en/pro/programs/drugs/edition 42.aspx).

You may also keep abreast of OMA issues by reading the Ontario Medical Review (OMR), the OMA monthly magazine available in print form and on the OMA website. A recent feature on OHIP payments for Special Visit Premiums in the October 2016 issue will be of interest to some of our members. As well, information about physician obligations under the amended Occupational Health and Safety Act and a physician toolkit can be found in OMR and at www.oma.org/OHSA


Dr Vandana Ahluwalia

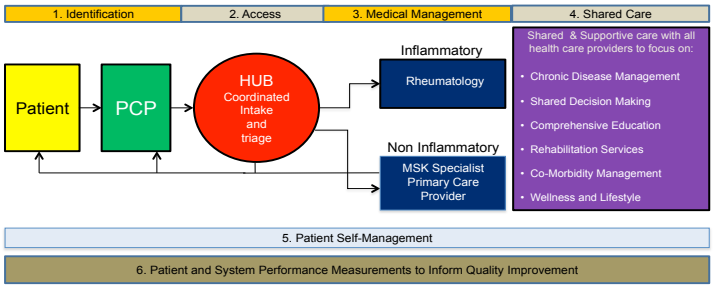
MODELS OF CARE (MOC)

DR. VANDANA AHLUWALIA
Director of Models of Care

The Models of Care Journey in Ontario

The landscape of arthritis care is changing. According to the Arthritis Alliance of Canada, over the next 20-30 years, the burden of arthritis is on the rise. The recent stand up and be counted survey measured and mapped the rheumatology workforce in Canada and highlights that currently none of the provinces are meeting the benchmark for health human resource expectations. To add to the burden, 1/3 of the workforce will be retiring over the next 10 years. In Ontario alone, the number of patients with rheumatoid arthritis seeking medical attention has tripled over the last 15 years with no increase in the number of rheumatologists available to care for these patients. In an effort to address this, the Ontario Rheumatology Association Models of Care (MOC) Project was established in 2010 to create a framework for improved access and quality of rheumatology care in Ontario. The MOC committee's work has been further enhanced through its collaboration with the Ontario Best Practices Research Initiative (OBRI) and the Arthritis Alliance of Canada (AAC).

The ORA Models of Care Framework- *adopted by the AAC as the national MOC framework*.



Over the last 6 years, the MOC committee has created and completed various projects specifically aligned to the 6 elements of the model. The projects for 2016-17 are outlined as such:

Access:
Allied Health Rheumatology Triage project: *a collaborative study between ORA, OBRI and The Arthritis Society*. The primary objective was to assess time from family doctor referral to Rheumatologist's first visit for patients with suspected inflammatory arthritis (IA). The Arthritis Society ACPAC trained Extended Role Provider (ERP) was able to decrease wait times to the rheumatologist to an average of 35 (24.5-55.0) days versus 59 (71.0-135.0) days in the control group, thus improving time to treatment decision. These findings indicate that triage by an ERP resulted in a high number of patients with suspected IA receiving more timely consultations and earlier treatment.

Results from the study have been accepted for presentation at national and international meetings and a research paper is currently being developed. The ORA is developing a collaborative relationship with the national Allied Heath Professionals (AHPA) organization to help facilitate and support the integration of ACPAC-trained ERPs in rheumatology models of care.

Patient Self-Management:
An Inflammatory Arthritis Care Plan was created to included disease education, rehabilitation, vaccination review, co-morbidity management and return to work support. The EMR tool for the new care plan is currently being created and will be integrated into the Accuro EMR platform for pilot testing in a few Ontario sites.

Patient and System Outcomes Evaluation:
The MOC has leveraged the OBRI to share real world clinical outcomes. Adopting and integrating the minimum core data of the OBRI within the EMRs, patient and system outcomes can now be easily evaluated, both at an individual and regional level to support best practices and quality improvement.

Knowledge Translation
To help educate rheumatologists around the principles and tools of the ORA MOC, a knowledge translation program was developed- "*Rheumatology Care Redesigned* - created nationally, developed provincially and delivered locally". Over the past year, interested rheumatologists have come together to learn and create a knowledge translation plan for the ORA MOC project. MOC facilitators are organizing various workshops with peers to deliver key principles of the program and increase awareness. To promote best practices across provinces, the ORA MOC KT plan was presented at the Annual AAC Research meeting. A debrief meeting is planned for early spring of 2017 to evaluate the success of the MOC knowledge translation program. Stay tuned for a workshop near you!!!


Dr Jane Purvis

PRIVATE PAYERS COMMITTEE UPDATE

DR. JANE PURVIS

Good News for Trillium Drug Plan (TDP) Recipients with Private Insurance!

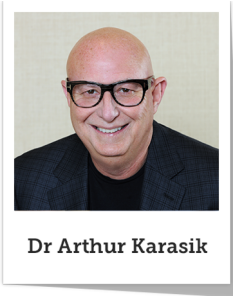
Currently, the Health Network System (HNS) does not support Coordination of Benefits (COB) on OLTP and paper claims for TDP recipients who have private insurance coverage. During the pre-deductible period, all prescription claims must be submitted to private insurance as the first payer, either by the patient or by the pharmacy billing private insurance online. The patient must pay out-of-pocket for the drug expenses not covered by their private insurance, then submit paper receipts along with a private insurance statement in order for the member(s) out-of-pocket expenses to be

counted towards the quarterly/annual deductible. If the deductible is exceeded, a reimbursement is issued. As a result, TDP recipients with private insurance are facing up to 6 weeks or longer in wait times in order to receive TDP benefits and reimbursement. The portion not paid by private insurance can be unaffordable to many households.

The Ministry recognizes that this is not ideal and is planning to implement the following changes in 2017:

1. Allow pharmacies to submit COB claims for TDP recipients with private insurance to the HNS for on-line adjudication once the initial claim has been adjudicated by the patient's private insurance plan(s).
2. The patient will no longer need to submit paper receipts to TDP if the pharmacy has already coordinated the benefits between ODB and the private insurance plan through the on-line system.
3. TDP deductible contributions will still need to be paid by the patient; however, it will be tracked in the HNS so that the patient can receive the TDP benefit immediately once the TDP quarterly deductible has been met.

Note: This information was presented to the ORA Executive on November 4, 2016. The ORA Private Payer Committee will provide an update in 2017 on the status of this development.



Dr Arthur Karasik

ORADE COMMITTEE UPDATE

DR. ARTHUR KARASIK

The Ontario Rheumatology Association Development and Education Committee (ORADE) was formed in 2014. The mandate of the Committee is to support and encourage members in their professional development through formal coursework, conferences, and informal learning opportunities situated in clinical practice. It is to provide opportunities to support the ORA Membership and licensed Allied Healthcare Professionals working in a Rheumatology environment to attend **ANY** international scientific Rheumatology meeting or courses through unrestricted educational grants. This will foster a network of best practices, continuous learning and better patient care. For 2017, we will be supporting 3 Rheumatologists and 1 Allied Health Professional to attend **ANY international scientific meeting** with an educational grant of **$5000.** For 2017 we will also be supporting 3 Rheumatologists and 1 Allied Health Professional to attend **ANY international Rheumatology-related course** with an educational grant of **$2500.** For more information visit the

Dr. Kimberly Legault was a 2016 ORADE recipient. She recently attended ACR in Washington and we are happy to share her learnings:

Report by Dr. Kimberly Legault:

Thank you to the Ontario Rheumatology Association for the opportunity to attend the American College of Rheumatology meeting in Washington, DC.

My principal goal during this meeting was to learn about rheumatology workforce issues affecting other countries, to see if they face similar challenges to those affecting the Canadian rheumatology workforce, and to determine whether

there are any evidence-based strategies being employed in other countries to improve rheumatology recruitment that could be used in Ontario and in Canada.

The results from the 2015 ACR Workforce survey are now available, and data from this survey formed the bulk of the abstracts and presentations on this topic. Projections of workforce need up to 2030 in the US were derived from this study, and factors potentially affecting rheumatology supply were highlighted. Strategies for addressing workplace deficit were proposed based on this data however there were very few studies evaluating the utility of these strategies.

The 2015 ACR Workforce survey was sent to 3366 rheumatologists, of whom 1297 (38.5%) responded, and to 497 fellows-in-training of whom 464 (93.7%) responded. The modelling when projected forwards to 2030 predicts a 31% decline in full-time equivalent (FTE) rheumatologists, with a 138% increase in demand based on age and disease projections (Battaferano et al). The demographic factors affecting the decline in FTE physicians are female gender and millennial status (defined as being born from 1982-2004). In 2015, female physicians saw fewer patients than male physicians (2,249 patient visits per year per female physician, compared with 3,133 for male physicians), and made up 41% of the current workforce. By 2030, women are expected to comprise 59% of the workforce. Moreover, millennials currently make up 6% of the workforce, though will constitute 50-75% in 2030. There has been a reported 5% decrease per week in patient load for this group (Deal et al). Supply and demand considerations must also account for the difference between academic and non-academic physicians. While academic physicians work slightly more hours per week, they spend 50% less time seeing patients, and see half as many patients per week (Monrad et al). Retirement in the next 10 years is planned for 40% of non-academic physicians and 29% of academic physicians.

A deficit in supply of rheumatologists is projected to persist even if all available rheumatology training spots in the US are filled to 100% capacity per year until 2030. There are 113 programs with 215 potential graduates per year. Based on adjustments for millennials and female work patterns as above, as well as accounting for a predicted 20% of graduates who are foreign medical trainees and are planning to work abroad, this would lead to an equivalent of 107 FTE physicians per year. Approximately twice this number of FTE physicians are expected to retire within this time period (Bolster et al).

The US also notes a maldistribution of rheumatologists with the Northeast and mid-Atlantic regions having the most rheumatologists, and the Northwest, North Central, and South Central areas having the highest increase in population to physician ratio (Lawrence-Wolff et al).

The most common factors affecting choice of rheumatology as a specialty for fellows-in-training were intellectual interest, lifestyle/work hours, and the influence of clinical rotations. The least commonly stated reason was income potential (Hausman et al). The top two barriers to practice reported by physicians include reimbursement rates and requirements for electronic health records (Monrad et al).

One of the strategies planned for bridging the need gap is the use of nurse practitioners (NPs) and physician assistants (PAs). Thirty-two NPs and PAs responded to the survey seeking information about practice patterns (30% response rate). NPs reported working an average of 43 hours per week, and PAs 39 hours per week. Most hours were in clinical care (NPs 30 hours/week, PAs 27 hours/week) with NPs reporting 31 patients seen per week and PAs 47 patients seen per week. Less than 18% of NP and PA's reported performing DEXA scan, ultrasound, or infusions. All PAs, and 72% of NPs, reported seeing follow-up patients independently. Twenty-seven percent of PAs and NPs are planning to retire in

the next 10 years (Smith et al.). Another abstract described NP/PA responsibilities, with the top five being: performing patient education (98%), adjusting medication dosages (97%), conducting physical exams (96%), treating patients (96%), and starting patients on medications (94%). Over 90% felt very or somewhat comfortable diagnosing RA and a similar percentage prescribed DMARDs. Approximately 50% used accepted disease activity measures (DAS, CDAI, SDAI, and/or RAPID) and a similar percentage followed Treat-to-Target strategies (Brown et al.). Clinics that employ NPs and PAs appear to be effective in managing rheumatoid arthritis patients when compared to rheumatologist-only practices, with lower disease activity (OR 0.32 for high disease activity p=0.004). Note however that there was no difference in change in disease activity between groups, thus it is possible that the patients in the NP/PA clinics may have lower disease activity at baseline (Solomon et al.).

Another strategy suggested as a potential solution to workplace shortages is the use of electronic digital consultation (e-consult). The US Army instituted an e-consult system to assist remote providers, using a secure email with file upload attachments, and rheumatologists were among those providing consultation services. A retrospective analysis of the rheumatology e-consults was performed. Twenty-four rheumatology staff and fellows performed a total of 193 consults over 8 years. The average response time was 5.3 hours with 98% of the consults answered within 24 hours. Diagnoses including inflammatory arthritis, spondyloarthropathy, arthralgia, connective tissue disease, among others. The authors concluded that the program was successful in providing timely subspecialty care, and that a similar model may improve access to subspecialty care in underserviced or remote areas (Schmidt et al.)

Telecommunication may also play a role in increasing the number of training positions by allowing distance learning. A paediatric rheumatology tele-learning program was created for the Texas Tech University Health Sciences Centre and comprised a 6-lecture curriculum. The lectures were given via TeamViewer which streams live video and PowerPoint. The residents could interact with the lecturer via text message using Poll Everywhere. Residents were surveyed for satisfaction over several measures, with mean response of 4.8 on a Likert scale ranging from 1-5. This may improve access for training in remote sites to increase potential rheumatology training positions (Shirley et al.).

It is also key to ensure continued interest in rheumatology to maximize recruitment. One study assessed the impact of a student-led rheumatology interest group on outcomes including number of students choosing a rheumatology elective, the number of rheumatology abstract submissions by medical students, and the number of medical student-rheumatologist manuscript submissions. All of these outcomes increased following the initiation of this interest group when the 6 months post-intervention was compared to the 6 months pre-intervention (Brady et al).

It is hopeful that in the future we will see further evidence of strategies to help manage workplace shortages that may be extrapolated to our situation in Ontario.

Thank you again for your support.

Dr. Kim Legault, MD, MSc, FRCPC
Assistant Professor, Division of Rheumatology, Department of Medicine
McMaster University

Battaferano D., et al. Abstract number 93
Bolster M., et al. Abstract number 1960
Brady et al. Abstract number 1142
Brown et al., Abstract number 2908
Deal C., et al. Abstract number 89

Housman et al., Abstract number 1140
Lawrence-Wolff et al. Abstract number 928
Monrad et al., Abstract number 99
Schmidt et al., Abstract number 103
Shirley et al., Abstract number 23986
Smith et al., Abstract number 2085
Solomon et al., Abstract number 1809

NEWS & UPDATES

Top 5 List of Things You May Not Know About Your OMA Benefits

The Ontario Medical Association (OMA) represents the political, clinical and economic interests of the province's medical profession. Today, more than 41,000 physicians, residents and medical students are members of the OMA. The Association offers many programs and services to support members' professional and personal lives. A few of these are highlighted below:

1. **Insurance Solutions:** OMA Insurance advocates solely on behalf of physicians and their families to provide them with objective advice and insurance solutions throughout their careers. These insurance solutions are designed to protect your assets (Home & Auto), protect your lifestyle (Disability, Life, Critical Illness and Travel) and protect your business (Office/ Clinic, Commercial, Professional Overhead Expense). At every stage, we tailor solutions to the needs you have now, while helping you stay prepared for your needs in the future. Your protection is our only concern. For more information, please email info@omainsurance.com, call 1.800.758.1641, or visit OMAinsurance.com. **OMA Insurance. Not for profit. All for doctors.**

2. **Special Offers and Discounts:** OMA members now have more options and benefits from more companies than ever before through the OMA Advantages Affinity Program. Members can enjoy preferred rates and services in the following categories: Auto, Communications, Entertainment, Fitness and Health, Moving and Real Estate Relocation Services, Office Services, and Travel and Leisure.

3. **Practice Management:** The OMA offers a broad range of resources, services and training programs that help physicians establish and maintain a successful practice throughout their medical career. By providing tools and evidence-based strategies for members, efficiency and effectiveness of medical practices can be enhanced, thereby improving the quality and delivery of patient care.

4. **Physician Health and Wellness:** The OMA's Physician Health Program (PHP) provides a range of direct services to support the health, well-being and resilience of physicians, residents and medical students. This program is open to members, their families and their workplaces when experiencing difficulties with substance abuse and addiction, psychiatric and mental health concerns, stress, burnout, work-related conflict and a variety of marital or family life issues.

5. **Legal Services:** The OMA offers legal counsel and support for General Practice issues, Regulatory issues, Contracts/Agreements, Incorporation, Corporate Renewal Service, and converting Medicine Professional Corporation upon retirement. These services are complimentary or available at a nominal charge. OMA

Incorporation Service helps keep things simple without the expensive legal fees. The OMA will provide all the necessary paperwork and answer questions that arise during the process. The service is provided for a fee of $518.09*.

**OMA Incorporation fee may fluctuate due to the discretion of the Ministry Government Services Incorporation Fees.*

2016 – 2018 ORA EXECUTIVE

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ORA Committees – Volunteers Welcomed!

If you are interested in joining an ORA committee or would like to learn more about opportunities within the ORA, we would be happy to speak with you! Please send an email to our Program Manager, Sandy Kennedy at admin@ontariorheum.ca.

SAVE THE DATE: MAY 26–28, 2017!

The 16th ORA AGM takes place May 26-28th at the JW Marriott Resort