NEWSLETTER

2025

CANADIAN RHEUMATOLOGY IMPLEMENTATION SCIENCE TEAM (CAN-RIST)

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*Updates to our roadmap to **generate actionable evidence** to **guide spread and scale** of interdisciplinary team-based models of care in Ontario for rheumatology*

1 PROCESS EVALUATIONS

- Completed a case study to learn **how these models operate** and identified **implementation strategies**
- Conducting a national consensus study to **identify agreement on all effective implementation strategies**

2 COLLATE EVIDENCE ON EFFECTIVENESS

Completed a literature review on the **impacts of these models** on improving:

- Patient experience
- Health outcomes
- Value ($)
- Provider well-being
- Health equity

3 EVALUATE EFFECTIVENESS

Currently evaluating the **long-term cost effectiveness** of this model using **real-world health data**

4 READINESS ASSESSMENTS

- Completed a workforce survey to **assess acceptability and capacity** for rheumatology workforce to change
- Completed a study to identify **barriers and facilitators to support equitable adoption and implementation** of IMoC for rheumatology in Ontario

5 ENVIRONMENTAL SCANS

- Completed a national study identifying **inequities in provincial funding models** to support team-based care
- Completed a scan of the **number of rheumatologists** and **geographic distribution**

6 BUDGET & POPULATION IMPACT ASSESSMENTS

Conducting **population-based forecasting studies** to inform policy decision-making

7 INFORMING DETAILED SPREAD & SCALE PLANS

- Prepared a **Policy Brief** to identify funding options
- Preparing a **Policy Report** to identify the optimal/most feasible funding solutions
- **Consolidating key learnings and resources/toolkits** to support adoption, implementation, and sustainability

8 PROVINCE-WIDE IMPLEMENTATION, SPREAD & SCALE

Through evidence-based funding reform & practice-based implementation resources

EVIDENCE SYNTHESIS

Collating the Evidence Base to Enhance Understanding of How Interdisciplinary Teams Advance the Quintuple Aim

To strengthen the case for the broader implementation of **team-based rheumatology care**, the goal of this scoping review was to comprehensively **synthesize the existing evidence** on its outcomes, processes, and impacts.

THIS REVIEW ALSO EXAMINED:

TERMINOLOGY used to describe team models

TEAM COMPOSITION AND ROLES across disciplines

How these models are advancing the QUINTUPLE AIM:

- Patient Experience
- Population Health
- Value
- Provider Well-Being
- Health Equity

Studies show **wide variation in how teams are structured and described** – ranging in the number and types of professionals involved, the level of collaboration, and the outcomes assessed.

EVIDENCE IS BUILDING!

The findings highlight a rapidly expanding body of literature that reflects a growing interest in collaborative, team-based care to meet rising demand and complexity and improve integrated care.

Research shows positive impacts across the Quintuple Aim, demonstrating a strong momentum toward more integrated, effective care in rheumatology.

LOOKING AHEAD

Keep an eye out for the publication: The manuscript (led by CAN-RIST trainee & PhD(c) Nicolas Bodmer) is currently undergoing peer review, and will be presented at upcoming conferences.

Bodmer, N. S. *et al.* Team-Based Outpatient Rheumatology Care: A Scoping Review of Terminology, Team Composition, and Impact on Advancing the Quintuple Aim. [Manuscript Submitted] (2025).

We are launching a study to improve reporting standards on team-based models of care to enhance comparability, reproducibility, and aid in implementation efforts.

The CArE Factor:
Lessons From an Effective Team-Based Model

CArE Centre of Arthritis Excellence
A Regional Program... A National Resource

We have completed our case study **to learn** from the Centre of Arthritis Excellence (CArE) in Newmarket, Ontario. We started our evaluation with CArE, as it is the only Ontario Ministry of Health-funded, community-based specialty health team in Ontario, and Canada's longest running interdisciplinary model of rheumatology care.

From our comprehensive evaluation, we **learned**:

- From **PATIENTS** about what they valued from this care model
- From **HEALTHCARE PROFESSIONALS (HCPs)** on what makes a high-performing team function well
- **IMPLEMENTATION STRATEGIES** critical to the success of team-based care
- **HOW THIS MODEL WORKS** at achieving optimal integrated care

[SUMMARY OF KEY FINDINGS]

HEALTHCARE PROFESSIONALS

WHAT HCPs VIEW AS IMPORTANT CHARACTERISTICS FOR TEAM-BASED CARE

1. **Key professional qualities** valued by HCPs:
   - **Dual expertise** (strong grounding in their own discipline plus rheumatology-specific training) supported by mentorship and continuous learning.
   - **"Team player"** traits such as adaptability, openness to feedback, collaboration, and mutual trust.
2. **Synergy of complementary skillsets:** Complementary skills both helped patients get better and made team members feel more satisfied in their work, encouraging them to keep learning and improving.
3. **Supportive structures**: A shared workspace, shared electronic medical records, competitive compensation, and stable funding were viewed as critical for both developing and sustaining team-based rheumatology care.

These elements are necessary to enhance collaborative practice and support both high-quality care and HCP well-being.

PATIENTS

WHAT PATIENTS VALUE ABOUT TEAM-BASED CARE

Patients shared their experiences receiving team-based care, emphasizing the aspects they felt influenced their disease management and positive outcomes:

1. **Educational empowerment:** Having thorough educational opportunities, hands-on support and practical skills training throughout their illness helped patients feel mentally prepared and confident to take an active role in managing their health and wellbeing.
2. **Unhurried thoroughness:** Having comprehensive visits allowed time to address concerns that might otherwise be missed, ensuring their needs were fully understood and there was a clear path forward to achieve equitable outcomes.
3. **Responsive care:** Patients valued a welcoming system that provided reassurance and consistent follow-up and as needed support between visits, with the right team member addressing each concern.
4. **Timely care:** Being seen promptly helped address patient needs quickly.
5. **Personalized** care through **multi-specialized collaboration**: The integration of multiple specialists working together allowed care plans to be tailored to each patient's unique needs, promoting convenient, coordinated and holistic management.

WHAT PATIENTS HAD TO SAY

"I'm really impressed with the care I'm getting. I mean really I am. **I don't think I've ever been as well cared for in my life**" - P24

"**It almost feels too good to be true**, that this is available [...] you could talk to anybody there, and they were knowledgeable about the questions you were asking." - P28

"I'm **blessed and certainly appreciative** of what I experienced." - P18

"I have a very high regard for that clinic [...] they've taken very good care of me. **I couldn't have asked for anything better**." - P5

"**It's been incredible**. I feel blessed to be there [...] I'm fortunate to be at CArE" - P14

"I really enjoy the experience. I think it's just so much more comprehensive in terms of the way that they understand the disease from various points of view so **you're not just looking at the medical, you're looking at the entire person.** It's more of a holistic assessment and experience" - P25

We also learned about **care processes** and **characteristics of the care model** ("innovation"), identified **determinants of optimal care** (including barriers and facilitators), identified a comprehensive list of **implementation strategies,** the **mechanisms of action,** and **outcomes**.

DIVERSE SKILL SETS of team members made care tailored to each person's needs possible.

STABLE FUNDING was critical to both launch and keep the program running.

Providers took on **EXPANDED RESPONSIBILITIES** in all areas of rheumatology care, improving capacity and access - **training and mentorship are essential.**

CONTINUOUS EVALUATION AND ADAPTATIONS OF THE MODEL were essential to meet changing care needs.

Beyond generating key insights for the research and practice community, this case study also provided valuable hands-on training in qualitative research and integrative care for several trainees, including doctoral students Daphne To and Zeenat Ladak, and medical students Jenna Wong and Gabriella Sraka.

"Witnessing a high-performing team in action and the meaningful impact on patients has inspired me to further my own clinical training through the ACPAC program"

- Daphne To, CAN-RIST trainee & Advanced Clinician Practitioner in Arthritis Care (ACPAC) Program trainee (2025-2026).

LOOKING AHEAD

Keep an eye out for our publications!

Sraka, G. *et al*. "It's like a OneStopShop": A Qualitative Study Exploring Patient Experiences in Receiving Interdisciplinary Team-Based Care for Rheumatic and Musculoskeletal Diseases. [Accepted to *JRheum Nov 1*].(2025)

To, D. *et al.* Considerations for optimal team-based rheumatology care: A qualitative study exploring the experiences of rheumatology health professionals. [Under Review].(2025).

King, L. K. *et al.* Constructing the Program Theory: An Implementation Science Approach to Understanding a Successful Interdisciplinary Team-Based Model of Rheumatology Care. [Under Review].(2025).

Building on the implementation strategies we identified from our case study, we have launched a national study to:

(1) Reach consensus on the usefulness of these strategies in other settings, and

(2) Identify additional strategies that were not captured in our single-site evaluation.

Upon study completion (end of 2025), we will initiate a subsequent phase: a collaborative co-creation workshop with special interest groups and key informants to determine how best to operationalize the key implementation strategies.

We have one final evaluation on CArE/The Arthritis Program that focuses on health system value which will be disseminated in the year ahead.

THANK YOU! We would like to thank all members of CArE/The Arthritis Program (past and present) who helped to support our evaluation efforts, and to all the patients for sharing their experiences.

ENVIRONMENTAL SCAN & WORKFORCE SURVEY
Assessing the Implementation Context of Ontario's Rheumatology Workforce

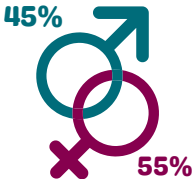
To understand how best to expand the integration of interdisciplinary health professionals (IHPs) in rheumatology care, we first needed a clear picture of how rheumatology practices are configured and their practice needs.

We gathered this information in two stages:

	ENVIRONMENTAL SCAN	WORKFORCE SURVEY
PURPOSE	Identify ALL rheumatologists with an active clinical practice in Ontario	Gain clearer understanding of implementation context for integration of IHPs into Ontario rheumatology practice settings
METHODS	Online searches (aided by CPSO* registry and rheumatology associations) Contacted rheumatology practices and peers to confirm active status	An online survey distributed to Ontario rheumatologists between January and March 2025 Rheumatologists were ineligible if they were 1. Retired/nearing retirement, or 2. Did not have an active clinical practice
DATA COLLECTED	Descriptive characteristics of workforce and practice setting	How rheumatology practices are currently organized Clinic infrastructure What rheumatologists see as priorities Willingness and readiness for integrating IHPs into their practices Other contextual factors that may affect the success of integrating IHPs into rheumatology practices (determinants)

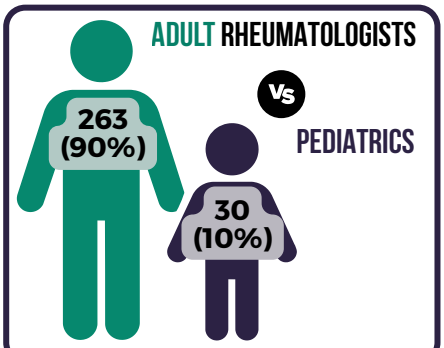
THE ENVIRONMENTAL SCAN

We identified **293** rheumatologists actively practicing in Ontario.



In Ontario, slightly more rheumatologists identify as women than as men

67% of Ontario rheumatologists **went to a Canadian Medical School**



26 (9%) **are about to exit** the rheumatology workforce

CLINICAL SETTINGS

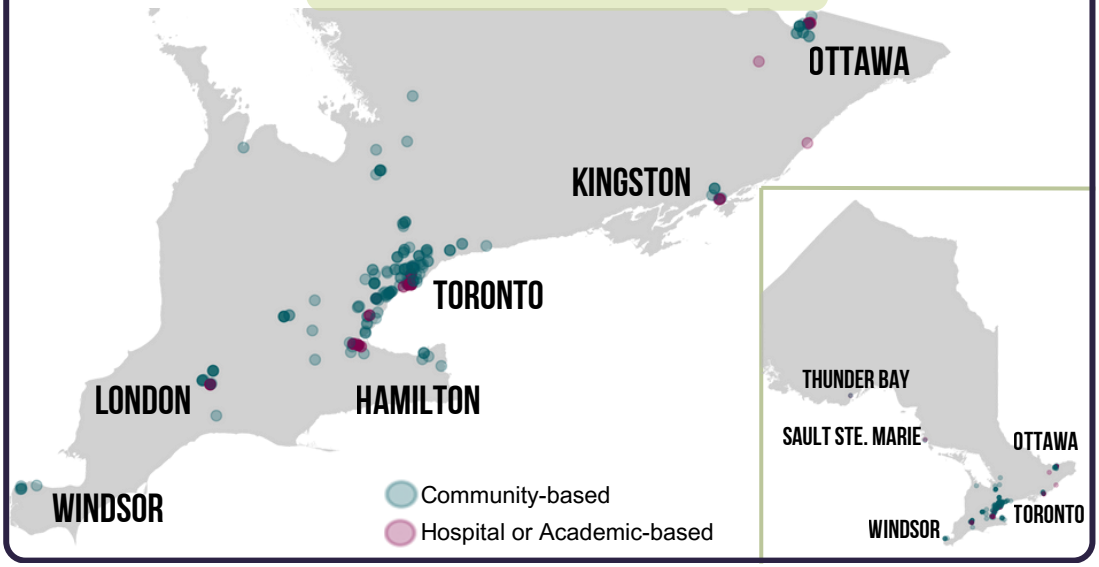
181 (62%) in **COMMUNITY** practices

112 (38%) in **HOSPITAL-BASED** practices

106 in **academic/teaching** hospitals

6 in **community** hospitals

GEOGRAPHIC DISTRIBUTION



141 total rheumatology practice sites

206 (70%) of rheumatologists share a practice site

*CPSO = College of Physicians and Surgeons of Ontario

THE WORKFORCE SURVEY

197 Ontario rheumatologists participated in the survey

Covering **>90%** of practice sites

74% Response rate

91% would add IHPs of any type to their rheumatology practice

65% preferred an Extended Role/Scope provider

INADEQUATE FUNDING

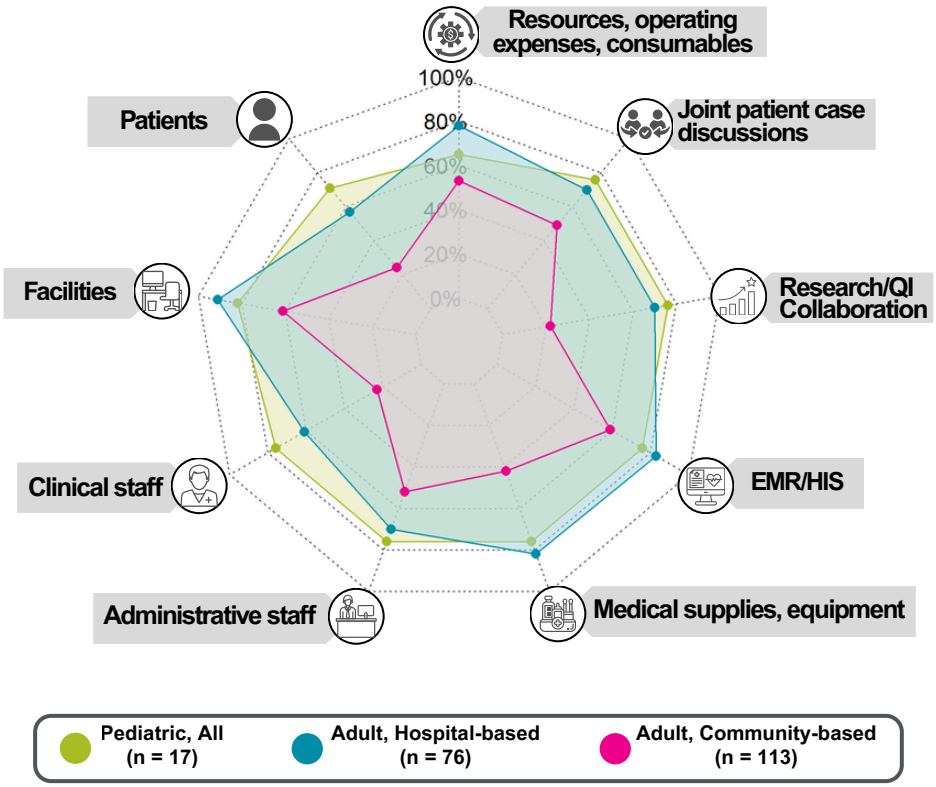
was the **key deterrent** to the adoption of an IHP team-based model

PEDIATRIC and **HOSPITAL-BASED** rheumatologists had

MORE STRUCTURAL & COLLABORATIVE SUPPORTS

than **COMMUNITY-BASED** rheumatologists

ONTARIO RHEUMATOLOGISTS SHARE:



MOTIVATIONAL READINESS WAS HIGH FOR THE IHP TEAM-BASED MODEL

92% saw it as an improvement

85% saw it as a good fit

83% saw it as a priority to better meet patient needs

Many noted **a lack of supportive climate**, including lack of support, processes, and resources **to enable this practice change**.

OUR FINDINGS REVEAL...

- Important differences between hospital and community settings
- Key factors and concerns that must be addressed to support effective implementation
- Critical pressures on a diverse but strained rheumatology workforce, with limited support systems in place.
- Yet, despite these constraints, most rheumatologists showed strong motivation to integrate IHPs **– A clear signal of readiness for change.**

LEARN MORE

SCAN HERE

Or click this link to read the full report

EMR = Electronic medical records, HIS = Health Information Systems., IHPs = Interdisciplinary Healthcare Providers, QI = Quality improvement

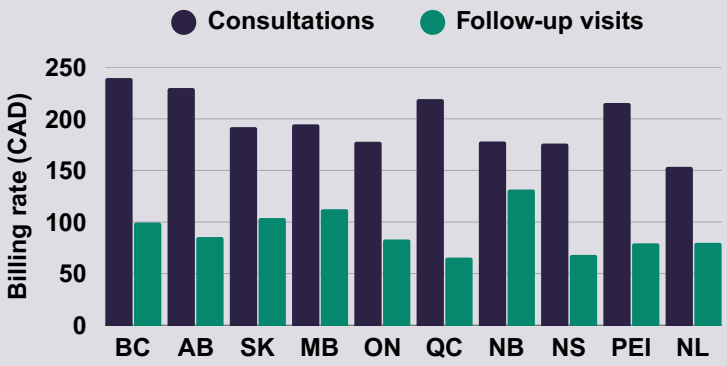
ENVIRONMENTAL SCAN

Inequities in Fee-For-Service Remuneration Affecting Rheumatologists & Patient-Centered Care Across Canada

WE AIMED TO:

- Compare fee-for-service reimbursement rates for rheumatologists across provinces
- Identify discrepancies in funding policies on reimbursement for specific services (including team funding)

PAYMENT FOR THE SAME SERVICES (CONSULTATIONS, FOLLOW-UPS) VARIES WIDELY ACROSS PROVINCES

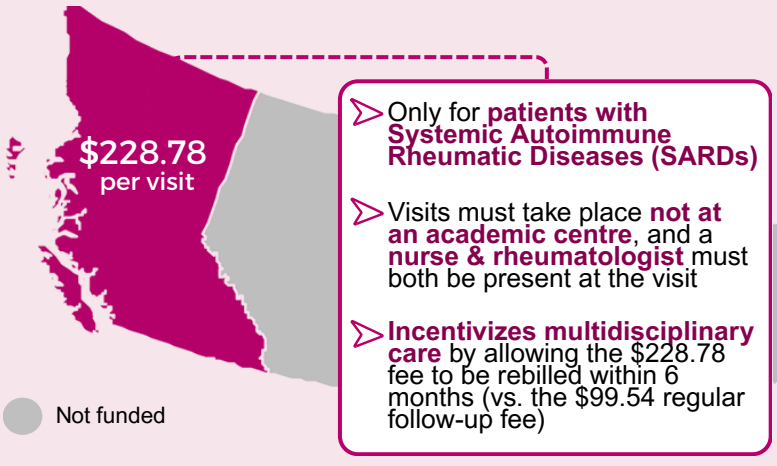


SOME SERVICES AND PROCEDURES ARE PAID MUCH MORE IN SOME PROVINCES THAN OTHERS

Low reimbursement may prompt rheumatologists to refer patients to other centres as **current rates are often insufficient to cover for additional personnel, supplies, equipment or time.** This can:

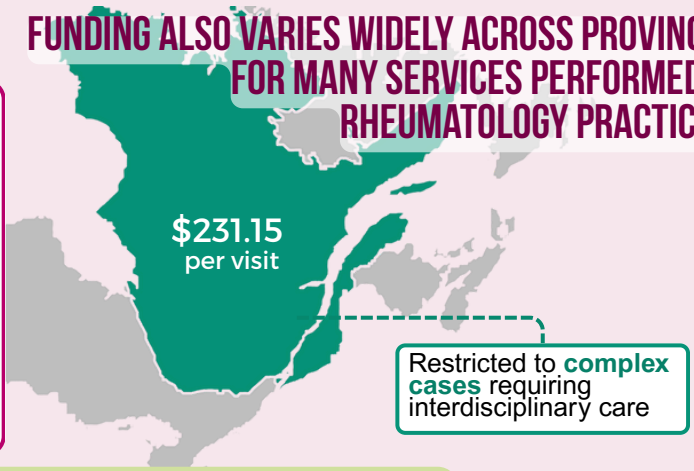
- Increase system costs,
- Delay care, and
- Undermine patient-centered services.

ONLY TWO PROVINCES (BRITISH COLUMBIA AND QUEBEC) HAVE FUNDING OPTIONS FOR INTERDISCIPLINARY HEALTH PROFESSIONALS IN RHEUMATOLOGY SETTINGS - AND EVEN THESE COME WITH LIMITATIONS.



- Only for **patients with Systemic Autoimmune Rheumatic Diseases (SARDs)**
- Visits must take place **not at an academic centre**, and a **nurse & rheumatologist** must both be present at the visit
- **Incentivizes multidisciplinary care** by allowing the $228.78 fee to be rebilled within 6 months (vs. the $99.54 regular follow-up fee)

FUNDING ALSO VARIES WIDELY ACROSS PROVINCES FOR MANY SERVICES PERFORMED IN RHEUMATOLOGY PRACTICES.



EQUITY IN FUNDING FOR TEAMS IS NEEDED!

WHY IT MATTERS:

- Uneven pay structures may limit access to care and make it harder to provide person-centered services.
- Standardizing payments could help improve fairness and care quality across Canada.

LEARN MORE

Read the full paper HERE

"Witnessing a group of providers collaborate, 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."

FROM DIAGNOSIS TO EMPOWERMENT: INTEGRATED CARE IN ACTION

CARRIE BARNES
CAN-RIST Patient Partner

Carrie has been a patient of the Centre of Arthritis Excellence (CArE) since 2009. CArE is a community-based interdisciplinary rheumatology health team supported by the Ontario Ministry of Health.

It is quite an experience to be diagnosed with a chronic illness. 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).

But at CArE, I was quickly 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; a social worker, an occupational therapist, a pharmacist, a physiotherapist, and a rheumatologist, all involved in developing my care plan with me. I could tell they respected each other's roles and input by the way they communicated and interacted. Witnessing a group of providers collaborate, 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 my diagnosis, I attended an education session delivered by professionals from 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, that have kept me out of flares and emergency rooms for nearly a decade and a half.

My care didn't end at diagnosis. My health has had ups and downs along the way, and I was always able to access the specific care I needed, with the appropriate team member each time. Whether it was tweaking my orthotics, ordering specific medications for travel, addressing a joint before it flared, injections, or everything in between, my team was always available and ready to assist.

I would not be where I am today if it weren't for the interdisciplinary care I received fifteen years ago and continue to have access to today. I have remained employed, been on many grand adventures, and have engaged in life to the fullest of my abilities time and time again. I am proud to help champion integrated care models so that every patient can benefit from the experiences that helped me to thrive.

REFLECTIONS ON INTEGRATED CARE AND THE INEQUITIES OF NAVIGATING THE SYSTEM ALONE

CATHERINE HOFSTETTER
CAN-RIST Patient Research Partner

Catherine Hofstetter is an award-winning patient advisor recognized for 25+ years of leadership and advocacy as a patient partner in the arthritis research community.

My experience working with the THINC CAN-RIST team has been truly eye opening. Before this, I was unaware that integrated care was something that could be practiced or was even available for patients like me. Hearing Carrie Barnes share her journey through an integrated care rheumatology practice made me realize how different my own experience has been.

Throughout my journey over the past 33 years, I have had to rely on my own initiative – identifying what I needed, figuring out the right questions to ask, and, at times, fighting for the care I required. Unlike patients in team-based models, I rarely if ever, had coordinated support. Instead of having a group of professionals working together, I had to seek out each of these services separately. When questions or problems arose, there was no one to help me manage the stress, or other needs outside of my regularly scheduled rheumatologists' visits. When doubts or questions arose, there was rarely anyone available to turn to for guidance. As a result, I was left to navigate the health care system largely on my own.

I, alone, shouldered most of the burden instead of being shared by a team, and I can fully appreciate the experiences, and the emotional and financial cost of not having interdisciplinary care.

I am the third generation in my family diagnosed with rheumatoid arthritis. Although my family history and acute symptom onset led to a quick diagnosis, I still waited many months to see a rheumatologist. At the time, I assumed, perhaps naïvely, that all rheumatology care was created equal and that it did not matter who I saw. My first rheumatologist operated as a solo practitioner with only the support of an administrative assistant. While the clinical care was solid, appointments were brief and there was rarely time to discuss how rheumatoid arthritis was affecting my life, work, or relationships. Recognizing I needed more support beyond medication management, I sought additional support from the Arthritis Society – what is now the Arthritis Rehabilitation and Education Program. But I had to obtain a referral from my family doctor to access these services. I benefited immensely from this additional care, provided by a physiotherapist, occupational therapist, and social worker. Eugenia Karpan (PT) and Marlynn Worling (OT) were my guardian angels during this time. They recognized my struggle to accept my diagnosis and gave me the tough love I needed to re-engage with my life. They also established an exercise program to maintain the range of motion in my affected joints and provided useful assistive devices to help me navigate my home more easily.

Catherine receiving the Queen Elizabeth II Diamond Jubilee Medal from Arthritis Society Canada from then President and CEO (Janet Yale, left) and then Chair of the National Board of Directors (Ken Ready, right), in 2012.

Continued on next page ➤➤➤

Catherine receiving the Province of Ontario Consumer Service award for 25 years volunteering with Arthritis Society Canada (2024).

Over the many years, I've been under the care of 6 different rheumatologists (many of whom retired or moved away), and received many medications (many didn't work for me). Biologic therapies were life-changing; for the first time, my disease was well controlled and my outlook improved dramatically. However, following my divorce, I lost my insurance coverage. After months of relief from the relentless pain, stiffness, and fatigue, I was suddenly faced with their return. I applied to Trillium's Exceptional Access Program but was denied. My rheumatologist filed the initial appeal but was hesitant to continue advocating for access. Taking matters into my own hands, I undertook a campaign of letter writing, appeared on TV and radio, and ultimately presented a business case for coverage. This approach was successful, but it took six months, and paying out of pocket during this period depleted my savings. This experience helps me relate to the many patients who continue to face barriers in accessing timely, high-quality health services they require.

Like most Canadians who struggle with accessing rheumatology care, I have simply been grateful for the rheumatologists who have been involved in my care. But I also had to independently select care specialists to manage my co-morbidities, with a focus on ensuring they would communicate and coordinate with my rheumatologist. Each referral or adjustment depended on my persistence rather than on a proactive, coordinated system. In accessing care, I have experienced many delays, and fragmented care experiences, which reinforced the sense that I was on my own. Neither my rheumatologists, nor myself, received the same kind of team support as Carrie's experience.

Catherine receiving the Qualman Davies Arthritis Consumer Community Leadership Award from Sir Marc Feldman (left) and Sir Ravinder Maini (right) in 2014.

While I am still grateful for the care I have received, I still cannot help but wonder, what if I had access to a true interdisciplinary team, as Carrie did, from the beginning? Would my disease have been controlled sooner? Would I have avoided financial hardship or emotional isolation?

As an arthritis advocate for over 25 years, I have worked to amplify the patient experience, promoted more effective treatments and healthcare policies, and motivated and mentored consumers to become more involved in research decision-making in order to positively reform of our healthcare system. I recognize that not all patients have the know-how or persistence like me. While my journey also shows that a positive outlook is possible without integrated care, they often come at great personal cost, leaving equity in rheumatology care still out of reach for far too many patients.

POLICY BRIEF

Potential Solutions for Sustainable Funding for Integrating IHPs in Rheumatology Settings in Ontario

ONTARIO FACES A GROWING CRISIS IN RHEUMATOLOGY CARE

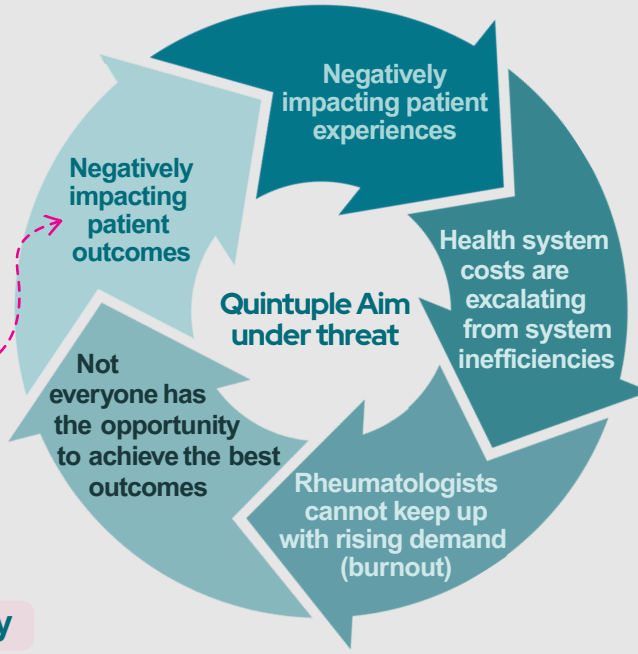
Only 300 rheumatologists serve approximately 350,000 patients annually

ACCESS TO TIMELY CARE, PATIENT EXPERIENCES, AND OUTCOMES HAVE BEEN **NEGATIVELY IMPACTED** BY

- A worsening workforce shortage
- Rapid population growth exceeding specialist supply
- Rising rates of arthritis/ rheumatology conditions
- Increasing complex patient care needs

Patients are struggling to access rheumatology services.

In turn, this is:



A more sustainable healthcare system must prioritize investments that strengthen rheumatology workforce capacity through integrated, interdisciplinary care models.

THE CENTRAL IMPLEMENTATION BARRIER

Ontario's physician fee-for-service model does not fund services provided by non-physicians who are required to deliver interdisciplinary team-based care in rheumatology settings.

IN OUR POLICY BRIEF

We examine **policy considerations** and **potential dedicated funding mechanisms** to support the equitable integration of IHPs into rheumatology practices. The identified funding solutions specifically **address IHP-related costs** – including salaries and associated expenses – needed **to support integrated care models within rheumatology settings.**

WORK IN PARALLEL

To advance this work and support policy decision-making, we are also:

- Conducting budget impact assessments
- Conducting cost-effectiveness evaluations
- Developing implementation resources
- Implementation strategy planning

This multi-faceted approach ensures that policymakers and organizational leaders gain a comprehensive understanding of:

- Financial feasibility and practical considerations
- Facilitating the evaluation of funding options
- Effective spread and scale strategies

Once these concurrent activities are completed, this Policy Brief will be updated with clear recommendations in a Policy Report and a financial business case, followed by an Implementation Plan.

LEARN MORE

Visit the Ontario Rheumatology Association website at https://ontariorheum.ca/can-rist

FROM ABSTRACT TO IMPACT

HIGHLIGHTS FROM CAN-RIST'S YEAR IN KNOWLEDGE TRANSLATION & EXCHANGE

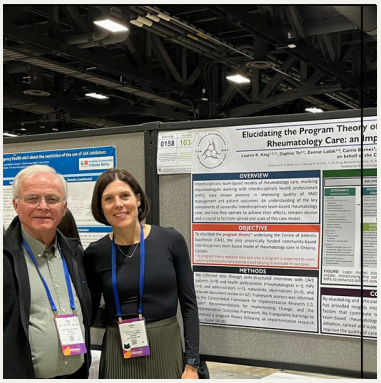
Several members of the CAN-RIST team at 2025 CRA Conference
Left to Right: Diane Tin (Past Executive Director at CArE), Melissa Holdren (Medical Lead at CArE), Gabrielle Sraka (undergraduate trainee), Lauren King (CAN-RIST lead), Daphne To (graduate trainee), Jessica Widdifield (CAN-RIST lead), Carter Thorne (founder of CArE)

Lauren King (CAN-RIST Lead) presenting the CArE Implementation Research Logic Model (IRLM) describing key components of CArE's team-based model of rheumatology care at 2025 CRA Conference

Lauren King (CAN-RIST Lead) and Daphne To (graduate trainee) at the 2025 CRA Conference reception

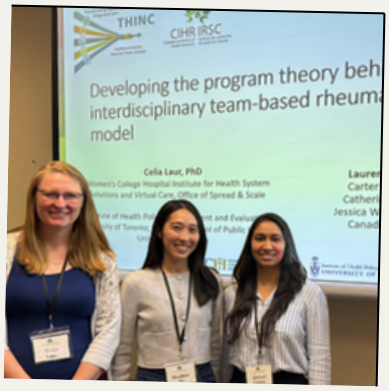
Daphne To (graduate trainee) presenting her research on healthcare provider perspectives on team-based rheumatology care at 2025 CRA Conference

CAN-RIST AT CONFERENCES



Carter Thorne (founder of CArE) and Lauren King (CAN-RIST Lead) presenting CArE IRLM at 2024 American College of Rheumatology (ACR) Conference in Washington, DC

Timothy Kwok presented on Inequities in Fee-For-Service Remuneration affecting Rheumatologists across Canada at the 2025 CRA Conference



Celia Laur (CAN-RIST Lead), and graduate trainees Daphne To and Zeenat Ladak presenting the CArE IRLM at CAHSPR 2025

ACR: American College of Rheumatology; CArE: Centre for Arthritis Excellence; CAHSPR: Canadian Association for Health Services and Policy Research; CRA ASM: Canadian Rheumatology Association Annual Scientific Meeting; ORA: Ontario Rheumatology Association

Jessica Widdifield (CAN-RIST Lead) presented an overview of CAN-RIST's progress at the 2025 ORA Annual Conference

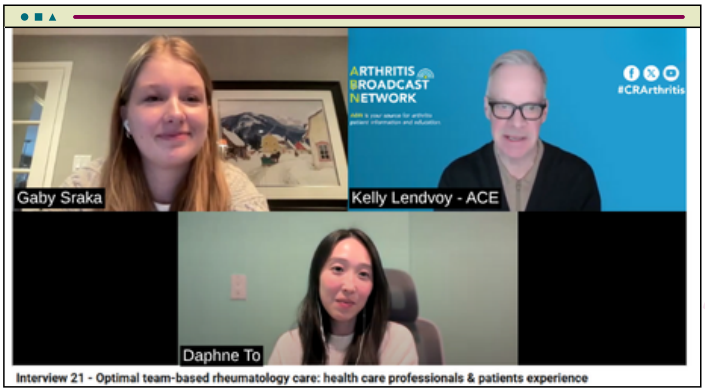
COMMENTARY PAPER

In her article, titled *"Stronger Together: The Opportunities of Interdisciplinary Models of Rheumatology Care"*, Dr. King reflects on the evolving landscape of rheumatology and opportunities for advancing care.

CLICK HERE **To read her piece in the Fall 2024 issue of the Canadian Journal of the Canadian Rheumatology Association (CRAJ)**

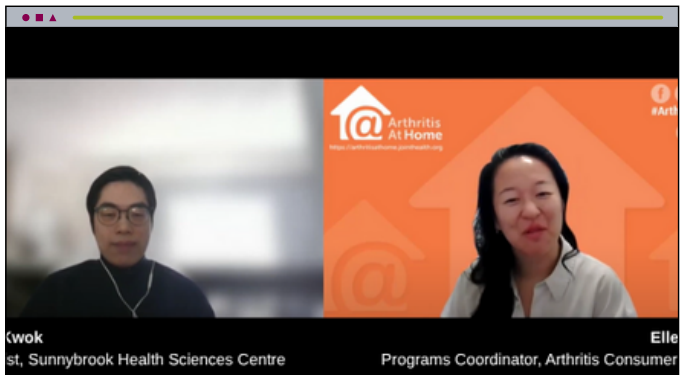
INTERVIEWS

Knowledge users interviewed members of CAN-RIST during the 2024 Canadian Rheumatology Association (CRA) Annual Scientific Meeting, held in Calgary from February 26 to March 1.



CAN-RIST trainees **Gaby Sraka** and **Daphne To** discussed their research exploring patient and provider perspectives on team-based rheumatology care at CArE.

CAN-RIST researcher and rheumatologist **Tim Kwok** also spoke about his environmental scan, Inequities in Fee-For-Service Remuneration Affecting Rheumatologists & Patient-Centred Care Across Canada.



THE ROAD AHEAD

SUPPORTING PARTNERSHIPS FOR LOCALLY TAILORED CARE IN UNDER-SERVICED COMMUNITIES

Dr. Lauren King (Left) meeting with some of the arthritis care providers in Thunder Bay, including Chamira (RN), Erin (ACPAC), and Dr. Elishka Pek (a visiting rheumatologist from Toronto)

There is a long road ahead to improve equity in rheumatic disease care. While our team continues to integrate equity principles into all our research activities, many challenges extend beyond what our research team can accomplish alone. Equitable access to rheumatology services remains particularly challenging for individuals in Northern and rural regions, including Indigenous communities. Limited specialist availability, long travel distances, and systemic barriers delay diagnosis and treatment, widening existing health disparities.

Advancing equity requires more than expanding services to enhance reach – it calls for culturally safe care models co-developed with local and Indigenous communities, supported by outreach initiatives and local provider training to promote earlier recognition and management of rheumatic diseases. CAN-RIST is currently seeking to understand ways we can lend our expertise to support integrated care models in Northern Ontario, through supporting the **Ontario Rheumatology Association (ORA)'s Northern Ontario Committee**, and local service providers. The committee is advancing a project to improve equitable access to rheumatological care in northern communities. In 2022, Ontario Health allocated Alternative Level of Care funding to support a pilot program in Thunder Bay. Early results showed the model was successful, leading to its expansion across Thunder Bay, Timmins, and North Bay, with further growth planned for next year. Sustaining this model is crucial to ensure ongoing access and continuity of rheumatological care throughout northern Ontario.

Planning and partnership-building efforts are also underway with **Dr. Patrick Donio, a new rheumatologist based in Thunder Bay** who brings a strong focus on Indigenous perspectives in healthcare.

Dr. Donio has been working to expand outreach services with First Nations communities but requires sustainable funding for his team. By supporting these efforts, we can help gather and share learnings that may guide tailored care models in other communities.

Dr. Patrick Donio is a rheumatologist in Thunder Bay, with a focus on removing barriers to arthritis care and health inequities amongst Indigenous populations.

Achieving this takes time and commitment: building trust, understanding community priorities, identifying knowledge gaps, and strengthening local capacity are all essential steps in creating sustainable and culturally grounded solutions.

By listening to people with lived experience, local service providers, and other community voices, and tailoring approaches to local contexts, **we can move closer to a healthcare system where geography and background no longer determine access to timely, high-quality rheumatology care.**

MILESTONES & MOMENTUM

UPDATES ON CAN-RIST TRAINEE & RESEARCHER ACHIEVEMENTS

Arthritis Society Canada awarded **Dr. Lauren King** the 2025 Stars Career Development Award

Zeenat Ladak successfully defended her PhD in October 2025 and is now a postdoctoral fellow at Women's College Hospital

In September 2025, undergraduate trainee **Gaby Sraka began medical school** at Toronto Metropolitan University

SUMMARY OF PUBLICATIONS *(TO DATE)*

Bodmer NS, Laur C, King L, Gomes M, Hawker G, Lootah S, Barber C, Hofstetter C, Thorne C, Widdifield J. **Team-Based Outpatient Rheumatology Care: A Scoping Review of Terminology, Team Composition, and Impact on Advancing the Quintuple Aim**. *Journal of Rheumatology*.(2025).

Widdifield J, Laur C, Kwok TSH, Oliva L, Appleton CT, Ahluwalia V, Thorne JC, Wong JC, Bodmer NS, Gomes M, Lee JJY, Barber CEH, Passelent L, King LK. **Evaluating Implementation Context to Prepare for Scaling-Up the Integration of Interdisciplinary Healthcare Providers in RheumatologyPractices: A Rheumatology Workforce Survey.** *Journal of Rheumatology*.(2025).

Kwok TSH, Lake S, Barber CEH, Katz S, Hitchon C, Jilkine K, Collins D, Lyddell C, Milne A, Stein MA, Deslauriers JP, Lazovskis J, Morais S, Goudie S, King LK, Widdifield J. **Inequities in Fee-For-Service Remuneration affecting Rheumatologists across Canada.** *Journal of Rheumatology*.(2025).

To D, Wong J, Laur C, Oliva L, Ladak Z, Passalent L, Widdifield J, King L. **What Characteristics are Needed for Optimal Team-Based Rheumatology Care? A Qualitative Study Exploring the Experiences and Perceptions of Rheumatology Health Professionals.** *Journal of Rheumatology*.(2025).

Sraka G, Ladak Z, Laur C, To D, Oliva L, Barnes C, Hofstetter C, Widdifield J, King L. **"It's like a OneStopShop": A Qualitative Study Exploring Patient Experiences in Receiving Interdisciplinary Team-Based Care for Rheumatic and Musculoskeletal Diseases.** *Journal of Rheumatology*.(2025).

King LK, To D, Ladak Z, Barnes C, Hofstetter C, Thorne C, Oliva L, Ivers N, Widdifield J, Laur C. **Elucidating the Program Theory of a Successful Interdisciplinary Team-Based Model of Rheumatology Care: An Implementation Science Exploratory Case Study**. *Journal of Rheumatology*.(2025), 52 (Suppl 2) 101; Revision submitted – Full publication pending

WHAT TO EXPECT FROM OUR TEAM IN 2026

A COMPREHENSIVE SUITE OF IMPLEMENTATION STRATEGIES

Across a series of evaluations, we have identified a comprehensive suite of implementation strategies, that culminated in a national study to obtain national consensus on the most useful strategies. Results of this Delphi study will be disseminated through scientific meeting abstracts and a peer reviewed publication.

AN IMPLEMENTATION TOOLKIT TO GUIDE IMPLEMENTATION EFFORTS

We are launching a co-design study to create an implementation toolkit that supports the adoption, implementation, and sustainability of interdisciplinary team-based rheumatology care. Through a series of co-design workshops, participants and researchers will collaboratively develop and refine the toolkit to ensure it reflects the needs of the rheumatology community.

BARRIERS AND ENABLERS TO ADOPTION OF INTERDISCIPLINARY MODELS OF RHEUMATOLOGY CARE

Among rheumatologists currently practicing in a conventional care model, we identified behavioural determinants of adopting an interdisciplinary model of care. Findings of this qualitative study advance our scale-up efforts and will be disseminated through scientific meeting abstracts and a peer reviewed publication.

COLLATING INFORMATION ON HOW DIFFERENT TYPES OF RHEUMATOLOGY CARE MODELS OPERATE

Understanding how different types of rheumatology teams are structured—who does what, and how care is delivered—is essential for guiding implementation and helping rheumatologists choose models that fit their patients and practices. To support this, we are conducting a follow-up review to map and compare care processes across different team-based models.

REAL-WORLD EVIDENCE ON COST EFFECTIVENESS

We are finalizing the first Canadian study that employs linkage of rheumatology EMR and administrative data to evaluate the cost effectiveness of interdisciplinary model rheumatology care compared to routine practice.

SCALING TEAM-BASED RHEUMATOLOGY CARE: GATHERING INSIGHTS FROM SPECIAL INTEREST GROUPS

We are launching a qualitative study with key informant interviews, including rheumatology leaders, policymakers, interprofessional educators and training program leaders, patient representatives, and special interest groups to identify system-level enablers, barriers, and requirements for scaling team-based care in Ontario.

ADVOCACY EFFORTS RAMP UP - IN PARTNERSHIP WITH THE ONTARIO RHEUMATOLOGY ASSOCIATION

We will be publishing a series of population-based health system evaluations and commentaries that utilize real-world health data to drive policy action, and advocating for the expansion of primary care team-based funding models for Rheumatology Health Teams!

INTERESTED IN GETTING INVOLVED TO SHAPE THE FUTURE OF RHEUMATOLOGY CARE?

HAVE ANY QUESTIONS FOR US?

CONTACT OUR RESEARCH COORDINATOR:

LAURA OLIVA
laura.oliva@wchospital.ca

FUNDING & SUPPORT

THINC Transforming Health with Integrated Care
Sunnybrook Research Institute
ORA Ontario Rheumatology Association
IC/ES
WCH Women's College Hospital | Office of Spread & Scale
CIHR IRSC Institute of Musculoskeletal Health and Arthritis | Institut de l'appareil locomoteur et de l'arthrite
Strategy for Patient-Oriented Research SPOR Putting Patients First