



2015 SUMMER NEWSLETTER



PRESIDENT'S UPDATE

"Sometimes, you may have to get lost first, to really find yourself."

Anonymous

Admittedly, when I first started my new role it was, as people had warned me, feeling like a deer in the headlights. There have been struggles of course, and tremendous challenges, but I take pleasure in what the ORA has accomplished. There is no association apathy or myopia. It's been anything but boring!

I applaud our supporters, who have helped us maintain our financial health. This solid financial standing means we have the resources and reserves to be effective in our service to our membership and all arthritis stakeholders. For 2016, we will re-examine, prioritize and lay the groundwork for our business plan.

There are many committee initiatives. I have observed our committee leads, executive and project managers, and I can say that the pleasure isn't in accomplishing an initiative; rather the pleasure is in planning it. Most of you already realize that the foundation of success of the ORA is a strong team of committees and their leads. Some of the executive are seasoned veterans, still skillfully guiding us. I have relied on and invested in their talents, in order to maintain advocacy, relevancy and strategic direction. They have brought creative thinking that leads to a more powerful, unified voice.

For 2015/2016, we will continue to work with the surge in the way we interact with technology (EMR, dashboards, registries, patient education), shape healthcare debates (EAP access, private payers, SEBs, national pharma care) and redesign our website and communications and commit to its continuous improvement. We will continue Models of Care work, particularly current key projects and knowledge translation. We hope to expand ORADE (Ontario Rheumatology Association Development and Education) to more members and international destinations in order to enhance our vision going forward. We will continue to represent when asked issues of national interest (manpower, private payers, Arthritis Alliance of Canada).

In the last year it has been enjoyable to learn and magnify that a president of an association or a doctor does not have unquestioned authority. This role has shifted towards being an effective and respectful team player. No hierarchy, just welcoming full participation of all interdisciplinary healthcare stakeholders ... *(cont on page 2)*

INSIDE THIS ISSUE:

President's Update
(Page 1)

News & Updates
(Page 2)

Committee Updates
(Pages 2-8)

ORA Executive
(Page 8)

(President's Update cont)

... who can help to achieve optimal health outcomes especially to patients with chronic diseases. New realities, involvement and energies continuously required to succeed. I encourage all of you, (and you know who you are) to just jump right in and take a chance.

"My heart is pounding," I said.

"That's how you know you're having fun," Margo said.

--- John Green, *Paper Towns*

NEWS & UPDATES



Each year the ORA identifies a Rheumatologist who has demonstrated outstanding leadership and commitment in the field of Rheumatology. Dr. Mary Bell has been recognized as a deserving recipient of this award. The announcement was made at the ORA Annual Meeting this past May. Congratulations Dr. Mary Bell!

In other news, The Arthritis Society has published a [New Medication Guide](#). You may visit this [link](#) to learn more or to download.

COMMITTEE UPDATES



OMA UPDATE

DR. PHILIP BAER
OMA Section Chair, Rheumatology

There is a new Ministry of Labour poster on Employment Standards that outlines important rights and requirements under the Employment Standards Act, 2000. This poster must be posted in the workplace in an area that will be seen by employees by **June 19, 2015**. An

English version of the poster may be found at the link: [English Employment Standards Poster](#). More information, including other language versions of the poster may be found at this link: <http://www.labour.gov.on.ca/english/es/pubs/poster.php>

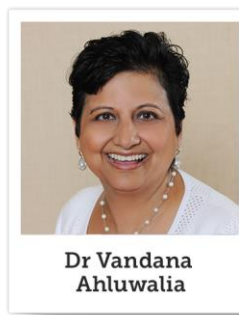
Nurse Practitioner Referrals to Physicians are allowed pursuant to changes to the OHIP Schedule effective May 1, 2015 (see link): [Nurse Practitioner Referrals](#)

The OMA is still at an impasse with the government. There are ongoing internal OMA discussions around whether our tactics/public relations efforts have been effective. I attended a special OMA leaders meeting to review our negotiation strategy. An expert from the BCMA was brought in as well as a labour consultant.

We are still having difficulties acquiring information from the government to tell physicians what is going to happen. We know there are budget cuts, but how much more will the government take back if they proceed to impose a "hard cap" reconciliation? Our strong preference is to have the government tell us month by month where our billing is tracking

versus what they are willing to pay. No tangible results to date.

We are also exerting pressure on the government to get them to agree to binding arbitration for future negotiations. Updates are always posted on the OMA website at www.oma.org.



MODELS OF CARE (MOC) & EMR COMMITTEE UPDATE

DR. VANDANA AHLUWALIA

Access to Specialist Care

AHRT- Allied Health Rheumatology Triage project is ongoing with now over 90 patients participating. The study will examine the role of specially trained extended role-practitioners working in a triage role to improve access for people with suspected IA.

Knowledge Translation Program

The *Models of Care Learning & Knowledge Translation Program* is near completion. A slide deck program has been fully developed by the ORA MOC working committee and will soon be available to all Rheumatologists in Ontario. Content and learning will be dialogued at regional sessions and facilitated by local rheumatology champions. Please stay tuned for fall schedules and details.

Meaningful use and Optimization with EMRs

The EMR committee continues to work with Ontario Certified EMRs to develop rheumatology specific tools and support work-flow efficiencies. Rheumatology specific packages are now available. EMR specific training sessions have been scheduled and are available to rheumatologists and their office staff:

- Oscar Training TBD
- Accuro Training: August 14 and August 21st – Space is still available. Please email scouto@uhnresearch.ca for more details. A fall training workshop will be scheduled for those unable to attend one of the August dates.

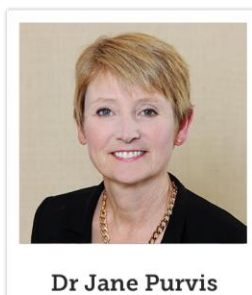
The Ontario Best Practice Research Initiative, along with the ORA EMR committee and IT experts has launched a pilot study to build and deploy a Rheumatic Diseases Multi-Registry (RDMR) platform that will securely and seamlessly integrate into rheumatology EMRs. The platform will work to seamlessly automate EMR data extraction, validation and aggregation that can then be used for researchers and practice improvement dashboards for clinicians. The Ontario Best Practice Research Initiative is funding the pilot project and once completed will be made available to all rheumatologists participating in the OBRI initiative.

ORA representatives recently participated in a data harmonization meeting led by the Arthritis Alliance of Canada. The goal of the meeting was to discuss the development of a national framework/process to harmonize a core dataset from amongst the provincial databases; and agree on rheumatology indicators (patient care & system) that can easily be used within EMR platforms. The outcome of this session was to plan for a larger stakeholder meeting during the AACs annual conference in Kananaskis, Alberta, October 22-23, 2015.

Shared-Care

The MOC committee continues to collaborate with the Ontario Pharmacists Association to help community pharmacists refine their knowledge about rheumatology medications. Building on the existing MedsCheck Program, an accredited

CE program is being developed for pharmacists that will focus on inflammatory arthritis, treatment options, compliance and adherence strategies and how to work closely with their local rheumatologists to improve health outcomes and support arthritis patients.



Dr Jane Purvis

MANPOWER COMMITTEE UPDATE

DR. JANE PURVIS

We are now [on Facebook](#)! We continue to work with the Canadian Rheumatology Association on increasing the number of medical students and residents exposed to Rheumatology earlier in their training, and helping to foster those interested in pursuing Rheumatology. Work is progressing on establishing Rheumatology electives

outside of the teaching centres to allow Rheumatology residents to see communities throughout Ontario that are in need of rheumatologists. If anyone is interested in participating in this initiative, please contact [Dr. Jane Purvis](#)

THIRD PARTY PAYERS COMMITTEE UPDATE

DR. JANE PURVIS

The committee continues to liaise with insurance companies and the Canadian Life and Health Insurance Association (CLHIA) to improve patient access to insured medications. With CLHIA, we have been able to create panCanadian criteria to access biologics for RA patients. This exciting initiative is a Canadian first and we are planning to speak to the provincial ministries in an attempt to get them to align with panCanadian criteria and understand their benefit. This will result in easier portability of coverage across insurance companies and across the country, as well as help to simplify forms.

Having any problems getting insurance coverage for patients??? For those ORA members in good standing, the Third Party Payer committee is happy to help! Just send your issues [to us](#) and we will communicate for you to get the best outcomes for your patients. This is a great plus of ORA membership so please don't forget to make use of this tool.

EAP COMMITTEE UPDATE

DR. ARTHUR KARASIK

The last update was at the annual ORA meeting in Muskoka in May 2015, where the executive director of EAP, Mr. Rob Campbell spoke to us about ORA/EAP combined issues of interest. The membership is by now aware of our successes with triple therapy, 5 year renewals, and changes to Rituxan access. Wait times for access is our major problem. Biologics in general are turning around at 22 business days due to having several EAP assessors dedicated only to biologics. Hopefully you are seeing similar improvements recently. There are several new pharmacist assessors and the fall co-op students that will be on board over the next month. It will take some time to train them, but by the autumn

we should be in much better shape. In the meantime there has been progress and improvements, but it is still not where we want to be. As a reminder, ORA members may call upon our EAP Committee when they need help managing an EAP “challenge.” This committee is dedicated to helping you and your patients, and they have been successful in resolving difficult cases. Don't hesitate to ask for help by emailing admin@ontariorheum.ca

ORADE COMMITTEE UPDATE

DR. ARTHUR KARASIK

Our mandate : Advocate for our work. The purpose of this initiative is to support the ORA pillars: Advocacy and Awareness, Research, Models of Care and Practice Efficiency. By supporting members to attend international educational events we would like to also gain knowledge around work being done by other professional organizations in other countries that specifically tie to our 4 key pillars. Our first rheumatologist to report to us is our ORA rheumatologist of the year 2015, Dr. Mary Bell, who attended EULAR in Roma.

Re: 2015 ORADE EULAR Report

Dear Dr. Karasik and ORADE Committee

I am grateful to the ORA for funding my attendance at EULAR 2015 in Rome, Italy. My attendance at the EULAR meeting and report back to the ORA executive and membership supports the mission of the ORA which is “to represent Ontario Rheumatologists and promote their pursuit of excellence in arthritis care in Ontario through leadership, advocacy, education and communications”. I will present my key learnings from the meeting as they relate to the four key pillars of the ORA and will underline opportunities identified for the ORA to discuss and potentially pursue in the future.

Four Key Pillars of the ORA

1. Advocacy and Awareness

Patients and healthcare professionals from Denmark, Belgium, and Sweden presented on their experience in developing collaborative partnerships to create a patient-centric research agenda, a needs-based education program, and accessible, lay language research summaries and EULAR recommendations. ARD now publishes lay summaries of research papers which are translated into local lay language by a trained group of patients in Belgium.

- Canadian rheumatic disease patients have been trained by the Cochrane Collaboration to do lay summaries in French and English. We could partner with the Cochrane Consumer Group and negotiate with The Journal of Rheumatology to create lay summaries of pivotal scientific papers.

The keys to success in these collaborative partnerships were: section of patient volunteers, clarifications of role and expectations, training in technical and medical terminology, and using a communications model, The Dialogue model (Tineke Abma et al.), to ensure balanced participation and engagement.

- For future collaborations with patient groups, we might explore “The Dialog” method of engagement and participation.

A German rheumatic disease patient organization is reaching out to GPs and MSK specialists to provide patient information on self-management in early osteoarthritis.

- Trained patients may become a new human resource for knowledge translation and guideline implementation where there are known gaps in MSK care.
- Creating dialogue with fellow patient organizations, such as Sjogren's syndrome (SS) patients and oral cancer patients, led to health policy changes good for two patient groups facing similar difficulties with dental care. This is a brilliant idea as our SS patients have great difficulty getting coverage for dental implants from the Ministry of Health. I have written many times to the MOH on behalf of my patients without success.

In Denmark, patient counsellors learned that RA patients had a strong need for foot care by foot therapists, as hand and foot deformities, due to their RA, made it difficult to perform foot care by themselves. The Danish Rheumatism Association set out to document the scope of the problem among RA patients and suggested policy changes that could better the foot care of affected patients. Realizing and documenting the scope of the problem, analyzing and formulating the wanted policy change, planning the campaign (identifying fellow stakeholders, political allies, PR-strategy and finding a so-called "hook"), and executing the campaign strategy resulted in health policy change and coverage of foot therapy service for patients. SP0025-28

Recommendations for ORA - *Strengthen relationships/ partnerships with local and national patient organizations to foster continuous dialogue and remain aware and support of current patient needs for improved access and quality of care*

2. Research (rheumatology practice improvement)

When considering the gap between primary and secondary care, the most commonly touted solution is more musculoskeletal and rheumatological education for family medicine doctors (General Practitioners – GPs). UK GPs have proposed that the rheumatology – primary care education paradigm needs to shift, with rheumatology considering what it can learn from primary care. GPs are expert in managing uncertainty, weeding out important symptoms in messy prodromes of disease, dealing with multi-morbidity and polypharmacy, and transferring evidence based population level medicine and making it relevant to the individual.

- We could explore collaborating with GPs to help us streamline our practice and help in the management of co-morbidities in our patients SP0119-121

Cardiff University has worked in collaboration with the Royal Colleges, Welsh and UK Government to undertake a program to shift attitudes on the management of work and health in everyday consultations. They have developed and piloted a face-to-face training program for Rheumatology team members (rheumatologists, nurse specialists, occupational therapists and physiotherapists) to address these issues and raise the importance of discussing work at an early stage in a patient's journey.

- To enhance this work Cardiff University has also developed and is piloting a tool to aid "shared decision-making" about work and health for both primary care and secondary care practitioners. SP0064-66

The UK has developed and validated health care quality indicators (HCQIs) for OA and RA and will be benchmarking rheumatology care in 6 EU rheumatology units in the near future. SP0235-238

Recommendations for ORA – *integrate and evaluate the role/impact of shared decision making tools through the use of the OBRI research platform*

3. Inter-professional Patient-centric Care Model

According to the Chronic Care Model, outcomes of health care for people with chronic musculoskeletal and rheumatic

diseases (RMDs) depend on a productive interaction between the informed, activated patient and a prepared, proactive practice team. Overall, evidence from systematic reviews as well as individual clinical trials supports improved functioning following multi-disciplinary team care for a number of rheumatic disease patients. Research also illustrates that multi-disciplinary team care can be effective in several forms. This variation does not only include the professionals involved, but also the treatments provided (content, intensity, complexity), the setting (primary care, secondary care and/or community), the method of communication with the patient and among professionals (face-to-face contacts, telephone, videoconferencing or other web-based modes for communication), funding and the use of process and outcome measures for evaluation. As currently the right care is not consistently delivered to the right person, at the right time, in the right place or by the right team, challenges for the future are to identify the key components of effective multi-disciplinary team care interventions and how their implementation can be supported across health care services in different health care systems. For that purpose, the consideration of alternative, network-based models of engagement and collaboration for clinicians, consumers and other stakeholders and the optimization of the use of digital technologies, as well as formal evaluations of effectiveness and costs are indispensable. SP0094-96

The Centre Chronically Ill and Work (CCZW), is a knowledge centre that focuses on living and working with a chronic disease or disorder, and has been set up and is run by people suffering from a chronic illness. The main activity of the Centre is the “Certification of experts-by-experience: Work and Participation” (Certificering ervaringsdeskundigen Werk en Participatie), for which the Centre works closely together with seven national patient organizations. The certification of experts by experience is financed by the Dutch Ministry of Health, Welfare and Sports. The project is built around the philosophy that certain coaching and training skills are not (only) generated by knowledge but also by personal experiences. People with a chronic illness are being trained for 60-80 hours in a 6-9 months period to make use of their own personal experiences (linked to their disease) in order to help others who are going through similar processes. The Centre works solely with professionals who have a degree in (patient) counselling or are trained in coaching. All coaches receive a certificate at the end of their training, which is accredited by Top Kairos, a Dutch training institute.

Work productivity is an important outcome for patients, so questions about absenteeism and presenteeism should be addressed in clinic and in clinical studies including clinical trials (RCTs). Early intervention may reduce the likelihood of work productivity loss and possible permanent work loss. There are more than 26 instruments available to measure absenteeism and presenteeism. These measures range from simple global measures (e.g. a visual analogue scale (VAS) to multi-item measures. Differences between measures also relate to the construct (e.g. productivity, ability to work, interference with work, instability), recall period (e.g. one day, 7 days, one month), reference (e.g. prior disease onset, colleagues) and attribution (e.g. generic, rheumatological condition). As part of the OMERACT worker productivity initiative and a EULAR-PRO study, UK researchers are investigating the meaningfulness of the different measures with an aim to recommend measures to be used in clinical practice, observational studies and RCTs. SP0064-66

Recommendations for ORA – Overall, evidence from systematic reviews as well as individual clinical trials supports improved functioning following multi-disciplinary team care for rheumatic diseases so we should continue to disseminate provincial enablers of the models of care framework through the efforts of the MOC working committee!

4. Practice Efficiency (electronic medical record (EMR) systems)

Artificial Intelligence (AI) applications in medicine are expanding and now include clinical decision support systems (CDSS), speech recognition, and computer-aided interpretation of medical images. A CDSS can be integrated with an electronic health record (EHR), and improve quality of care by offering the consulting physician recommendations on the diagnosis and choices of treatment for a patient. It may also rationalize the number of investigations performed and thus have cost-savings implications for the health care system. SP 0042-44

A template of 8 primary care appropriate OA quality indicators was installed in 8 UK general practices and was triggered when the health care professional entered a morbidity code for OA. An evaluation study showed that it was feasible to use such a template to measure the quality of OA care. Assessment indicators were well-captured but, for example, consideration of physiotherapy was less so. An increase in some routinely recorded indicators (weight recording and prescription of paracetamol and topical NSAIDs) was also seen after the template was introduced. The recording template and associated indicators are now being introduced to other general practices as a part of routine care.

SP0235-238

Recommendations for ORA – *leverage the work being doing on national quality indicators (for inflammatory diseases including OA) and integrate these with our Canadian clinical guidelines into the EMR platforms. We may wish to evaluate the CDSS currently being developed to evaluate the quality of care and share feedback for practice improvement for our clinicians.*

Yours very truly,



Mary J. Bell, M.D., FRCP

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Lost & Found in Sedona – June 2015

