

ORA Models of Care Legacy Report



Models of Care



***Rheumatology
Care Redesigned***
*Created Nationally
Developed Provincially
Delivered Locally*



Background

Over the past decade, the burden of inflammatory arthritis (IA) in Canada has grown and so too have the health care needs of patients and families living with arthritis. Today, it is estimated that over 4.6 million Canadians are living with arthritis and this number is expected to rise to 7.5 million over the next 15 years.¹ The costs of arthritis are expected to double over this same time frame and represent a substantial burden on the Canadian health care system. The situation in Ontario is further exacerbated by a growing imbalance in the number of patients with IA seeking care and the stagnant number of rheumatologists available to care for them.²

Models of Care

Vision: Improved care for patients with arthritis in Ontario

Mission: Enabling timely, comprehensive, inter-professional team-based care to support patients living with musculoskeletal conditions.

In an effort to proactively address the changing landscape of arthritis care and treatment, the Models of Care (MOC) Project was launched by the Ontario Rheumatology Association (ORA) in 2010. The overarching goals of this project were to improve access to care, thus improving patient and system outcomes, and value for the health care system in Ontario. Over the past seven years, many of the components of this project have been successfully implemented to help reach these goals.

With most of the deliverables now fully completed, the MOC Project will come to a close in May 2017. This report documents the legacy of the MOC project by detailing its activities from inception through to its many enduring accomplishments.

The ORA Models of Care Project

1) Why was it developed?

The MOC project was launched by the ORA to address the evolving landscape in the care of arthritis, specifically the rising incidence and prevalence of arthritis against the shortage of rheumatologists, the cost of managing arthritis in Ontario, and the variations in treatment and health care outcomes.

i) Rising incidence and prevalence of arthritis against the shortage of rheumatologists: From a population demographics perspective, there is a growing imbalance in the number of patients seeking medical attention for IA and a stagnant number

Early identification and treatment could result in substantial savings to the health care system over the next 30 years and improve the lives of Canadians living with arthritis.

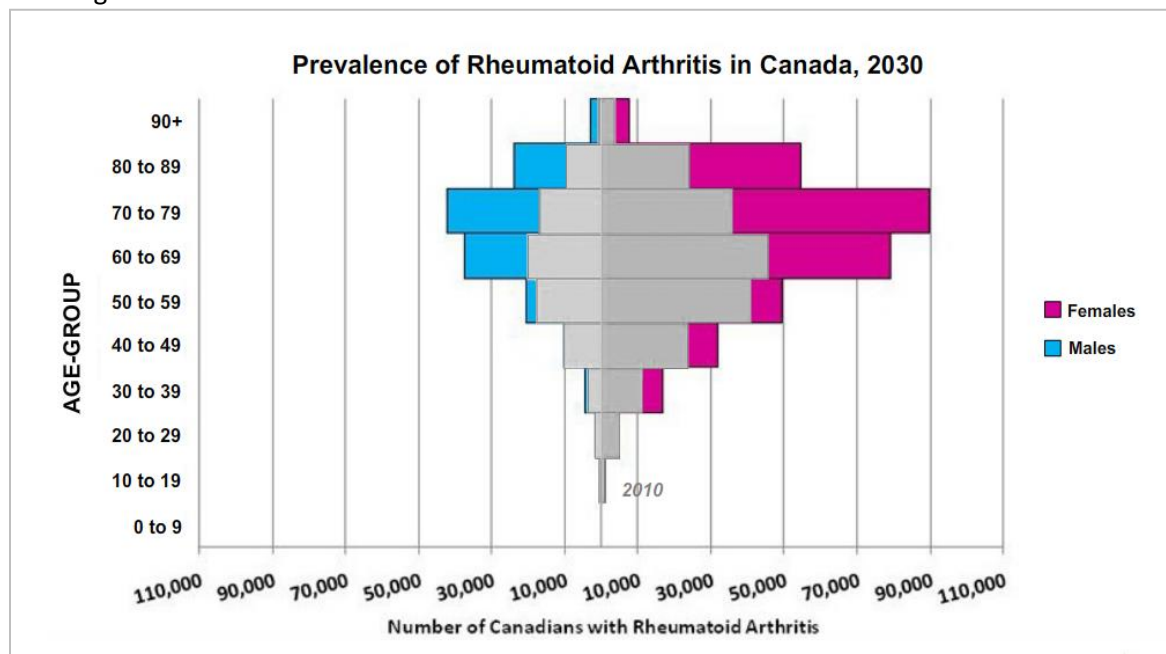
¹ The Arthritis Society of Canada. Arthritis Facts & Figures. Available at <https://arthritis.ca/understand-arthritis/arthritis-facts-figures>.

² Widdifield J, et al. The rising burden of rheumatoid arthritis surpasses rheumatology supply in Ontario. Can J Public Health 2013;104:e450-5.

of rheumatologists available to care for them. This situation is expected to worsen as the number of patients with IA seeking care is projected to increase by nearly 50% over the next 15 years.³ This is a result of patients with IA living longer and a higher incidence of IA in patients above the age of 70 years. At the same time, a third of practicing rheumatologists are expected to retire in the next 5-10 years (Figure 1).⁴ Notably, none of the provinces is currently meeting the Canadian Rheumatology Association's workforce benchmark of 1 rheumatologist per 75,000 Canadians (after adjusting for full-time equivalents [FTE] in clinical practice).

Figure 1. Growing imbalance in the number of IA patients seeking care and the rheumatology work force in Canada.

A. Rising Prevalence of RA in Canada: 2010-2030³

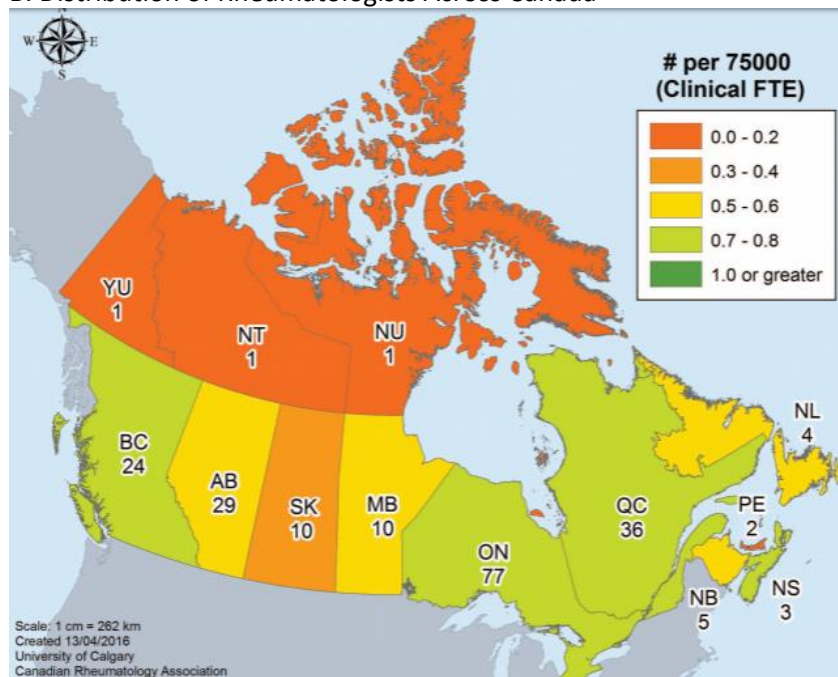


Adapted from: Bombardier C, Hawker G, Mosher D. Arthritis Alliance of Canada. "The Impact of Arthritis in Canada: Today and Over the Next 30 Years." October 2011.

³ Bombardier C, et al. Arthritis Alliance of Canada: The Impact of Arthritis in Canada: Today and Over the Next 30 Years. <http://www.arthritisalliance.ca>. October 2011.

⁴ Barber C, et al. Stand Up and Be Counted: Measuring and Mapping the Rheumatology Workforce in Canada. J Rheumatol 2017;44:248-57.

B. Distribution of Rheumatologists Across Canada⁴



Map of Canada showing the number of FTE-practicing rheumatologists per 75,000 population and the number of FTE rheumatologists required to meet the target of 1:75,000 benchmark (superimposed provincial count). FTE were estimated based on the national median reported time allocated to clinics from all respondents of the 2015 Stand Up and Be Counted survey and used to adjust the 2015 Canadian Medical Association numbers of rheumatologists in each province. Reprinted with permission from The Journal of Rheumatology, Barber C et al. J Rheumatol 2017;44(2). All rights reserved.

ii) Cost of managing arthritis in Canada: From a health economics perspective, arthritis is a significant driver of health care costs in Canada overall, and in Ontario specifically. The direct and indirect costs of IA are substantial and these are projected to rise exponentially in the coming years (Table 1).³ Drugs represent 60% of the direct treatment costs for rheumatoid arthritis in Ontario, with the remainder accounted for by health professionals 16%, hospitalization 8%, tests 8% and other services 8%.

Table 1. The economic burden of rheumatoid arthritis in Canada and in Ontario.^{3,5}

	2010	2040 (projected, in \$2010)	Increase 2010 to 2040
Canada			
Canadians living with rheumatoid arthritis	272,000	549,000	2-fold
Direct health care costs	\$2.4 billion	\$94.6 billion	39-fold
Indirect health care costs (lost productivity)	\$3.3 billion	\$162.8 billion	49-fold
Ontario			
Ontarians living with rheumatoid arthritis	104,000	225,000	2-fold
Direct health care costs	\$916 million	\$37.4 billion	40-fold
Indirect health care costs (lost productivity)	\$1.29 billion	\$67.8 billion	52-fold

⁵ Risk Analytica. Alliance for a Canadian Arthritis Program Life at Risk® Arthritis Application. Provincial results: Ontario. October 17, 2011.

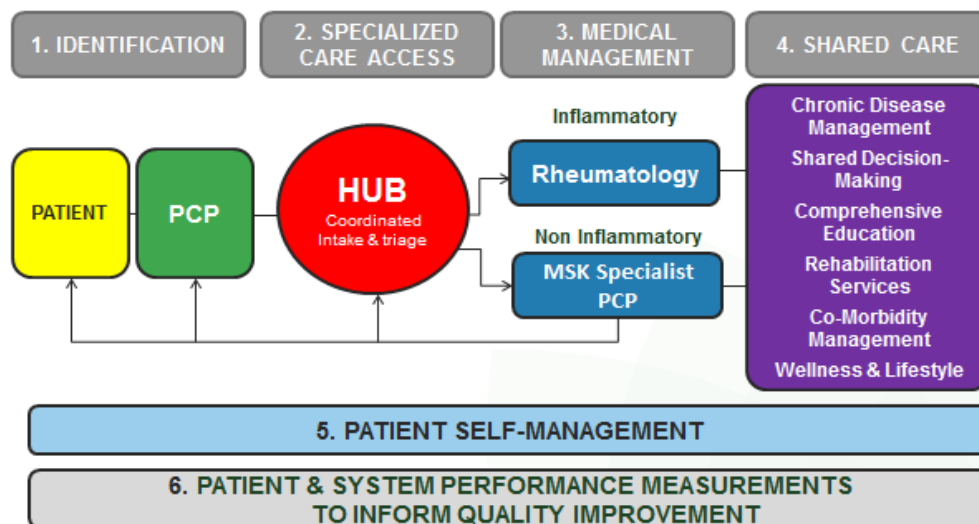
iii) **Variations in care and outcomes:** Data from two longitudinal cohorts suggest there are significant variations in care and outcomes of Canadians with IA. For example, the national CATCH (Canadian Early Rheumatoid Arthritis Cohort; www.earlyarthritis.com) reported significantly different DAS28 remission rates based on site of care,⁶ and the OBRI (Ontario Best Practices Research Initiative; www.obri.ca) reported similar variations in patient outcomes across Ontario rheumatology sites.⁷

2) What is it?

The ORA's Models of Care can be conceptualized as a framework to facilitate timely delivery of high-quality, evidence-based care to patients with IA (Figure 2). This framework is based on a patient-centred approach to caring for IA patients across their journey through the health care system. It is fundamentally a reorganization in the way care is delivered which mobilizes and maximizes the use of existing resources including primary care providers, specialists (i.e. rheumatologists, orthopedic surgeons), allied health care providers (i.e. nurses, physical therapists [PTs], occupational therapists [OTs], and pharmacists) and community programs aimed at improving chronic disease management. The framework was designed with sufficient flexibility to accommodate different geographical regions and to make use of their existing resources.

Although the ORA MOC project was designed to specifically reflect the situation and challenges in Ontario, the generality of the framework makes it applicable for the assessment and treatment of rheumatologic conditions in other provinces. As such, it has therefore been adopted by the Arthritis Alliance of Canada (AAC) as their national MOC framework.⁸

Figure 2. The ORA Models of Care Framework.



⁶ Harris JA, et al. Determining best practices in early rheumatoid arthritis by comparing differences in treatment at sites in the Canadian Early Arthritis Cohort. J Rheumatol 2013;40:1823-30.

⁷ Ontario Best Practice Research Initiative, Data Management Centre 2013.

⁸ Arthritis Alliance of Canada. Pan-Canadian Approach to IA Models of Care. <http://www.arthritisalliance.ca/en/initiativesen/pan-canadian-approach-to-ia-models-of-care>.

The ORA Models of Care encompasses six key elements:

1. Identification
2. Access
3. Medical management
4. Shared care
5. Patient self-management
6. Patient and system performance measurements to inform quality improvement

As the MOC was being developed, it was recognized that efforts around knowledge translation would be another essential component of the program.

3) Who is involved?

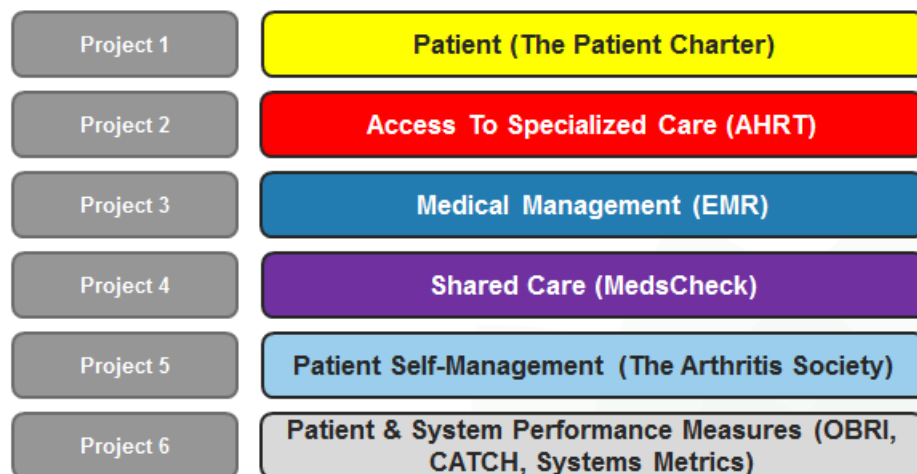
The ORA has been a leader in implementing Models of Care on a provincial level through the establishment of a working committee dedicated to re-defining how care is delivered to patients with IA. Three subcommittees were also established to support the implementation of the MOC Project across Ontario.

The ORA's MOC committee has worked in collaboration with the Arthritis Alliance of Canada (AAC), who initiated their own Pan-Canadian approach to IA models of care (www.arthritisalliance.ca/en/pan-canadian-approach-to-ia-models-of-care),⁸ the Ontario Best Practices Research Initiative (OBRI; www.obri.ca), The Arthritis Society (www.arthritis.ca) and the Advanced Clinician Practitioner in Arthritis Care (ACPAC) programme (www.acpacprogram.ca). Dr. Vandana Ahluwalia, the Chair of the ORA's MOC committee, is one of the co-chairs of the AAC's IA Models of Care along with Dr. Diane Mosher (Alberta), and Dr. Michel Zummer (Quebec).

MOC Accomplishments

In the seven years since its inception, the ORA's MOC committee has accomplished many of the goals and initiatives it set out to achieve. The following pages will detail these accomplishments, using the MOC framework's pillars as a guide (Figure 3). The final chapter in the MOC's activities, "Knowledge Translation," will also be summarized.

Figure 3. Projects under the Models of Care framework.



1. Identification

In 2014, the Arthritis Patient Charter was published as a joint initiative between the ORA's MOC committee and the Canadian Arthritis Patient Alliance (CAPA).⁹ This document is an update of the earlier Canadian Arthritis Patient Bill of Rights, which was published in 2001.* The Arthritis Patient Charter reflects more contemporary issues faced by patients, their families, and caregivers today. It was developed with input from over 730 stakeholders from across Canada who responded to an online survey and with engagement from several patient groups including Arthritis Consumer Experts, Canadian Spondylitis Association, Patient Partners in Arthritis, and The Arthritis Society, as well as professional organizations including the Canadian Rheumatology Association (CRA) and the AAC.

The Arthritis Patient Charter was distributed to all rheumatologists practicing in Canada to help guide their discussions and interactions with patients. The charter can be accessed in English and French online at <http://arthritispatient.ca/projects/arthritis-patient-charter/>.

The Arthritis Patient Charter serves as an advocacy document that is structured in a more succinct, streamlined format than the previous Patient Bill of Rights.

*Funding to update the charter was provided from the ORA to CAPA with in-kind support also received from the CRA and The Arthritis Society.

⁹ Richards DP. The Arthritis Patient Charter. CRAJ 2014;24:8-9.

Arthritis Patient Charter



Canadian Arthritis
Patient Alliance
experience · perspective · voice

People with arthritis have the right to:

- Be treated with dignity, respect and consideration.
- A timely and accurate diagnosis.
- Timely access to all types of high-quality care.
- Readily available current information, education and support programs about arthritis and evidence-based arthritis care.
- Be informed and participate with their healthcare providers in all treatment decisions.
- Equal public reimbursement and timely access in all provinces and territories to available medication and non-medication treatments.
- Live their lives fully without discrimination.
- See that research is underway to find a cure and improve quality of life.
- Be included in the development of health policies and programs that affect them.

People with arthritis have the responsibility to:

- Learn about arthritis and arthritis care.
- Live a healthy lifestyle and speak openly with their healthcare providers.
- Ask questions about treatment and follow the agreed upon course of treatment.

This charter can be found online at:
<http://arthritispatient.ca/projects/arthritis-patient-charter/>

2. Specialized care access

The Canadian Rheumatology Association and Wait Time Alliance have published the following wait time benchmarks for arthritis care:¹⁰

¹⁰ Canadian Rheumatology Association 2016. Available at: www.waittimealliance.ca/wp-content/uploads/2014/05/Arthritis_Care_CRA_Benchmarks.pdf. Accessed 24 August 2016.

Diagnoses/Treatment	Acceptable Wait Time
Rheumatoid Arthritis (RA)	
Recommended maximum wait time to see a patient with suspected RA	4 weeks
Ideal wait time to start of disease-modifying anti-rheumatic drugs (DMARDs) once diagnosis is confirmed	2 weeks
Spondyloarthritis (SpA)	
Recommended wait time to see a patient with potential inflammatory back pain	3 months
Ideal wait time for MRI of spine requested by rheumatologist	6 weeks
Psoriatic Arthritis (PsA)	
Recommended wait time to see a patient with possible psoriatic arthritis	6 weeks
Systemic Lupus Erythematosus (SLE)	
Maximum wait time to see a patient with SLE	1 month
Juvenile Idiopathic Arthritis (JIA)	
Recommended wait time to see a patient with Systemic Onset JIA (SOJIA)	7 days
Recommended wait time to see a patient with JIA (except SOJIA)	4 weeks
Juvenile Idiopathic Arthritis (JIA) Uveitis Screening	
Ideal wait time for uveitis screening by eye care provider in patient with oligoarticular JIA, psoriatic JIA, RF negative JIA, or undifferentiated JIA	

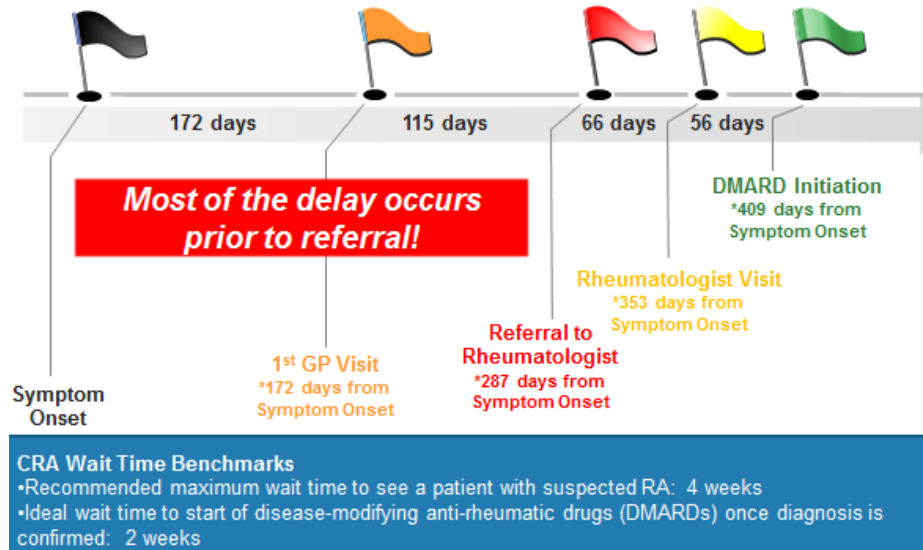
- According to a recent study by Widdifield, patients with IA face long wait times that lead to substantial delays in receiving appropriate care (Figure 4).¹¹
- The wait times were further examined to show that patients with RA (on average) wait **172 days** from symptom onset until documentation of the complaint in primary care; **115 days** in primary care until the referral to the specialist is made; **66 days** from time of referral to see a rheumatologist; and **56 days** from 1st rheumatologist visit to DMARD initiation.¹²

The total delay from symptom onset to DMARD initiation was over 400 days long. The ORA Model of Care was developed to address the delay from referral to rheumatologists to DMARD initiation, which is currently at 122 days. It is important to note that most of the delay occurs prior to referral.

¹¹ Widdifield J, et al. Patterns of care and referrals to rheumatologists in Ontario, Canada. Arthritis Care Res 2016;69:104-114.

¹² Bombardier C et al. The effect of triage assessments on identifying inflammatory arthritis and reducing rheumatology wait times in Ontario [abstract]. Arthritis Rheumatol 2016;68(suppl 10).

Figure 4. Rheumatology wait time measures along the RA care pathway.¹¹



It takes 409 days on average from symptom onset to initiation of disease-modifying anti-rheumatic drug (DMARD) therapy for patients with rheumatoid arthritis in Ontario. Most of that delay occurs between the first primary care visit and referral to a rheumatologist. About one third of patients referred to rheumatology care in Ontario have IA. Appropriate triage of these patients could help reduce the time needed for them to access specialized care and initiate disease-modifying treatments.¹¹ Extended role practitioners (ERPs) have the capacity to help achieve this goal by correctly triaging patients so that those with suspected IA are prioritized for rheumatology consultation and follow up care.¹³

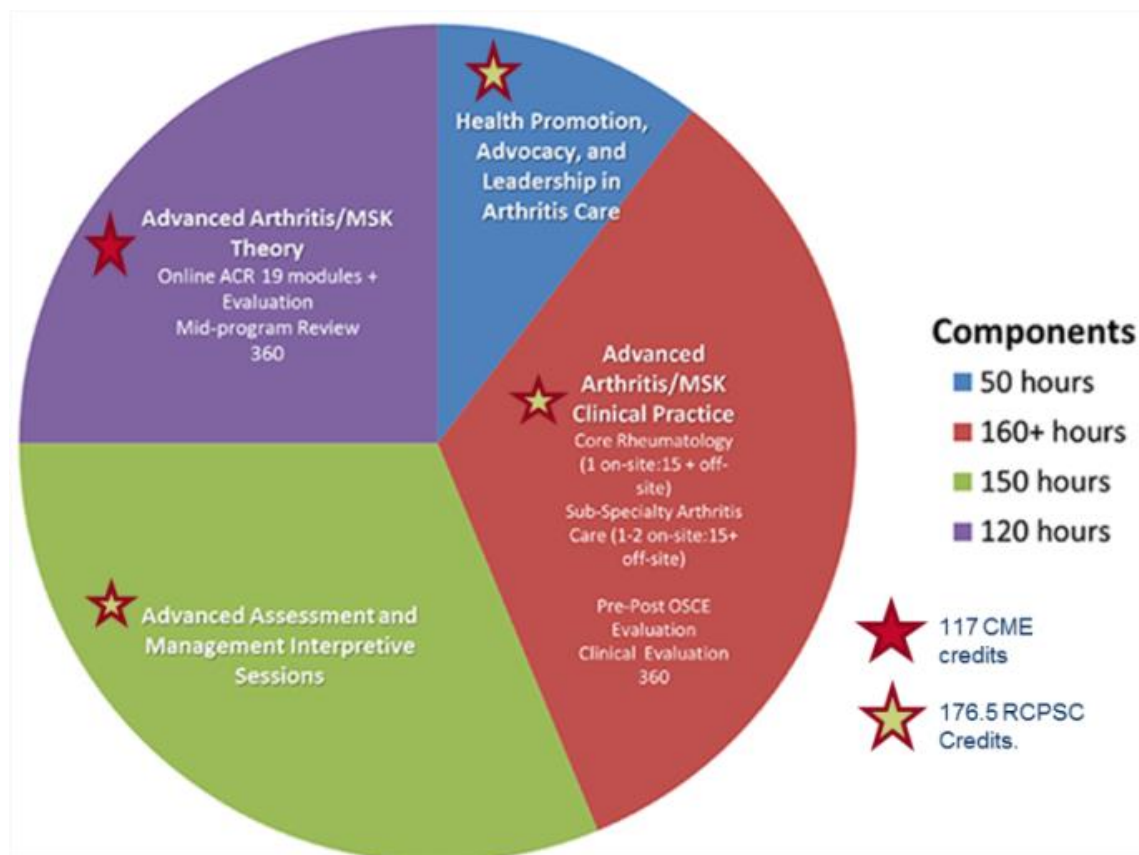
Through the University of Toronto, the Advanced Clinician Practitioner in Arthritis Care Program (ACPAC) was developed as an inter-professional, comprehensive training program for OTs, PTs, and recently select nurses, already engaged in arthritis care, to expand their skills to become ERPs (Figure 5). Over 90 faculty were involved in the development and delivery of this program, which has trained 62 ERPs up to July 2016, with another seven currently completing the program in 2017.¹⁴ It is a pan-Canadian initiative with graduates from BC, Alberta, Saskatchewan, and Ontario. To date, ACPAC-trained ERPs are working in a variety of shared care settings including community-based rheumatology practices (39%), urban-academic sites (45%) and rural/remote regions (16%). A patient survey reported a high level of satisfaction with ERP care delivery, education, and wait times.¹⁵

¹³ Ahluwalia V, Larsen T. Using an ACPAC trained physiotherapist and a standardized EMR triage assessment tool to efficiently and accurately detect inflammatory arthritis in a community rheumatology office setting. Abstract 112 presented at CRA Annual Meeting 2014.

¹⁴ ACPAC – The Advanced Clinician Practitioner in Arthritis Care Program. ACPAC - The Advanced Clinician Practitioner in Arthritis Care Program. 2016. Available at: www.acpacprogram.ca.

¹⁵ Warmington K, et al. The patient perspective: arthritis care provided by Advanced Clinician Practitioner in Arthritis Care program-trained clinicians. Open Access Rheumatol 2015;7:45-53.

Figure 5. ACPAC training program components (2013-2018).



Subsequent to the success of the ACPAC training program, a study was undertaken to provide quantitative data on the value of integrating ACPAC-trained ERPs in rheumatology practices. The study evaluated the effectiveness of an ACPAC-trained physiotherapist to triage priority patients in a solo rheumatology practice in Brampton, Ontario.^{13,16,17} Using an advanced directive and standardized EMR triage tool, the ACPAC-trained PT conducted 15-minute assessments on patients with suspected IA (Figure 6), and this was compared to the rheumatologist's evaluations to determine the concordance between the ACPAC and specialist evaluations. The ACPAC-trained PT identified

"98% of patients surveyed felt the arthritis care they received [from ACPAC-trained ERPs] was comparable to care previously received from other health care professionals."¹⁵

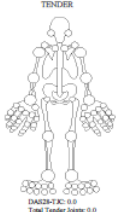
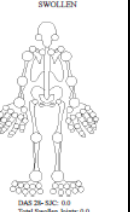
- Warmington et al. 2015

¹⁶ Ahluwalia V, Larsen T. Using an Advanced Clinician Practitioner in Arthritis Care trained physiotherapist and a standardized EMR triage assessment tool to detect IA and initiate DMARDs earlier in a community rheumatology office setting. ACR 2014 (Abstract 1168).

¹⁷ Ahluwalia V et al. An advanced clinician practitioner in arthritis care plan can improve access to rheumatology care in community-based practice. (manuscript submitted).

priority patients with IA with 100% sensitivity and 93% specificity, and a positive predictive value of 91%. Using the ACPAC-trained PT to triage referrals resulted in patients with IA seeing the rheumatologist earlier, and reduced time to DMARD initiation by 6 weeks.

Figure 6. 15-minute triage assessment form.

Dear Dr:		Patient's Name:	
CC:		DOB:	
		Assessment Date:	
<input type="checkbox"/> Consent for Assessment		Physical Examination:	
HPI:		Weight: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> In <input type="checkbox"/> Out Skin & Nails: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> In <input type="checkbox"/> Out MTP spaces: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> In <input type="checkbox"/> Out MCP spaces: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> In <input type="checkbox"/> Out	
AM stiffness <input type="checkbox"/> < 30 min <input type="checkbox"/> > 30 min <input type="checkbox"/> none <input type="checkbox"/> Pain /10 Fatigue /10 Sleep /10 Constitutional Features: <input type="checkbox"/> Yes <input type="checkbox"/> No		TENDER:  Total Tender Joints 0.0 SWOLLEN:  Total Swollen Joints 0.0	
Extra Articular Features: <input type="checkbox"/> red eyes <input type="checkbox"/> photophobia <input type="checkbox"/> alopecia <input type="checkbox"/> photosensitivity <input type="checkbox"/> dry eyes/mouth <input type="checkbox"/> oral nasal ulcers <input type="checkbox"/> chest pain <input type="checkbox"/> SOB <input type="checkbox"/> <input type="checkbox"/> cough <input type="checkbox"/> SBO symptoms <input type="checkbox"/> osteoarthritis <input type="checkbox"/> psoriasis <input type="checkbox"/> <input type="checkbox"/> rashes <input type="checkbox"/> skin thickening <input type="checkbox"/> myalgia <input type="checkbox"/>		Impression (ERP Query Diagnosis) <input type="checkbox"/> Seropositive <input type="checkbox"/> CTD <input type="checkbox"/> Other <input type="checkbox"/> Seronegative <input type="checkbox"/> Crystals <input type="checkbox"/> <input type="checkbox"/> MSK <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Carpal Tunnel <input type="checkbox"/>	
Lab Data CBC: <input type="checkbox"/> normal <input type="checkbox"/> abnormal RF: <input type="checkbox"/> positive <input type="checkbox"/> negative ANA: <input type="checkbox"/> positive <input type="checkbox"/> negative ESR: <input type="checkbox"/> positive <input type="checkbox"/> negative CRP: <input type="checkbox"/> positive <input type="checkbox"/> negative		Plan <input type="checkbox"/> B/W ordered <input type="checkbox"/> referral OT splints <input type="checkbox"/> x-ray ordered <input type="checkbox"/> referral PT <input type="checkbox"/> referral Arthritis Society <input type="checkbox"/> Other <input type="checkbox"/> booked priority <input type="checkbox"/> <input type="checkbox"/> booked non-priority <input type="checkbox"/> <input type="checkbox"/> booked injection clinic <input type="checkbox"/>	
Imaging: Xray CT MRI Other:			

As a result of these promising findings from the single centre study, funding was obtained from collaborative partners including the OBRI, The Arthritis Society and the ORA to embark on a province-wide validation study using four ACPAC-trained ERPs working with six Ontario rheumatologists. The Allied Health Rheumatology Triage (AHRT) Study's quantitative findings were found to be so important that it was the recipient of the 2016 AHPA Clinical Innovation Award.¹⁸

Within the same study, qualitative findings were also explored to assess rheumatologists, ERPs' and patients perspectives on the clinical and logistical impact of the intervention. Rheumatologists and ACPAC-trained ERPs expressed a high degree of agreement that the rheumatology triage intervention reduced wait times to rheumatology consultation, diagnosis, and treatment for patients with IA. The unintended benefits were that those patients who were not expedited (non-IA) also received education, exercises,

AHRT demonstrated that ACPAC trained ERPs could correctly prioritize patients with inflammatory arthritis to expedited rheumatology consultation. The findings highlight significant reduction in wait times (median 37 days, substantially lower than the provincial median of 66 days).¹⁵

¹⁸ Arthritis Health Professions Association. Available at www.ahpa.ca/awards/clinical-innovation-award/. Accessed 9 May 2017.

joint protection and lifestyle management recommendations while waiting for their consultation appointment. Findings support the benefit to the patient's access to care by integrating an ACPAC-trained ERP into a community-based model of arthritis care.

Based on these results, the ORA is collaborating with the Arthritis Health Professions Association (AHPA) to facilitate and support the integration of ACPAC-trained ERPs in rheumatology practices.

3. Medical management

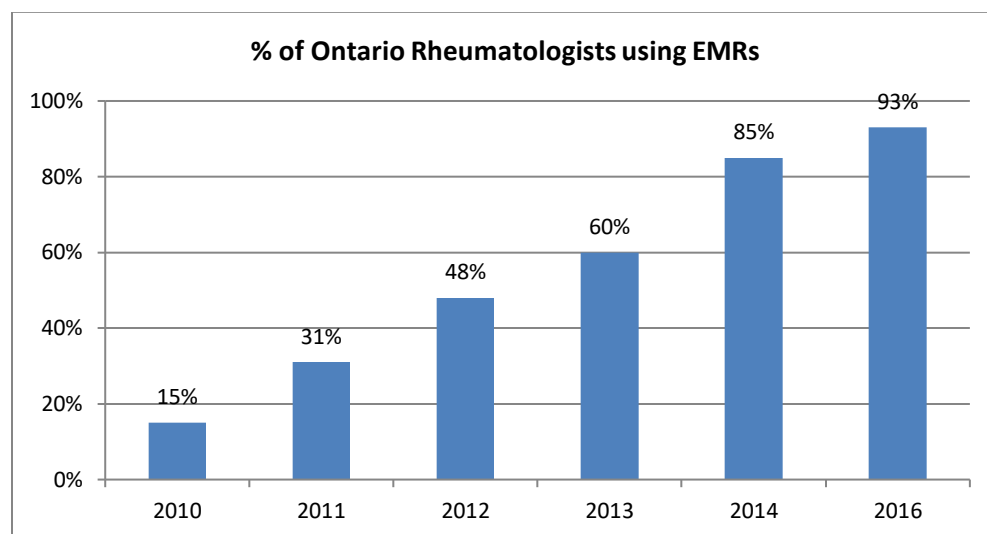
The integration of EMR solutions into clinical practices has been supported in Ontario by a government-led initiative that started almost 10 years ago. OntarioMD was established to help community physicians in the selection, implementation and adoption of EMRs. While OntarioMD is a wholly-owned subsidiary of the Ontario Medical Association, it serves as the conduit to provide funding and assistance to physicians to transition from paper records to EMRs. Today over 13,000 Ontario community physicians are enrolled in OntarioMD programs.¹⁹

When Ontario physicians were encouraged to transition to EMRs, many if not most of the certified EMR platforms were created to support primary care physicians and not fully prepared to support specialist needs. In the absence of essential tools and functionality for the rheumatology community, the ORA established an EMR subcommittee to identify the needs of the rheumatology community and implement rheumatology-specific tools within existing EMR platforms. By 2016, through the efforts of the ORA, 93% of Ontario rheumatologists were documenting clinical care using a certified OntarioMD EMR system with the majority using QHR-Accuro, Oscar or Telus-Practice Solutions (Figure 7). Within the EMR Sub-Committee, individual champions were appointed to support end-users through various workshops and training sessions: Dr. Arthur Karasik and Dr. Vandana Ahluwalia (QHR-Accuro); Dr. Henry Avern and Dr. Manisha Mulgund (Oscar); and Dr. Ami Mody and Dr. Andrew Chow (Telus-Practice Solutions).

As a result of the ORA's EMR work, Ontario rheumatologists have the highest adoption of EMRs (93%) among any specialty group in Ontario.

¹⁹ OntarioMD website. Available at www.ontariomd.ca. Accessed 19 May 2017.

Figure 7. Increasing use of EMRs by Ontario community rheumatologists: 2010 to 2016.¹⁹



Several tools have been developed and continue to be integrated into EMR platforms to facilitate documentation of IA patient care and implementation of appropriate treatment plans that enable a Treat to Target approach (Figure 8).

Figure 8: Rheumatology Smart forms now available in clinician's EMRs.

General form
RA
Psa/AS

With the increased availability and adoption of EMR platforms in clinical practice, data is now more readily available to users than ever before.

Recently, the ORA established a dedicated Informatics Committee to explore the feasibility of creating a rheumatology data platform to house and maintain aggregated clinical datasets that can be accessed by clinicians for practice improvement as well as for research purposes.

Within this focused scope, the ORA in collaboration with the OBRI have completed a pilot project to quantify and qualify clinical data that can be seamlessly extracted from clinician's EMRs. The pilot successfully demonstrated that data quality and integrity can be well maintained when extracted from EMRs, provided that the clinical data are collected and entered in a standardized manner.. The pilot also builds on the recent work developed by the Arthritis Alliance of Canada to develop the national core data set for rheumatology variables.²⁰ Building on this work, the ORA Informatics Committee is working to create consensus for rheumatologists on best practices to collect the core data set variables in EMR platforms, so that data extraction and integrity can be fully realized.

There are several other ongoing projects under the ORA informatics committee scope of work including:

- ✓ Create a secure rheumatology data platform to automate seamless data extraction, enable data validation and data readiness to support practice improvement and research initiatives
- ✓ Pilot project to create a package of Rheumatology Practice, Disease & Quality Indicators that can be used in EMR dashboards

The EMR Sub-committee is partnering with multiple collaborators on these EMR projects, including:

- ✓ Ontario Medical Association



- ✓ OntarioMD



- ✓ E-health Ontario



- ✓ Arthritis Alliance of Canada



- ✓ OBRI



²⁰ Barber C et al. Development of a National Rheumatoid Arthritis Core Clinical Dataset (RACCD) in Canada to support high quality care for RA patients. Proceedings of the Canadian Rheumatology Association Annual Scientific Meeting 2017.

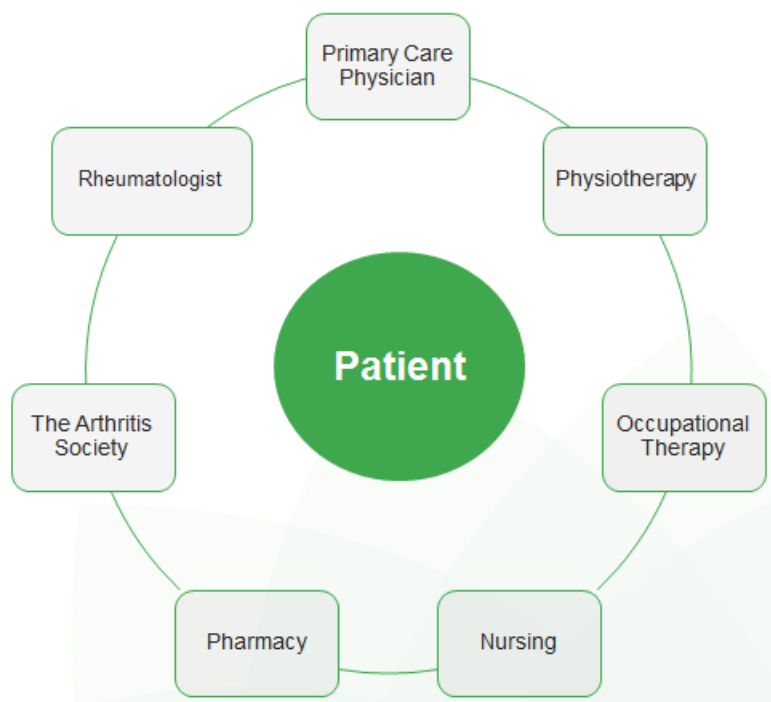
- ✓ Disease education
- ✓ Medication adherence
- ✓ Comorbidity management
- ✓ Rehabilitation
- ✓ Vaccination review
- ✓ Return to work support

[illegible]

The MOC framework was designed to optimize delivery of patient-centred care through a shared care management model (Figure 10). This model recognizes the range of knowledge and skills delivered by a

wide array of health professionals that can benefit the IA patient. Making these health professional resources available to IA patients can improve patient care in a cost-effective manner.²¹

Figure 10. Patient-centred approach to shared care.



MedsCheck is a consultation service that gives patients the opportunity to meet with a pharmacist to review prescriptions, over-the-counter products and complementary and alternative medicine (including vitamin supplements). The service is paid for by the Ontario government and is available to eligible patients who take three or more prescription medications for an ongoing, chronic condition and any resident in a long-term care home.

The ORA Models of Care has partnered with the Ontario Pharmacist Association to develop two rheumatology EMR tools that optimize MedsCheck referrals. The tools consist of a patient information form and a pharmacist referral letter and are accessible through ORA approved EMRs.

5. Patient self-management

The MOC Project makes use of existing resources for patient self-management including:

²¹ Canadian Health Services Research Foundation. Interprofessional Collaborative Teams. 2012.

- ✓ Online tools developed by local arthritis organizations including The Arthritis Society (www.arthritis.ca), RheumInfo (www.RheumInfo.com) and patient associations including the Canadian Arthritis Patient Alliance (www.arthritispatient.ca) and the Arthritis Consumer Experts (www.jointhehealth.org)
- ✓ 1-on-1 education sessions with OTs/PTs through the Arthritis Rehabilitation and Education Program funded by The Arthritis Society (www.arthritis.ca)
- ✓ St. Michael's Hospital's "Prescription for Education" program (www.stmichaelshospital.com/programs/rheumatology/)
- ✓ Southlake Regional Health Centre's The Arthritis Program (TAP; www.southlakeregional.org)

The ORA Model of Care recommends a variety of reputable patient self-management resources

6. Patient & system performance measurements to inform quality improvement

Patient metrics

Many of the MOC Project initiatives have been fully completed and there is increased awareness around these initiatives by Ontario rheumatologists. Efforts are underway to evaluate these programs to inform quality improvement. Some have been detailed in this report (e.g. the MOC has leveraged the OBRI to share real-world clinical outcomes data and to adopt a minimum core dataset within EMRs). Assessing the performance of MOC projects will help continue to support best practices and quality improvement at the regional and national levels.

Six key system metrics are now being evaluated (figure 11) in sites across Canada

System metrics

The Arthritis Alliance of Canada is developing a systems-level performance measurement framework to evaluate IA models of care in Canada.^{22, 23} This will serve as an aid for health care decision-makers to identify and prioritize areas for improvement and to measure outcomes of health system changes whose goals are to improve the care of patients with IA. This effort involved broad input from rheumatologists, allied health professionals, persons with arthritis, researchers, and other stakeholders.²³ A recent survey initiative entitled "Stand Up and Be Counted Too (2)" has recently been launched, and will capture global metrics on non-physician healthcare practitioners (e.g. ERPs, APPs, and others who identify as specialists or having a special interest in arthritis care) across Canada.²⁴

²² Arthritis Alliance of Canada. Measurement Framework for IA Models of Care. Available at <http://www.arthritisalliance.ca/en/measurement-framework-for-ia-models-of-care>.

²³ Barber C, et al. Development of system-level performance measures for evaluation of models of care for inflammatory arthritis. J Rheumatol 2016;43:530-40.

²⁴ London K, Shupak R, Kennedy C, McGlynn M, Inrig T. Stand Up and Be Counted Too (2). Ongoing research.

Figure 11. Six measurement themes focused on access to care for patients with IA.

Measurement Theme #1	Wait times for rheumatologist consultation for patients with IA
Measurement Theme #2	Percentage of patients with IA seen by a rheumatologist within the first year of onset of symptoms
Measurement Theme #3	Percentage of patients with IA seen in yearly FOLLOW-UP by a rheumatology team member
Measurement Theme #4	Percentage of rheumatoid arthritis patients treated with a DMARD
Measurement Theme #5	Time to Disease-modifying Anti-Rheumatic Drug Therapy (DMARD) in rheumatoid arthritis
Measurement Theme #6	# of Rheumatologists per capita

7. Knowledge translation

Educating rheumatologists about the principles and tools that are the foundation of the Models of Care project is the final step in implementing the MOC across Ontario. To this end, a knowledge translation program entitled “Rheumatology Care Redesigned – Created Nationally, Developed Provincially and Delivered Locally” was created. This branded educational program consists of four distinct modules. Module 1, “The Ontario Approach to Models of Care,” provides an overview of the ORA and its organizational priorities and highlights the burden of arthritic diseases in the context of changing population demographics.

Module 2, “National & Provincial Models of Care,” aims to increase awareness of the ORA’s Models of Care toolkit and initiatives as well as the AAC Models of Care toolkit, and challenges participants to identify potential changes they could apply in their own clinical practice.

Module 3, “Incorporating Allied Health Professionals in a Rheumatology Practice,” offers an in-depth review of shared care models and triage techniques.

Module 4, “Models of Care in Action!” aims to further increase awareness of the ORA’s Models of Care, how to apply them in clinical practice, and highlights opportunities for peer-to-peer sharing.



Ten knowledge translation facilitators were trained on the modules and each delivered one to two sessions in their local regions between October 2016 and February 2017. Participants (n=47) generally rated the educational sessions highly and overall the feedback was positive. Most agreed that they learned new information about Models of Care, the available tools, and the role of ERPs, but they were interested in learning more about the operational aspects of the MOC and how to integrate them into their routine practice. Notably, the educational intervention was deemed to be “really helpful to understand the various models physicians utilize and how this impacts both patient care and satisfaction, but also practice efficiency and wait times.”

The purpose of the Knowledge Translation program is to build advocacy for implementing the Models of Care.

Addressing the cost of caring for patients

Canadians want and expect exceptional health care, but this comes at a cost, and our health care budgets are already under stress. This was exemplified in a recent series of articles on

www.HealthyDebate.ca on the long wait times for Canadians to see specialists.²⁵ Indeed, Canada ranked the worst out of 11 Commonwealth countries surveyed about wait times to see specialists. The answer to Canada's long wait times to see specialists is not a simple one of just increasing the number of specialists – there are challenges related to the distribution of specialists across areas of need, funding for sub-specialists and support staff, and resource constraints that can cause bottlenecks throughout the health care system.

Adopting new models and systems of care can help make better use of existing resources, increase health care system capacity, and specialists' ability to see more patients. Although there may be associated with up-front costs with implementing new models of care, evidence suggests that the right investments can pay off in the long-term. A German cost-effectiveness study reported that the increased direct costs of adopting a model of care in RA were offset by substantial reductions in sick leave, disability pension, and other indirect costs.²⁶

There is a need for a long-term vision for health care that acknowledges the up-front costs to establish appropriate models of care that could allow for the delivery of excellent health care at an affordable cost.

There is interest in applying health economics outcomes research (HEOR) to evaluate the potential cost savings of integrating ACPAC-trained ERPs into community practices from an overall health care system perspective. There could also be cost savings to individual rheumatology practices that adopt ERPs into their models of care. The MOC committee has collaborated with Dr. Deborah Marshall (Canada Research Chair Health Services and Systems Research and Arthur J.E. Child Chair Rheumatology Outcomes Research at the O'Brien Institute for Public Health at the University of Calgary) and the AAC to explore the feasibility of generating an economic model and argument for the MOC framework, and specifically, to evaluate the "cost" and "consequence" of implementing a patient-centred approach to shared care in patients with IA.

²⁵ Milne V et al. "The solution is really system wide": Long wait times defy quick fixes. Available at www.healthydebate.ca/2017/03/topic/wait-times-specialists-hhr.

²⁶ Huscher D, et al. Evolution of cost structures in rheumatoid arthritis over the past decade. Ann Rheum Dis 2015; 74: 738-745.

The Future is NOW

Over the seven years since its inception, the ORA's MOC Committee has worked diligently to fully implement its goals and activities. As it is wrapping up its work in establishing the core elements of the MOC, the Committee is now focusing its efforts on mobilizing what it has accomplished through communications and further educational activities to continue to raise awareness and encourage implementation. Efforts are underway to develop newsletters summarizing the key activities of the MOC Committee for rheumatology and allied health professional audiences, as well as for other stakeholders (e.g. administrators, government decision-makers). The Spring 2018 issue of the CRA Journal will showcase the many MOC accomplishments including quality performance metrics that will be generated in the coming year.

The ORA took on a leadership role in implementing models of care at a provincial level. The adoption of its MOC framework nationally by the Arthritis Alliance of Canada is a testament to the quality and robustness of the ORA MOC Committee's work. It is hoped that champions from other provinces and jurisdictions will consider and adopt some of the activities and tools established by the ORA in developing their own models of care, and that over time, these can be further refined to optimize the delivery of care to patients living with IA. Not only does the framework suit the rheumatology area, it is sufficiently flexible that it could be adopted across numerous other chronic disease conditions.

Working within a multifaceted model of care framework offers benefits to patients, clinicians, and the health care system as a whole through better coordinated services that ensure patients get access to great care when they need it.

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