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.\(^2\)

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

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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: 2010-2030\(^3\)


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B. Distribution of Rheumatologists Across Canada

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.

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**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.**\(^3,5\)

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

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](http://www.earlyarthritis.com)) reported significantly different DAS28 remission rates based on site of care, and the OBRI (Ontario Best Practices Research Initiative; [www.obri.ca](http://www.obri.ca)) reported similar variations in patient outcomes across Ontario rheumatology sites.

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.

Figure 2. The ORA Models of Care Framework.

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7 Ontario Best Practice Research Initiative, Data Management Centre 2013.
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), 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.
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/](http://arthritispatient.ca/projects/arthritis-patient-charter/).

\(^*\)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.

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2. Specialized care access

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

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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).\textsuperscript{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 1\textsuperscript{st} rheumatologist visit to DMARD initiation.\textsuperscript{12}

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\begin{tabular}{ | l | c |}
\hline
\textbf{Diagnoses/Treatment} & \textbf{Acceptable Wait Time} \\
\hline
\textbf{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 \\
\hline
\textbf{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 \\
\hline
\textbf{Psoriatic Arthritis (PsA)} & \\
Recommended wait time to see a patient with possible psoriatic arthritis & 6 weeks \\
\hline
\textbf{Systemic Lupus Erythematosus (SLE)} & \\
Maximum wait time to see a patient with SLE & 1 month \\
\hline
\textbf{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 \\
\hline
\textbf{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 & \\
\hline
\end{tabular}
\end{center}


\textsuperscript{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).
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.\(^\text{11}\) 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.\(^\text{13}\)

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.\(^\text{14}\) 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.\(^\text{15}\)

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\(^{14}\) ACPAC – The Advanced Clinician Practitioner in Arthritis Care Program. ACPAC - The Advanced Clinician Practitioner in Arthritis Care Program. 2016. Available at: www.acpacprogram.ca.

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. 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.”

- Warmington et al. 2015

14 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.

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.\(^\text{18}\)

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,

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 Averns and Dr. Manisha Mulgund (Oscar); and Dr. Ami Mody and Dr. Andrew Chow (Telus-Practice Solutions).

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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.
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. Building on this work developed by the Arthritis Alliance of Canada to develop the national core data set for rheumatology variables, 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

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An EMR-based Inflammatory Arthritis Care Plan has been developed to facilitate patient self-management and it has been integrated into the Accuro EMR platform and will be pilot tested in a few Ontario rheumatology sites. This care plan shown in Figure 9 contains:

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

Figure 9: EMR-based Inflammatory Arthritis Care Plan Template.

4. Shared care

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.

5. Patient self-management

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

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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.jointhealth.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)

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.

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

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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 Provincialy 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.”
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. 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.

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.

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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.
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