Potential Solutions for Sustainable Funding for Integrating Allied Health Providers in Rheumatology Settings in Ontario

Policy Brief

Contributors

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The document is open for public comment throughout 2026, with feedback from special interest groups and individuals to be addressed in a subsequent Policy Report.
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About The Authors

The **Ontario Rheumatology Association (ORA)** is a not-for-profit professional organization that represents Ontario rheumatologists and promotes the pursuit of excellence in arthritis care through leadership, advocacy, education, and communication. The ORA has over two decades of experience in advocating and negotiating for its members with the government and private payers to ensure appropriate funding for rheumatology services and patient treatment options.

Through the ORA's Models of Care initiative, and various other ORA activities, the ORA has long been striving to improve equitable access to rheumatology care and promote inter-professional relationships between rheumatologists and Interdisciplinary Health Providers (IHPs).

Purpose

The purpose of this policy brief is to summarize potential dedicated funding mechanisms to support the equitable integration of AHPs/IHPs into rheumatology practices in Ontario.

The **Canadian Rheumatology Implementation Science Team (CAN-RIST)** is a team of researchers, providers and persons with lived experiences who have partnered with the ORA to generate actionable evidence to guide implementation, spread, and scale of interdisciplinary models of rheumatology care and other best practices in a sustainable manner across Ontario.

In 2023, under the Transforming Health with Integrated Care (THINC) initiative, the Canadian Institutes of Health Research (CIHR), in collaboration with various partners, invested $26.6 million to support 13 Implementation Science Teams (ISTs) and the Network for Integrated Care Excellence (NICE) Canada (a knowledge mobilization and impact hub to support amplifying key learnings and ensure transformative positive changes are made through the implementation of effective integrated care policies).

The ISTs that proposed the most promising solutions to transform integrated care models across Canada were selected across diverse areas (primary care, mental health, respiratory health, other clinical areas with complex care needs). Evaluating, implementing, spreading and scaling interdisciplinary team-based models of rheumatology care was identified as a policy priority to improve integrated care.

CAN-RIST's efforts are currently concentrated in Ontario, with the goal to share learnings to support the broader, equitable uptake of rheumatology-integrated care research and practices across Canada.

List of Abbreviations

ACPAC	Advanced Clinician Practitioner in Arthritis Care
AFA	Alternative Funding Arrangement
AFP	Alternative Funding Plan
APP	Alternative Payment Plan
AHP	Allied Healthcare Provider
AHPA	Arthritis Health Professions Association
CArE	Centre of Arthritis Excellence
CFMA	Commitment to the Future of Medicare Act
CHA	Canada Health Act
CHC	Community Health Centre
CMPA	Canadian Medical Protective Association
CPCP	Community Physiotherapy Clinic Program
CFMA	Commitment to the Future of Medicare Act
ECHO	Extension for Community Healthcare Outcomes model
EMR	Electronic Medical Record
EOC	Episodes of Care
ERP	Extended Role Provider
ESP	Extended Scope Provider
FFS	Fee-For-Service
FHT	Family Health Team
FTE	Full-Time Equivalent
IHP	Interdisciplinary Healthcare Provider
MPC	Medicine Professional Corporation
MOH	Ministry of Health
MSK	Musculoskeletal
NPLC	Nurse Practitioner-Led Clinic
OHIP	Ontario Health Insurance Plan
OMA	Ontario Medical Association
ORA	Ontario Rheumatology Association
PHIPA	Personal Health Information Protection Act
RA	Rheumatoid Arthritis
RMD	Rheumatic and Musculoskeletal Disease

Executive Summary

Ontario faces a growing crisis in rheumatology care, with only 300 rheumatologists serving approximately 350,000 patients annually across community and hospital-based outpatient settings. Rising **arthritis / rheumatic and musculoskeletal disease (RMD)** prevalence, an aging and growing population, and a worsening workforce shortage are straining access to timely care and negatively impacting patient experiences and patient and health system outcomes.

Expanding the rheumatology workforce with **allied health providers (AHPs)/interdisciplinary health providers (IHPs)** is critical to improving service capacity, and elevating quality of care, patient outcomes, patient and provider experience, and value. However, Ontario's **fee-for-service (FFS)** funding model does not fund team-based, interdisciplinary care, limiting the integration of essential AHPs/IHPs – such as physiotherapists, occupational therapists, nurses, pharmacists, advanced arthritis care practitioners, and other extended role providers – which are also instrumental in managing complex RMDs. While certain IHP services receive public funding in other healthcare settings, those delivered within rheumatology outpatient clinics remain uninsured.

This policy brief examines **policy considerations** and **potential dedicated funding mechanisms** to support the equitable integration of AHPs/IHPs into rheumatology practices. The identified funding solutions specifically address **IHP-related costs**, including salaries and associated expenses, to support integrated care models within **rheumatology settings**, without making specific recommendations. In parallel, budget impact assessments, readiness assessments, cost-effectiveness analyses, implementation resources are underway to further inform policy decision-making. This multi-faceted approach ensures that policymakers and organizational leaders gain a comprehensive understanding of financial feasibility and practical considerations, facilitating the evaluation of funding options and the development of effective spread and scale strategies. Once these concurrent activities are completed, this policy brief will be updated with clear recommendations in a Policy Report with a financial business case, followed by an Implementation Plan.

Summary of Policy Options to Support Funding and Implementing IHPs in Rheumatology Settings

The Federal Government could:

- Establish targeted/earmarked funding to prioritize IHP services in hospital budgets to influence provincial government priorities.
- Establish targeted/earmarked funding Transfers to support Advanced Clinical Practitioners in Arthritis Care (ACPAC)-trained Extended Scope Providers (ESPs) in a global budget system to directly support ESP payments (similar to midwifery services).

The Provincial Government (Ministry of Health/Ontario Health) could:

- Expand OHIP policy on delegation of procedural tasks to be inclusive of clinical assessments to enable rheumatologists to submit billing claims for the services of IHPs under their supervision.
- Implement a fee code for rheumatologists to be reimbursed for services of IHPs they employ and supervise.
- Establish/implement/formalize standard funding agreements for blended payment models for individual rheumatologists or rheumatology group practices to receive IHP funding via alternative payment plans (like the Family Health Team Funding Model).
- Integrate OHIP shadow billing requirements for rheumatologists to enable system-wide monitoring of IHP services and reduce reporting requirements on individual rheumatologists.
- Establish/Implement a global budget system for directly administering bundled care funding to ACPAC ESPs who are granted privileges to provide care in designated rheumatology clinics, with funding to support operating costs (similar to midwifery services).
- Develop/implement OHIP billing codes for ACPAC ESPs who have been granted privileges and medical delegation in rheumatology settings.
- Embed Community Physiotherapy Clinic Programs (CPCP) into rheumatology settings.
- Expand patient OHIP eligibility for CPCPs to be inclusive of all patient demographics when care is provided in rheumatology settings.
- Fund arthritis care IHP training programs to scale up the IHP workforce.

What are Advanced Clinical Practitioners in Arthritis Care-trained Extended Scope Providers?

Healthcare practitioners (physical therapists, occupational therapists, chiropractors, and nurses) with advanced training and experience in arthritis care. Like Physician Assistants (PAs), Extended Scope Providers (ESPs) or Extended Role Providers (ERPs) are supervised by physicians, perform delegated activities under medical directives, and work as physician extenders, providing patient care in a range of settings as members of inter-professional health care teams.

Background and Context

Ontario is currently home to only 300 active rheumatologists (spread across ~140 practice sites), with two-thirds practicing as clinical full-time equivalents (FTEs) and around 30 specializing in pediatric rheumatology (and the non-clinical FTEs represent rheumatologists involved in medical training, research and administrative roles). By 2030, workforce projections estimate there will be 308 to 363 rheumatologists (of which only 185 to 218 will be clinical FTEs – based on different scenarios[1]) which is not keeping pace with population growth trends.

The rheumatology workforce is diverse, with some rheumatologists further subspecializing to serve specific populations such as those with particular clinical conditions, pediatric patients, or other complex care needs. Others provide on-call services in hospitals, providing consultations for inpatient wards and emergency departments.

The distribution of rheumatologists across the province is uneven, with practices concentrated in southern urban areas, leaving northern and rural regions underserved. To bridge this gap, some rheumatologists travel to northern communities to provide care through outreach clinics. Others engage in hub-and-spoke models, where rheumatologists at central hubs in Southern Ontario support local interdisciplinary health providers (IHPs) in Northern Ontario through virtual and in-person consultations[2]. Additionally, some participate in telementoring programs, such as the ECHO (Extension for Community Healthcare Outcomes) model[3], which partners rheumatologists with primary care physicians to enhance local capacity for managing rheumatic diseases.

What is a Rheumatologist?

Rheumatologists are advanced medical subspecialists that diagnose, treat, & manage rheumatology conditions such as inflammatory arthritis & osteo-arthritis, auto-immune conditions (lupus, scleroderma, vasculitis), & other MSK conditions.

Medical training generally includes 4 years of medical school, followed by 3 years of internal medicine or pediatrics residency, then 2 years of rheumatology subspecialty residency.

15 medical schools across Canada provide rheumatology training programs. In Ontario, University of Toronto, McMaster, Ottawa, Queen's & Western collectively train ~15 new rheumatologists who enter the provincial workforce each year[1].

New graduates mainly inherit retiring rheumatologists' patient-filled practices.

Few rheumatologists immigrate to Ontario[1] due to the global shortage of rheumatologists.

[1] Widdifield J, Bernatsky S, Ahluwalia V, Barber C, Eder L, Gozdyra P, Hofstetter C, Kuriya B, Ling V, Lyddiatt A, Paterson JM, Pope J, Thorne C. Evaluation of Rheumatology Workforce Supply Changes in Ontario, Canada from 2000 to 2030. Healthcare Policy. 2021;16(3):118-133

[2] Steiman A, Inrig T, Lundon K, Murdoch J, Shupak R. Telerheumatology Shared-Care Model: Leveraging the Expertise of an Advanced Clinician Practitioner in Arthritis Care (ACPAC)-Trained Extended Role Practitioner in Rural-Remote Ontario. Journal of Rheumatology. 2024;51(9);913-919.

[3] Rheumatology – Project ECHO® at University Health Network

Rapid advancements in diagnostics and therapeutics have made rheumatology increasingly complex, solidifying rheumatologists as the leading experts in managing over 200 RMDs. Systemic RMDs—such as lupus, inflammatory arthritis, vasculitis, scleroderma, and autoinflammatory syndromes—can affect multiple organ systems and require rheumatology expertise for accurate diagnosis, management, and advanced therapies. In contrast, non-systemic (e.g. Osteoarthritis) or regional musculoskeletal conditions (e.g., gout, tendonitis) are often managed in primary care, with specialist referrals for complex or atypical cases. Due to limited exposure during undergraduate medical training, general practitioners and other specialists lack the advanced skill sets of rheumatologists. When non-specialists manage systemic RMDs, care is suboptimal, inefficient, and costlier due to poorly managed disease leading to excess complications. Thus, rheumatologists provide significant health system value by helping to maintain patient care in outpatient settings, reducing overall healthcare expenditures by minimizing disease progression, complications, and the need for more intensive treatments and surgical interventions later. Canadian guidelines recommend that suspected systemic RMD cases be referred to a rheumatologist promptly, while select non-systemic RMD cases may benefit from rheumatologist involvement alongside primary care physicians and IHPs.[4]

Patients need a referral from a primary care provider, nurse practitioner, or other specialist to see a rheumatologist. Access to rheumatologists is challenging, with wait times among the longest for any specialty in Canada and patients further struggle to maintain ongoing rheumatology care as they age with their illness. The rising burden of chronic RMDs is outpacing rheumatology supply. For instance, the Ontario population prevalence of rheumatoid arthritis (RA) is projected to increase by 52% from 2020 to 2040[5]. RA is already one of the most common conditions requiring chronic rheumatology care, with 168,000 individuals living with RA in Ontario in 2023[6]. This high demand for rheumatology care amongst a small workforce is contributing to long wait-times and rushed appointments that negatively impact patient experiences and outcomes, and rising physician burnout. As a result of a strained rheumatology workforce, the capacity to see new patients remains limited.

Additionally, individuals with RMDs have increasingly complex care needs and are best served by integrated care models, which reduce care fragmentation by ensuring a **coordinated, patient-centered approach** across healthcare providers and disciplines. This approach provides **comprehensive care** without gaps or duplications in services.

Integrated care models in rheumatology currently exist on a continuum, from multidisciplinary (where providers work independently in a sequential manner within their specific roles/disciplines, like a rapid access clinic where IHPs triage patients for rheumatologists) to interdisciplinary (where IHPs collaborate in decision-making with rheumatologists and assume responsibilities beyond their traditional scope). These types of models are effective solutions to improving rheumatology

[4] Canadian Rheumatology Association. Position Statements on Priority Areas to Support the Sustainability of the Canadian Rheumatology Workforce
[5] Rosella LC, Buajitti E, Daniel I, Alexander M, Brown A. Projected patterns of illness in Ontario. Toronto, ON: Dalla Lana School of Public Health; 2024
[6] Ontario Rheumatoid Arthritis Database. ICES. Toronto, ON. www.ices.on.ca

care delivery and meet growing patient demands. Intuitively, integrating IHPs into rheumatology settings within an integrated model enhances care capacity by expanding the pool of rheumatology health professionals to increase service availability and efficiency, but also the diversity of expertise within these healthcare teams may improve patient outcomes and experience. The value of IHPs in a rheumatology team not only benefit patients, but also the IHP's services are intertwined around the rheumatologist's practices needs, by supporting them in patient screening/triage (assessing new referrals, gathering patient history, and determining appropriateness and urgency for specialist consultation), providing physical examinations, delivering patient education in disease management (self-management strategies, lifestyle modifications) and medication management (education on medication administration, adherence, minimizing side effects and self-monitoring treatment response). Some IHPs may also provide therapeutic support (mobility exercises/rehabilitation, assistive device training on mobility aids, braces, and ergonomic tools), support chart documentation to streamline consultations, independently monitor stable patients, support care coordination/transitions (between rheumatologists, primary care, and other specialists and health services), and provide community resource navigation (connecting patients with support groups, home care services, and financial aid programs). By handling these tasks, IHPs enhance rheumatology care, freeing up rheumatologists to focus on complex cases, improving patient access, and reducing healthcare system burden.

The integration of IHPs into Ontario rheumatology practices is limited as there is no universal funding to cover the costs of IHP services within rheumatology settings. With the exception of salaried rheumatologists in some hospital-based settings, most rheumatologists receive reimbursement for their services from the Ontario Ministry of Health / Ontario Health Insurance Plan via fee-for-service payments for the services they provide. Ontario's current physician funding model does not support team-based, interdisciplinary rheumatology care, as rheumatologists can only submit billing claims for the services they individually provide. In the outpatient setting, services by non-physician health professionals (such as physiotherapists) are generally not covered by the provincial health insurance plan and must be paid for directly by the patient or through private insurance, with partial exceptions for individuals on social assistance or those over the age of 65. The main services that rheumatologist submit billing claims for are consultations and follow-up visits. In 2022, Ontario rheumatologists collectively received a total of $90 million in payments—averaging about $315,000 per physician across 285 rheumatologists[7]. Considering outpatient Ontario physicians typically incur overhead costs of approximately 30–35% of their gross billings (for expenses such as office rent, administrative staff, supplies, and other operational costs), and current pay scales for nurses, physiotherapists, pharmacists, and extended role providers range between $75,000 and $120,000, there is insufficient remuneration to cover the costs of hiring additional clinical staff. Presently, British Columbia (BC) and Quebec rheumatologists have a billing code to fund services for multi-/inter-disciplinary care ($230 per shared visit). Unfortunately, the BC funding is restricted to nurses supporting rheumatology care, community-based practices, and only individuals with selected diagnoses (systemic autoimmune

[7] ICES | Payments to Ontario Physicians from Ministry of Health and Long-Term Care Sources: Update 2005/06 to 2022/23

rheumatic diseases). Moreover, as physicians must perform part of the service to be able to bill for them, services rendered solely by the nurse are not compensated/reimbursed which minimizes optimizing the role of additional arthritis-trained IHPs.

Outside of the FFS funding model, IHP services within Ontario rheumatology practices are sparsely funded. Certain types of IHPs (such as physiotherapists) working in hospital-based outpatient settings are typically salaried employees funded by various mechanisms, which may include global hospital funding from the provincial government, grant-based funding from specific programs, or alternative payment plans (APPs) supporting interdisciplinary care. However, hospitals preferentially place arthritis-trained IHPs in orthopedic settings, where surgical wait times are tied to global budget payments. In community rheumatology practices, as IHPs are not funded by the OHIP, sustainable funding is further limited. Financial support often needs to be garnered through several different sources to adequately fund IHP costs. This may include time-limited grants, research studies, or pilot projects evaluating new models of integrated care, attempts to increase patient volumes to offset IHP costs, reliance on contributions from the Arthritis Society, and to a limited extent, alternative payment plans from Ontario Health that have recently been piloted. In 2021, Ontario Health funded the Centre of Arthritis Excellence (CArE) in Newmarket via an APP/bundled payment contract that is based off of the Family Health Team (FHT) funding model. CArE is an autonomous self-governing not-for-profit corporation with a Board of Directors. A contract and budget (including start-up and monthly payments) supports the model (IHP salaries and other operating expenses). Rheumatologists involved with CArE remain FFS. Separately, in 2023, Ontario Health has provided funding to support the “hub-and-spoke” model, where Advanced Clinical Practitioner in Arthritis Care-trained extended scope practitioners (ACPAC ESPs), based in core northern communities provide in-person rheumatological care, centralized triage, and virtual consultation in partnership with affiliated rheumatologists across southern Ontario. Thunder Bay was the initial pilot site, with ongoing efforts to expand to additional regional hubs in North Bay, Timmins, Sudbury and Sault Ste Marie. Although these recent investments represent improvements, the fragmented, patchwork funding for interdisciplinary rheumatology care undermines Canada's commitment to universal access, creating inequities in patient care and limiting the integration of essential healthcare providers.

Given the inconsistent nature in which IHPs are (un)funded in Ontario rheumatology settings, equitable, sustainable, dedicated funding remains a priority area of policy interest to resolve.

Key Considerations for Funding Reform

Before decision-makers can enact funding reform, several factors must be considered. Below are key considerations:

Legal Considerations

- IHPs providing care within rheumatology outpatient clinics are currently an uninsured service. The Ontario Medical Association (OMA) Physician's Guide to Uninsured Services simply defines uninsured services as "services which are not insured services". Selected uninsured medical services that are not covered by the OHIP may be charged directly to the patient (or third party)[8]. Physicians may be able to establish an Uninsured Services Program that can help raise practice revenue to offset unpaid work, without resorting to increasing daily patient volume to unmanageable service levels. The College of Physicians and Surgeons of Ontario outlines policies regarding uninsured services, mandating reasonable fees and that patients should be informed about these charges in advance. For example, family physicians may institute block fees that are "charged to patients to pay for the provision of one or more uninsured services from a predetermined set of services during a predetermined period of time."[9]. Additionally, the OMA provides a guide detailing appropriate billing practices for these uninsured services, ensuring transparency and fairness in physician billing.[10] However, the Canada Health Act (CHA), Commitment to the Future of Medicare Act, 2004 (CFMA), and Ontario Health Insurance Act prohibit charging patients for faster access to OHIP-insured healthcare services. The legal framework under the CHA defines and restricts two-tiered healthcare through key legislation that prohibits 1) extra-billing (charging patients for insured services beyond what the public plan covers); 2) user fees (charging for access to insured healthcare services); and 3) queue-jumping (allowing private payment for faster access to publicly insured services). The CFMA reinforces the CHA in Ontario by explicitly banning: 1) "two-tier medicine" (defined as allowing people to pay for faster access to OHIP-covered care); 2) paying for priority access (Section 17 states that no one can pay for expedited access to insured services); and 3) requiring payment for non-insured services as a condition for receiving OHIP services (e.g., bundling non-insured and insured services to bypass the law). This means that private payment for faster specialist visits that are already covered under OHIP is illegal. Since most IHP services in rheumatology clinics are currently uninsured, funding their role—particularly in facilitating faster access to rheumatologists—must comply with legal provisions. As a result, rheumatologists cannot take advantage of revenue-generating strategies, such as block fees, that are available to other physicians. Further, additional legal considerations pertain to different types of IHPs and practice settings. Physiotherapy services in hospital settings are defined under the CHA, where patients cannot be charged for either inpatient or outpatient physiotherapy care.

[8] Ontario Medical Association: Implementing an Uninsured Services Program – A Guide for Physicians
[9] Ontario Physicians and Surgeons: Uninsured Services: Billing and Block Fees.
[10] Ontario Medical Association: Physician's Guide to Uninsured Services A Guide for Ontario Physicians (January 2025 Edition)

- When physicians share infrastructure, resources, and personnel with other providers, several legal and regulatory frameworks may indirectly influence how overhead and service payments are structured and allocated among physicians in a group practice. These may include Contract Law (Partnership or Cost-Sharing Agreements), Canada Revenue Agency tax implications, and OHIP/Ministry of Health Policies (physicians practicing under Alternative Payment Plans may have overhead considerations outlined in their contracts with the government, and group registration with OHIP (e.g., obtaining a group number) may affect how payments are distributed among physicians. If funding is introduced for IHPs, practices which contain must physicians must determine who owns and controls the funds—whether payments flow to individual physicians, the group, or IHPs directly. If funds bypass physicians and go directly to IHPs, or the group (as an entity), additional tax implications for individual physicians are eliminated. Standardized agreements are needed to ensure transparent allocation of funds (for equitable cost sharing and services) among providers sharing a practice.

- Physicians who hire/work with IHPs and delegate tasks through medical directives must comply with several laws, standards and regulatory frameworks to ensure patient safety and appropriate delegation of controlled acts and physicians retain responsibility, accountability, and liability for delegated tasks. These laws include:
  - Regulated Health Professions Act, 1991 – Defines specific healthcare tasks that can only be performed by regulated professionals with the appropriate authorization);
  - Medicine Act, 1991 – Grants physicians the authority to delegate controlled acts/specific tasks);
  - Regulated Colleges (e.g., College of Physicians and Surgeons of Ontario, College of Nurses of Ontario, College of Physiotherapists of Ontario, etc.)– Outlines delegation and supervision requirements for physicians who authorize IHPs to perform controlled acts and requires that delegation be clearly documented through medical directives or direct orders;
  - Ontario Human Rights Code and Employment Standards Act – Ensures fair hiring practices, workplace rights, and appropriate compensation for healthcare providers.;
  - Public Hospitals Act (if in a hospital setting) - Governs how medical directives and delegation are structured in hospital environments and requires hospital credentialing and approval for non-physicians to perform certain tasks;
  - Personal Health Information Protection Act (PHIPA) – Outlines physicians' (data custodians of their electronic medical record system) responsibility in sharing/accessing/protecting personal health information with their agents—such as nurses and physiotherapists within the same clinic—for purposes consistent with providing healthcare.

  Thus, funding reform must account for physician liability pertaining to task delegation and medical directives.

- Additional factors can influence physician liability insurance coverage and costs. Most Canadian physicians receive professional liability protection from the Canadian Medical Protective Association (CMPA), where membership fees are based primarily on specialty, practice location, and risk profile. Currently, CMPA does not charge higher fees based on team size or task delegation, but future CMPA fee adjustments could arise. In private community practices,

rheumatologists who employ additional healthcare providers may require separate commercial liability coverage beyond CMPA for their employees. In contrast, those working in hospital settings or academic centers may be covered under institutional policies. Further, certain types of IHPs like registered physiotherapists are required to have their own Professional Liability Insurance, while others do not.

Practice Setting Considerations

- Hospital-based physicians benefit from greater institutional support and structured policies compared to independent community-based private practices. These advantages may include malpractice and liability coverage (previously noted), centralized administrative services (IT support, human resources, facility management, legal services) and streamlined processes for hiring and onboarding new care team members. Additionally, hospital settings offer standardized pay scales, and more competitive wages and benefits, making it easier to attract and retain IHPs[11]. To ensure the equitable implementation of interdisciplinary rheumatology care models, funding for IHPs must account for these practice setting differences, minimizing administrative burdens that could hinder adoption, and reducing the current pay disparity that currently exists (i.e. hospital-based IHPs receive higher wages than community counterparts).

- Rheumatology practices are not equitably distributed across Ontario and not all rheumatologists provide the same level of clinical service. Currently, many IHPs are also not equally distributed throughout Ontario. As rheumatologists cannot financially support separate secondary practice locations, outreach clinics may require additional financial resources to cover both infrastructure costs in addition to IHP costs. These regional setting differences may require tailored funding levels or sharing of resources across settings.

Considerations related to the diversity of AHP/IHPs

- Rheumatologists and the patients they serve have different needs for different types of IHP services (such as extended role providers who have advanced clinical training, nurses, physiotherapists, occupational therapists, pharmacists, social workers). Presently, most IHP disciplines/professions do not provide standard pay scales to inform standardized funding agreements, with the exception being the Ontario Nurses Association[12]. The Canadian Physiotherapy Association reports national wages[13,14] and the Ontario Physiotherapy Association publishes compensation reports[15] and fee guides[16] which all can inform funding remuneration models. To equitably fund team-based rheumatology care, funding levels should be tailored to reflect the specific needs and roles of the IHPs involved, their training, experience, and scope of practice.

[11] Association of Family Health Teams of Ontario. Ensuring Access to Primary Care: A Path Forward to Health Equity in Ontario (2025)
[12] Ontario Nurses Association. Compensation, Wages and Premiums: RN Salary Grid
[13] Canadian Physiotherapy Association: Physiotherapy Profession Profile: Key Insights
[14] Government of Canada. (2024) Job Bank. Wages: Physiotherapists in Canada
[15] Ontario Physiotherapy Association: Compensation Reports
[16] Ontario Physiotherapy Association: 2024 Physiotherapy Fee Guideline

Funding Considerations Based on Roles:

- Specialized Training & Certifications: IHPs with additional training and experience (e.g., Advanced Clinician Practitioner in Arthritis Care [ACPAC]-Trained Extended Role Practitioners, Pharmacists) may justify increased funding as they take on expanded roles in assessment, treatment, and patient education.
- Level of Autonomy: IHPs with independent prescribing, patient management, or procedural roles may require higher compensation.
- Equipment/Resources: Roles requiring specialized devices, tools (e.g., ultrasound, splints, infusion materials) may need additional operational funding.
- Caseload and Scope of Practice: IHPs seeing higher patient volumes or providing specialized roles may require increased compensation.

By adjusting funding levels based on these factors, Ontario can ensure fair and sustainable support for IHPs in rheumatology care.

Fee-For-Service (FFS), Non-FFS, and Shadow Billing Considerations

- Most rheumatologists in Ontario are funded through fee-for-service (FFS) payments, while a small number receive compensation for patient services through alternative funding arrangements (AFAs), alternative funding plans (AFPs), or alternative payment plans (APPs). Whether these rheumatologists funded under AFAs/AFPs/APPs can also bill the Ministry for services depends on the terms of their agreements, which has implications if funding for IHPs is only tied to rheumatology billing claims. Pediatric rheumatologists in hospital settings (and adult rheumatologists at Kingston Health Sciences Centre for example) are most likely to fall under these non-FFS models and would be excluded if IHP funding was solely linked to FFS billing codes. Physicians paid by APPs often shadow bill their patient encounters, meaning they submit claims for patient encounters without receiving direct payment. Shadow billing enables the Ministry to track service volumes, monitor compliance with contractual obligations, and support health system planning. However, physicians—whether submitting FFS or shadow billing claims—can only submit claims for services they personally provide. There are limited exceptions where a physician can directly bill or shadow bill for services performed by another provider under their supervision, depending on the type of service, the level of supervision, and OHIP billing rules. For APP-funded physicians, physicians can submit shadow claims for services provided by residents, fellows, or medical students under their supervision (as learners cannot submit billable claims independently). A physician can also shadow bill in their own name if they have formally delegated an approved insured service to another provider (e.g., a nurse or non-physician) under OHIP-recognized direct physician oversight (and remain available for immediate consultation and retain overall responsibility for patient care); or when a physician is responsible for supervising or interpreting a procedure, they may submit a shadow claim even if another provider carries out the technical components. For FFS compensated physicians, physicians can bill OHIP for certain delegated procedures performed by non-physician employees under their supervision (e.g., nurses or other healthcare providers who are properly trained to perform the procedure) provided that the physician assumes full responsibility for

the service and meets OHIP's delegation requirements. Unfortunately, as rheumatologists are non-procedural specialists, they are disadvantaged by OHIP's procedure delegation policy and cannot recover costs associated with tasks completed by their non-physician employees as "assessments, counselling, therapy, consultations" cannot be delegated to a non-physician for OHIP payment purposes.[17] If an ultrasound is performed by a trained sonographer (who is an employee of the radiologist) and the radiologist is permitted to bill OHIP for this delegated task, rheumatologists should be similarly compensated if they employ a similarly qualified healthcare professional to conduct an advanced musculoskeletal assessment. Amending OHIP's delegation policy to be inclusive of additional services beyond technical procedures is an important consideration for equity in reimbursement practices. However, in team-based models where most patient encounters involve both the rheumatologist and an IHP (on the same visit), amending OHIP's task delegation policy alone would not provide financial benefit, as the rheumatologist is already submitting claims for the encounter.

- If IHP funding is provided in an alternative payment plan funding model that bundles the reimbursement costs of the IHP services in regular installments, shadow billing of IHP services may also be relevant for rheumatologists who are compensated under both FFS and APPs. In this bundled payment model scenario, rheumatologists can continue to directly bill FFS or shadow bill for their individual claims, but could shadow bill for the services rendered by their IHP(s) that are under their supervision and the shadow billing claims track patient encounters without generating additional payments for the physician and help monitor service utilization, while ensuring transparency and accountability of compensation agreements. For this to work, a new OHIP fee code (with a $0 fee) would need to be implemented. If IHP funding is provided in an alternative payment plan that supports a group of rheumatologists, each individual rheumatologist could shadow bill for any service that an IHP provided to their individual patients under their supervision, enabling the monitoring of patient services and funding shared across rheumatologists. For this to work, rheumatologists would need to register for an OHIP group ID[18] and provide it along with their individual OHIP billing number when submitting claims.
- It should also be noted that the Ministry of Health currently does not mandate shadow billing for all healthcare settings under alternative payment models (e.g. Aboriginal Health Access Centres, Nurse Practitioner-Led Clinics, and Community Health Centres). Instead of shadow billing, these organizations collect and report service volumes and patient data through alternative accountability mechanisms (e.g., performance indicators, reporting to Ontario Health or the MOH). However, funding for IHPs in rheumatology settings that requires or mandates additional reporting requirements may hinder adoption. If reporting is not embedded in the healthcare system (e.g. OHIP billing claims), it also hinders overall population evaluation efforts to monitor the effectiveness of the implementation strategy such as monitoring population access to rheumatology care and other patient and health system outcomes.

[17] OMA: OHIP Payments for Delegated Procedures: Quick Reference Guide (2020)
[18] OHIP Group Registration: https://www.ontario.ca/page/ohip-billing-number-registration#section-1

Considerations on Administration of Funds

There are several funding models and *mechanisms* for administering funds to support IHPs in rheumatology practices. Below are five overarching funding administration strategies, along with key health policy legislation and processes that must be considered and addressed to operationalize funding agreements in both hospital-based and community rheumatology settings. Additional considerations are highlighted to align potential funding models with Ontario's Transparent and Accountable Health Care Act, 2023, which promotes transparency, accountability and the development of standardized funding models to ensure equitable resource distribution and consistent care quality.

1. Hospital-Based Administration – In this model, funds are allocated to hospitals, which manage and distribute them to support IHPs in rheumatology divisions or hospital-based rheumatology practices.
   - Hospitals are an unlikely source for sustainable funding for IHPs in rheumatology hospital-based practices, but they may support funding administration. Ontario hospitals receive funding primarily through global budgets, which are fixed annual allocations from the Ministry of Health. The Canadian federal government does not directly mandate how provinces or provincially-funded hospitals allocate funding within hospitals, but it can influence hospital funding decisions through conditional health transfers and bilateral agreements for specific priorities (i.e. additional funds tied to advance specific health sectors, clinical areas, or performance indicators - such that it pressures provincial government to prioritize these areas). Hospital global budgets are determined based on factors such as historical funding levels, hospital size, and the populations served, including patient volume and quality metrics (related to specific procedures and efficiency). Once funding is allocated, hospitals have the autonomy to distribute these funds internally to various departments and services, guided by strategic priorities and operational needs. This internal allocation process, primarily governed by the Public Hospitals Act, is overseen by hospital administration and internal policies to ensure alignment with patient care objectives and organizational goals. While hospitals have some discretion in how funds are spent, the provincial government can establish earmarked or restricted funding for specific services. Prior examples include dedicated mental health and addictions funding, and targeted funding for rapid access clinics for orthopedics (hip/knee/lower back pain), where hospitals must use these funds as directed or risk claw-backs. Unless the Ministry of Health specifically earmarks funding for IHPs for rheumatology care, securing IHP funding within existing global budgets would require individual advocacy and negotiation with each hospital to access discretionary funds in the global budgets. Alternatively, through the Connecting Care Act, 2019, Ontario Health can allocate funds directly to hospitals (or physicians in hospital settings) for specific initiatives. Working with Ontario Health to establish a standardized funding model for which hospitals/hospital-based rheumatologists could apply for funding of IHP(s) is a more likely viable option. Ontario Health already has an established funding mechanism to support IHPs in outpatient orthopedic hospital settings, thus, the structure and funding agreements could be leveraged for hospital-based rheumatology settings. Furthermore, Ontario Health now has a pilot funding mechanism to support IHPs

working in a rheumatology 'hub-and-spoke' model which could be expanded to include settings where both rheumatologists and IHPs provide care in the same local setting. Thus, as Ontario Health has the authority to allocate and distribute funds directly to hospitals for specific initiatives, hospitals in-turn could distribute this funding to support IHP costs in hospital-based adult and pediatric rheumatology settings. Alternatively, if IHP services are tied to an OHIP FFS fee code, hospitals support rheumatologists at their institutions as they often submit billing claims on their behalf, in which reimbursement is deposited into the rheumatology practice pan which get distributed to the rheumatologist as part of their compensation. The reimbursement costs associated with IHPs on these billing claims could then be distributed to fund the IHPs at these institutions. In general, rheumatologists may benefit by involving hospitals in administering funds in order to reduce the administrative burden on physicians (e.g. administering payroll) but rheumatologists may have limited control and autonomy in hiring, workload allocation, and scope of practice. However, any funding scenario involving hospital disbursement of funding to IHPs would only benefit hospital-based practices.

Appendix A includes a list of Ontario Hospitals with rheumatology practices that could potentially benefit from this funding administration model.

2. Physician-Directed Funding and Administration– In this model, individual rheumatologists receive and allocate funds to support IHPs for work in their individual rheumatology clinics. Most physicians operate as independent contractors rather than employees of the government or hospitals (except in some salaried roles, such as hospital-based alternative payment plans). Physicians bill OHIP for services rendered to patients but are responsible for managing their own business expenses. Many physicians establish Medicine Professional Corporations (MPCs) to manage their practice finances. An MPC allows physicians to receive income, pay staff, and cover operational expenses. Whether an individual rheumatologist was to receive funding for IHPs via FFS payments (if a new fee code was implemented) or via an alternative payment model, they would have the capacity to administer payment to IHPs via their MPCs. Advantages of rheumatologists administering funding to IHPs include greater autonomy in hiring, workload allocation, and scope of practice. Disadvantages include increased administrative burden on rheumatologists to manage hiring, payroll, compliance, and liability. IHP funds provided in installments via an alternative payment plan (APP) would likely minimize potential financial risk of rheumatologists employing IHPs over OHIP FFS payments that are tied to rheumatologists' patient volume. To minimize the administration burden, implementation strategies need to involve standardizing funding models and contracts, policies and processes to support hiring and retention.

3. Group-Based Funding and Administration – In this model, a group of rheumatologists jointly administers funds to support IHP(s) and their services that are being shared across rheumatologists who are jointly overseeing supervision of the IHP(s). Many Ontario rheumatologists share a practice location, sharing facilities (e.g., lease, exam rooms, waiting room), other resources/operating expenses/consumables (e.g., wifi, janitorial services, office supplies, medical supplies/equipment), staff (administrative and clinical), and electronic medical record (EMR) systems. A group of physicians may establish a group-based

medical corporation to handle their financial affairs, as it may be beneficial for tax and financial management purposes. Alternatively, the group of physicians may establish a not-for-profit corporation to oversee disbursements of IHP funding, and then the affiliated physician group does not need to form a group-based medical corporation unless they choose to do so for financial and tax efficiency. Whether the individual rheumatologists in the group receive funding for IHPs via FFS payments (if a new fee code was implemented) or via an alternative payment model (that funds the collective group practice), they could then participate in group-based administration of funds. Advantages for group-based funding and administration includes sharing administrative responsibilities to reduce individual burden, supporting interdisciplinary team-based models in larger clinics or networks, and supporting more sustainable and equitable distribution of resources among multiple providers (considering there are limited numbers of arthritis-trained IHPs). Considerations for implementation strategies if multiple rheumatologists co-administer IHP funding include formal cost-sharing agreements among rheumatologists on fund allocation and governance, and processes to support financial accountability and minimize conflicts over decision-making and resource distribution.

4. Non-Profit Administration – In this model, funds are managed by a non-profit organization that administers funds to support IHPs and their services in rheumatology settings. In Ontario, several healthcare services and clinics must establish a non-profit organization to receive public funding and administer funding for clinical staff and operations. Examples include Nurse Practitioner-Led Clinics (NPLCs) – where clinicians may act as consultants to oversee the clinic; Community Health Centres (CHCs) – where clinicians and IHPs are salaried employees; Aboriginal Health Access Centres and Mental Health and Addictions Clinics where funding may come from multiple sources (MOH, Ministry of Indigenous Affairs, Ontario Health, or Local Ontario Health Teams); and Specialized Chronic Disease and Integrated Care Clinics/Programs, such as The Arthritis Society's Arthritis Rehabilitation and Education Program, diabetes education centres at Ontario hospitals (e.g North York General Hospital's multidisciplinary diabetes care program funded by the MOH and Ontario Health Team funding), and the Centre of Arthritis Excellence (CArE) – an interdisciplinary model of rheumatology care that includes IHPs and patient education programs funded by Ontario Health, and the physicians are FFS and receive a consultant stipend to oversee the clinic/team.
   Establishing a non-profit organization involves the clinic/program being incorporated as a non-profit corporation under the Ontario Not-for-Profit Corporations Act, establishing a board of directors, bylaws governing operations, submitting a business case/proposal with advocacy and community partnerships to secure funding and entering into Service Accountability Agreements with Ontario Health to formalize funding and service delivery expectations. The clinic/program would need to establish a financial management system to administer government funds and ensure transparency, comply with Ontario's Health Protection and Promotion Act and the Connecting Care Act, 2019, OHIP billing rules (if applicable), establish policies for data security, patient privacy (PHIPA – Personal Health Information Protection Act), and clinical governance. The clinic/program may also require insurance and liability coverage for clinical staff and organizational operations.

Advantages of this funding model is that it may reduce financial liability for individual physicians, provides an independent, neutral structure for fund management, and ensures accountability and transparency in resource allocation. Disadvantages included the additional administrative costs and complexity, and additional reporting obligations if clinical services are not integrated into OHIP billing interactions (e.g. if shadow billing for IHP services is not mandated separately).

5. Direct Payment to IHPs – In this model, IHPs receive funding directly from the Ministry of Health through alternative payment arrangements or fee-for-service billing, and the rheumatologists are not involved in administration. This model would likely be restricted to certain types of regulated IHPs with advanced arthritis clinical training (competency-based) for the Ministry to consider funding, such as Advanced Clinical Practitioner in Arthritis Care (ACPAC)-trained Extended Role/Scope Practitioners (ERPs/ESPs). A comparable example is midwifery funding in Ontario, where midwives are paid directly by the Ministry on a per-course-of-care basis rather than per visit or per hour. Since midwives do not bill OHIP for individual services but instead receive funding through a global budget system, a similar funding structure would need to be developed for ACPAC ESPs in rheumatology care. This would require the provincial government establishing a dedicated global budget for these services, with defined costs per course of care, which may need to be tailored based on the basket of services the ACPAC ESPs provide at different clinics. Like midwives who hold hospital privileges to attend births in hospitals (but are not hospital employees), ACPAC ESPs could be granted privileges to provide care in designated rheumatology clinics, under a Ministry-funded agreement, or a tripartite agreement involving the rheumatologist(s), MOH, and the ACPAC-ESP. While ACPAC ESPs could have the option to establish private practices, their advanced practitioner role necessitates medical delegation from a supervising rheumatologist, who also supports their continuing medical education. Given that the Ministry provides operating funding for Midwifery Practice Groups to cover overhead costs, additional funding should be considered to offset the expenses incurred by rheumatologists who integrate ACPAC ESPs into their practices and invest in their ongoing education and supervision. A key challenge with this model is tracking services provided by IHPs, since payments would not be integrated into OHIP billing data or linked to a supervising rheumatologist or group for post-implementation monitoring. Potential solutions include introducing an OHIP shadow billing fee code to track ACPAC ESP services within a rheumatologist's patient population; or allocating additional overhead funding directly to rheumatologist's OHIP billing number where ACPAC ESPs are active.
An alternative model involves the Ministry granting OHIP-billing privileges to ACPAC ESPs. This would require establishing clear billing structures and integrating them into the existing payment system and implementing new fee codes related to IHP patient assessments. However, FFS-based funding may not be the ideal model considering the types of care ESPs provide, and a FFS system typically incentivizes patient volume over comprehensive, interdisciplinary care. Additionally, concerns about duplicate billing (e.g., both the rheumatologist and the ACPAC ESP billing for the same patient and same day) could trigger clawbacks on rheumatology billing codes, including fee premiums. Additional OHIP-funding may be possible if ACPAC ESPs are designated under OHIP Specialty Code 85, which already

exists for 'Alternate Health Professionals' which include selected types of audiologists, speech-language pathologists, respiratory therapists, registered dietitians, orthoptists, chiropodists, podiatrists, and physiotherapists and occupational therapists working in approved health care settings under authorized OHIP-funded programs[19]. Non-physician regulated health professionals under OHIP Specialty Code 85 (Alternate Health Professionals) do not have independent OHIP billing privileges like physicians. Instead, they access OHIP funding through specific mechanisms based on their practice setting, the type of service provided, and the funding structure in place. Key considerations for OHIP Specialty Code 85 is that it does not grant independent OHIP billing privileges to permit these professionals to submit claims individually; rather claims are submitted by an OHIP-funded institution, such as a hospital, community clinic, or Ontario Health-funded program, and the billing is typically linked to a supervising physician or facility – and in some cases, services may be billed under a physician's OHIP number (e.g., through delegation rules) or as part of a bundled payment system. Similar structures are in place related to the use of OHIP Specialty Code 81 (Physiotherapy) which may be used in designated physiotherapy clinics and hospitals for OHIP-funded physiotherapy services where the clinic, hospital, or an affiliated physician submits claims to OHIP, not individual physiotherapists. This also only applies to physiotherapy services covered under community physiotherapy clinic funding agreements and certain hospital outpatient programs. Once OHIP reimbursement is received, the funds are discharged to the IHP.

Overall advantages of funds being directly administered to ACPAC ESPs may help reduce administrative burden on rheumatologists and improve recruitment and retention of IHPs by offering more stable funding. However, to ensure ACPAC ESPs remain embedded in rheumatology services rather than shifting to primary care or orthopedic settings, policies must address shared overhead costs of rheumatologists sharing their practices with ACPAC ESPs, clear clinic role definitions and delegation agreements, and incentives for interdisciplinary collaboration within rheumatology practices.

Finally, as this funding model only addresses one type of IHP (ACPAC ESPs), additional sustainable funding models are needed to equitably fund and support other types of IHPs beneficial to rheumatology care.

[19] Ontario Ministry of Health. Specialty Codes - Ontario Health Insurance Plan (2024)

Existing Funding Programs that Could be Expanded

Expanding and adapting existing funding programs in Ontario may be the most practical and efficient approach to feasibility establish funding for IHP services in rheumatology programs. Three potential strategies include integrating the Community Physiotherapy Clinic Program (CPCP) into rheumatology practices, expanding the OHIP fee-for-service (FFS) billing system to cover IHP services, and utilizing Ontario Health's alternative payment plans (specifically expanding the Family Health Funding Model to outpatient specialists- i.e. rheumatologists). The following discussion outlines the rationale and considerations needed to advance these options.

1. Embed Community Physiotherapy Clinic Programs (CPCP) into rheumatology practices.

Ontario physiotherapists lost OHIP billing privileges in 2004, which significantly altered how physiotherapy services were delivered and compensated within the provincial healthcare system. The CPCP model was introduced in 2013 as a way to address access issues that arose after physiotherapists lost their OHIP billing privileges[20]. The CPCP program was designed to provide publicly funded physiotherapy services to Ontario residents in community-based settings, including physiotherapy services for people who did not qualify for services in hospitals but still needed physiotherapy for rehabilitation, musculoskeletal conditions, and other chronic issues. According to Publicly-funded physiotherapy - clinic locations, there are currently 256 CPCP locations. For patients to be eligible for publicly-funded physiotherapy in Ontario's CPCP, they must have a valid Ontario health card and fall into one of the following categories: be 65 years or older, 19 years or younger, or any age after an overnight hospital stay or outpatient/day surgery for a condition requiring physiotherapy, or be a recipient of Ontario Works or the Ontario Disability Support Program. In 2024, several changes have been made to the CPCP including removing the requirement for a referral from a primary care provider, allowing virtual care services (to align with the College of Physiotherapists of Ontario standards), and allowance of concurrent and consecutive Episodes of Care (EOC)[21]. Funding for physiotherapy clinics in Ontario is based on an Episode of Care model where funding covers an entire course of treatment instead of individual visits. An Episode of Care refers to all clinically-related health services used to treat one patient who has been diagnosed with distinct conditions arising from injury or health-related issues. An Episode of Care lasts from the physiotherapist's assessment and diagnosis of the symptoms, and the delivery of treatment until the patient has reached their goals as indicated by the treatment plan and is discharged. OHIP has negotiated to pay clinics $312 per patient "Episode of Care". An EOC must not be provided concurrently with any other funding source, such as WSIB and automotive or extended health insurance. Historically, patients were limited to one Episode of Care per condition, meaning they could not receive concurrent (at the same time) or consecutive (back-to-back) episodes for the same diagnosis. Recent changes have introduced greater flexibility, including the allowance for multiple Episodes of Care in certain circumstances. As a result, embedding CPCPs within rheumatology sites may now represent a viable funding model for

[20] Expanding Community Physiotherapy Clinic Services
[21] OHIP Bulletin: Community Physiotherapy Clinic Program Changes

these rheumatology practices wishing to integrate physiotherapists (or physiotherapists with ACPAC training). A physiotherapist working in this context under the CPCP model would operate differently compared to traditional CPCP roles as the physiotherapist would be supporting team-based care as opposed to working independently.

2. Expand the OHIP fee-for-service (FFS) billing system to reimburse rheumatologists for IHP services in their practices.

Adding new fee codes to the OHIP Schedule of Benefits and Fees is a multi-step process that involves multiple special interest groups, including the Ontario Rheumatology Association (ORA), the Ontario Medical Association (OMA), and the Ministry of Health (MOH). A proposal must be submitted to the OMA-MOH Physician Payment Committee which evaluates new fee code proposals. The proposal typically includes a description of the service, justification for why a new fee code is needed, and supporting evidence (which may include an economic impact analysis). If the Physician Payment Committee approves the proposal, then OHIP funds already designated for rheumatology may be allocated to cover the new fee code. This assumes that a portion of fee increases allocated to rheumatology would be invested in such a new fee code. In a scenario where the rheumatology global funds available for physician payments are not increasing, the money for new fee codes may have to be taken from existing fee codes. Alternatively, proposals for IHP funding could be submitted to the OMA's Negotiations Task Force, which negotiates with the MOH as part of broader physician services agreement discussions. The joint OMA-MOH Physicians Services Committee may also become involved as it co-manages the physician-involved aspects of the health care system. Once the Physicians Payment Committee approves the implementation of new fee code(s), the new fee code is formally added to the OHIP Schedule of Benefits and Fees, and the MOH communicates changes through official updates, bulletins, and the OHIP Claims Manual. Generally, the OMA and specialty interest groups (e.g. ORA) educate physicians on how to properly bill using the new fee code and billing audits may be conducted to ensure compliance with OHIP regulations. The OMA and the MOH typically renegotiate the OHIP Schedule of Benefits as part of broader physician services agreements every four years. These negotiations cover physician compensation, including updates to existing fee codes and the introduction of new ones. Interim changes to the OHIP Schedule of Benefits can be made outside the formal negotiation cycle. These changes may occur through ongoing bilateral discussions based on emerging needs, new medical evidence, or system priorities; Specialty groups can also propose new fee codes or modifications, which go through a similar approval process involving clinical and financial assessments; The MOH may also introduce adjustments in response to policy shifts, healthcare system demands, or budget considerations.

3. Expand Ontario Health's alternative payment plan funding models (i.e. Primary Health Team Funding Model) to rheumatologists

Ontario Health is currently funding interdisciplinary models of rheumatology care at a few locations via alternative payment plans (bundled payments to support IHP salaries and other operating expenses). Ontario Health also currently administers a range of alternative payment plan (APP) models designed to support interdisciplinary, team-based care, most prominently within primary care (e.g., Family Health Teams). These models provide bundled, team-based funding that supports salaries for IHPs, administrative staff, and practice infrastructure—allowing clinicians to deliver coordinated, comprehensive care without relying solely on fee-for-service billing.

Expanding an APP model to include outpatient specialist practices, such as rheumatology, represents a promising strategy to support team-based Rheumatology Health Teams. A "Specialist Health Team Funding Model" or an extension of the existing Family Health Team funding framework could enable rheumatologists to integrate IHPs (e.g., ACPAC-trained physiotherapists, occupational therapists, other types of IHPs such as nurses, social workers, pharmacists) through stable, dedicated, and predictable funding.

Under such a model, rheumatologists would receive a team-based funding envelope tied to defined population needs, scope of services, and performance expectations. Funding could flow directly to specialist-led clinics via Ontario Health, similar to other community-based primary care teams (which have similar operational needs). This approach would:

- Support recruitment and retention of specialized IHPs
- Enable collaborative care models that improve access and quality
- Reduce reliance on episodic, fragmented funding structures
- Provide flexibility in how services are organized and delivered
- Align with Ontario's broader system direction toward integrated, team-based care

Adapting existing APP frameworks would require collaboration between Ontario Health, the Ministry of Health, the Ontario Medical Association, and specialty groups (e.g., Ontario Rheumatology Association). Key considerations include defining eligibility criteria, determining funding formulas, establishing accountability and reporting mechanisms, and ensuring alignment with existing compensation arrangements for specialists.

Expanding APPs to rheumatology has the potential to create a scalable, sustainable mechanism for delivering high-quality team-based arthritis care across Ontario.

Other Implementation Considerations

Even with a funding resolution to support IHPs in rheumatology settings, several additional system enablers are needed to ensure effective, scalable, and sustainable implementation of team-based rheumatology care.

1. **Strengthening and Sustaining IHP Training Programs**: A critical enabler of team-based rheumatology care is the availability of adequately trained IHPs, yet Canada currently has limited training capacity for arthritis-focused providers. Expanding team-based funding must be accompanied by investment in workforce development, including stable funding to grow and sustain specialized training pathways.

   ### Current Training Pathways

   There are only a small number of training programs in Canada

   - The Arthritis Society Canada offers a short introductory 5-day course on 'Clinical Practice Skills for Inflammatory Arthritis' where participants who complete all program requirements receive a Certificate of Program Completion issued by Arthritis Society Canada. While valuable, this course provides only an initial level of training and does not fully prepare IHPs for advanced roles within rheumatology teams.
   - The Advanced Clinician Practitioner in Arthritis Care (ACPAC) training program is a unique, interprofessional, clinical, and academic training program currently offered for physical therapists, occupational therapists, chiropractors and nurses experienced in the musculoskeletal field. It is a post-licensure program offered through the Department of Continuing Professional Development, Faculty of Medicine, at The University of Toronto, Canada. The ACPAC program is offered principally at two main academic health care centers – St Michael's Hospital (adult) and the Hospital for Sick Children (pediatric), but additionally relies upon a broad network of health care (community and academic) institutions and involves over 90 faculty. The vision for the ACPAC program, including competency development, was formulated under the leadership of two academic rheumatologists (the adult and pediatric medical directors) and a physical therapist with a PhD in bone pathophysiology (program director) all of whom have worked collaboratively to direct and coordinate the program since its inception. The focus of the ACPAC program is on the assessment, diagnosis, triage, and independent but collaborative management of select MSK and arthritis-related disorders.

   ### Challenges and Needs

   - With limited training programs, the current training volume falls short of the level required to meaningfully address workforce shortages and currently limit the scale at which new IHPs can be trained each year. To achieve meaningful and sustainable workforce expansion and support ongoing training development, there is a need to ensure these valuable programs have sustainable funding to support program

operations, faculty time, clinical placements, and trainee support (e.g. tuition subsidies).

***The Canadian Rheumatology Implementation Science Team is evaluating this key enabler as part of ongoing evaluations.

2. Developing a Data and Evaluation Framework:

To ensure that investments in team-based rheumatology care lead to meaningful improvements in access, quality, and system efficiency, a robust data and evaluation framework is essential. Establishing standardized performance metrics will enable Ontario to monitor progress, demonstrate value, and guide continuous improvement across rheumatology practices implementing interdisciplinary team models.

A comprehensive evaluation framework may need to include domains that encompass:

1) Patient Outcomes and Experience: Measuring clinical and patient-reported outcomes ensures that team-based care is improving the health and well-being of people living with arthritis and other rheumatic diseases. Measuring experience through timeliness of care (e.g., wait times for assessment and follow-up), satisfaction with team-based care, and equity metrics (e.g., access by geography, socioeconomic status, other important groups).
2) Healthcare Utilization and System-Level Impact: Evaluating changes in utilization patterns will help determine whether team-based care is improving efficiency and reducing downstream system costs. Metrics may include: Emergency department visits and hospitalizations for rheumatic disease, other healthcare utilization (medication, diagnostics), improved triage, continuity of Care, integration of services.
3) Provider Experience and Workforce Sustainability: Team-based models are intended to enhance provider capacity, reduce burnout, and support more satisfying and sustainable practice patterns. Monitoring provider satisfaction, well-being, and other experiences may be important to consider.
4) Implementation and Fidelity Measures: To understand how team-based models are being adopted, the framework should also track the degree of implementation across settings (e.g., which IHP roles are deployed and how), variability in team configurations, adherence to care pathways, or barriers and facilitators encountered during roll-out.
5) Data Infrastructure and Reporting: Reliable data sources and standardized reporting processes are important to evaluate implementation and impact. Key considerations include: leveraging existing health administrative data where possible, supporting practices to collect PROMs and clinical data consistently within EMRs, supporting clinical dashboards or reporting templates, or establishing expectations for data submission as part of team-based funding agreements

Establishing an evaluation framework will help to support funding negotiations at inception, but also generate the evidence needed post-implementation to demonstrate impact, refine the model over time, and support ongoing policy and funding decisions. Without clear metrics

and reliable data collection, the system will be unable to assess value or scale effectively. Moreover, practice-level metrics – to guide continuous learnings and improvements overtime – are needed.

***The Canadian Rheumatology Implementation Science Team is supporting the development of this evaluation framework.

3. Mobilizing Implementation Strategies:

Developing and mobilizing a coordinated suite of implementation strategies and resources is needed to ensure that funding is used effectively, leading to high-functioning Rheumatology Health Teams that improve patient outcomes, enhance provider experience, optimize practice operations, and long-term system value. Without these supports, practices may struggle to operationalize team-based models, limiting the impact of funding investments.

A structured set of implementation strategies—developed in collaboration with rheumatologists, IHPs, and health system partners—can strengthen readiness, mitigate operational barriers, and promote consistent and equitable delivery of team-based care across Ontario.

Key areas for mobilizing implementation strategies include: practice readiness and change management support (to enable clinics to transition smoothly and avoid disruptions to patient care); operational tools to enhance efficiency and standardization (to ensure teams function effectively, training and care delivery consistency, and maximize the value of IHPs); leadership and governance (for rheumatologists to confidently supervise and collaborate with new IHP roles; resources for logistical, administrative, and medico-legal support; and sustainability supports, continuous learning, and resources for monitoring and evaluating implementation progress and ongoing model improvements.

***The Canadian Rheumatology Implementation Science Team is supporting the development of these implementation resources.

Summary and Next Steps

In summary, Ontario faces a growing burden of rheumatic diseases, with increasing demand for rheumatology services and the rheumatology workforce cannot sustainably support population needs. A more sustainable healthcare system must prioritize investments that strengthen rheumatology workforce capacity through integrated, interdisciplinary care models. The integration of IHPs in rheumatology practices has been shown to improve patient outcomes, enhance efficiency, and optimize specialist capacity. However, existing physician funding models do not adequately support AHP integration. This policy brief identifies funding solutions that support the integration of IHPs into rheumatology practices in Ontario. Funding reform must navigate legal constraints, practice differences, IHP types/roles, and billing policies to ensure sustainable and equitable support for interdisciplinary rheumatology care. Several models exist for funding and administering payments for IHP services in Ontario rheumatology settings and there is no single funding solution that addresses all needs. A summary of funding options include:

- Hospital-based administration only benefits rheumatologists with practices in hospital settings and involves allocating funds to hospitals, which distribute them internally; however, this model depends on Ministry-directed earmarked funding, with Ontario Health offering potential funding avenues.
- Physician-directed funding (via additional OHIP FFS payments or bundled payments) allows individual rheumatologists to manage funds, providing autonomy but increasing administrative burden.
- Group-based funding enables rheumatologists to establish a group of rheumatologists to jointly administer and share IHP funding and services, offering efficiency and sustainability but requires governance structures.
- Non-profit administration involves rheumatologists establishing a non-profit entity to manage IHP funding, ensuring accountability but adding complexity.
- Direct payment to IHPs—via a bundled care or FFS model or alternate FFS arrangement—would provide financial stability but requires new billing structures and policies to integrate IHP services within rheumatology care.
- Changes to consider to OHIP include expanding OHIP's delegation policy to allow rheumatologists to bill for IHP-provided assessments, and implementing a dedicated fee code for reimbursing rheumatologists for IHP services provided in their practices.
- Establishing standardized funding agreements under blended payment models would enable individual rheumatologists or group practices to receive IHP funding through alternative payment plans, like Family Health Teams. To improve accountability and reduce administrative burden on reporting requirements, OHIP shadow billing could be integrated for rheumatologists receiving IHP funding, along with a specific shadow billing code to track IHP services in bundled funding models.

- A global budget system could be introduced to support ACPAC-trained Extended Role Practitioners with designated clinic privileges, alongside new rheumatology OHIP billing codes for other types of IHPs.
- Embedding Community Physiotherapy Clinic Programs into rheumatology settings and expanding OHIP eligibility to cover all patient demographics for these services would further improve access to care.

These options aim to strengthen funding structures, expand access to care, and integrate IHPs into interdisciplinary rheumatology care models in a more effective and sustainable way. However, not all funding options are equally viable, and the Ontario Rheumatology Association does not currently endorse these funding models to the same degree. The most feasible and sustainable options are now being prioritized for further assessment. A clear set of recommendations—along with a costed program proposal—is currently under development and will be shared in the next stage of this work.

Furthermore, even with dedicated funding for IHP roles, additional system-level and practice-level implementation strategies are required to ensure that team-based rheumatology care is adopted successfully and can be scaled across Ontario.

The Ontario Rheumatology Association and the Canadian Rheumatology Implementation Science Team are actively assessing these funding options and co-developing the implementation tools and resources needed to support practice transformation.

We welcome input from special interest groups and individuals. Feedback and ongoing dialogue will be incorporated into the next Policy Report.

Appendix A

List of Hospitals with Rheumatology Practices

Municipality	Hospital Name	Hospital Type
Brockville	Brockville General Hospital	Community
Carleton Place	Carleton Place and District Memorial Hospital	Community
Hamilton	Hamilton Health Sci - Juravinski Hospital and Cancer Centre	Teaching
Hamilton	Hamilton Health Sci - McMaster University Medical Centre	Teaching
Hamilton	St Joe's Hamilton - Charlton Campus	Teaching
Kingston	Kingston Health Sci - Hotel Dieu Hospital	Teaching
Kingston	Kingston Health Sci - Kingston General Hospital	Teaching
London	London Health Sci - Children's Hospital	Teaching
London	St Joe's London - St. Joseph's Hospital	Teaching
Mississauga	Trillium - Credit Valley Hospital	Teaching
North York	NYGH - General Site	Teaching
Oakville	Oakville Trafalgar Memorial Hospital	Community
Ottawa	Children's Hospital of Eastern Ontario-Ottawa Children's Treatment Centre	Teaching
Ottawa	The Ottawa Hospital - Riverside Campus	Teaching
Sault Ste. Marie	Sault Area Hospital	Community
Thunder Bay	St. Joseph's Hospital	Community
Toronto	SickKids	Teaching
Toronto	Sinai - Mount Sinai Hospital	Teaching
Toronto	Sunnybrook - Bayview Campus	Teaching
Toronto	UHN - Toronto General Hospital	Teaching
Toronto	UHN - Toronto Western Hospital	Teaching
Toronto	Unity Health - St. Joseph's Health Centre	Teaching
Toronto	Unity Health - St. Michael's Hospital	Teaching
Toronto	Women's College Hospital	Teaching
Vaughan	Mackenzie - Cortellucci Vaughan Hospital	Community