Dr. Sharron Sandhu – ACR 2015

Firstly, I would like to thank the Ontario Rheumatology Association for funding me to attend the recent ACR 2015 in San Francisco. Among the sessions I attended included sessions dealing with the following pillars of ORA

1) Advocacy and Awareness
2) Research
3) Models of Care

1) Advocacy

Whilst the advocacy sessions at The ACR were targeted towards the US healthcare system(s), they did provide some insights that could be generalizable.

In a session on State Advocacy, California State Assemblyman David Chu discussed price transparency of new drugs. He described his attempt to pass legislation in his home state requiring makers of expensive specialty drugs (costing> $10000pa) to reveal their actual expenditure on research and development of the drug as well as marketing costs, and to disclose the amount of government funding received in development of the drug.

In a Government Affairs session (*Advocacy Training: How –to From a US Senator*), Senator Tim Hutchinson discussed the importance of grassroots involvement by ACR members and gave examples of successful advocacy. He encouraged doctors not to stand at the sidelines of policy making but to get involved in public policy so that their voices could be heard.

Both speakers also touched on the involvement of ACR in the Coalition for Accessible Treatments (made up of 2 dozen health care organizations), to advocate for insurance companies to adopt a fair and reasonable approach to handling new drugs fro treatment of a number of diseases including Rheumatoid Arthritis. As part of this, the ACR is supporting the Patient's Access to Treatment Act, which would stop insurers from replacing current fixed-cost co-pays with percentage charges, when it comes to specialty drugs, including biologics.

Key Points:

- The proposed legislative changes in US states towards greater pharmaceutical transparency may be a strategy the ORA and provincial government could collaborate on in an effort to improve pricing and therefore access to expensive drugs.
- ORA is already working with CLHIA towards a pan Canadian criteria for biologic therapy. Whilst the challenges in the US are different, collaboration with the Coalition for Accessible Treatments, perhaps from a "lessons learned" perspective might be helpful.

2) Research

The ACR coincided with 2015 ACR guidelines for the treatment of RA being released. Some key differences in this update on the 2012 guidelines include the addition of Tofacitinib and corticosteroids. They also provide recommendations on how to taper or discontinue medication in patients in low disease activity / remission, recommendations on treatment of RA in high risk populations and on vaccination use. There were no recommendations on management of RA in pregnancy and no biosimilars were included.

In a Rheumatoid Arthrits Concurrent Abstarcts session, the results of a Longitudinal Analysis of the BIODAM Study was presented by Dr Sofia Ramiro. This international study looked at whether treat-to target in clinical practice led to more RA patients achieving target. This analysis provided further evidence on the treat to target approach. The study found that patients were 3.7 times more likely to achieve remission when treatment was based on a systematic protocol aiming for remission cv less systematic treatment.

Osteoarthritis remains a large burden of disease in our populations. There has been much controversy in the past on use of Glucosamine, with many rheumatologists no longer suggesting this as an option of treatment because of a number of negative studies. In a Concurrent Abstracts session, Dr Jean-Pierrre Pelleistier presented the results of a study looking at the use of Chondroitin in OA of the knee. Over a 2 year follow-up period, there was less MRI evidence of cartilage loss in the group of patients randomized to Chondroitin Sulphate 1200mg daily cv the control group, who were on Celecoxib 200mg daily.

From the late breaking abstracts, there were 2 RCTs looking at the use of biologics in treatment of GCA. An oral presentation by Dr Sabine Adler presented results of a single center RCT on the use of Tocilizumab in the treatment of GCA and showed that TCZ treated patients were more likely to achieve remission at week 12 and relapse free survival at week 52, with lower doses of cumulative corticosteroids than the control group who remained on corticosteroids alone; both groups had the same standardized corticosteroid reduction schedule. A poster presentation by Dr Carol Langford reported on a Randomised Double Blind Trial of Abatacept and Glucocorticoids for the Treatment of Giant Cell Arteritis. The results showed a (only just) statistically significant improvement in Abatacept/corticosteroids arm compared with corticosteroids alone.

Key points:

- The 2015 ACR Guidelines do not make any recommendations on biosimilars –patients and healthcare professionals would benefit from more information about biosimilars; the ORA published a position paper on Subsequent Entry Biologics in 2012.It should remain a key player in providing more guidance to

its members and the public with respect to biosimilars – Perhaps now would be an ideal opportunity for the ORA to update this position paper.

3) Models of care

Population management may provide better quality care to patients with rheumatoid arthritis. In an abstract presentation, Arnold et al (Abstract no 2487) describe how a voluntary collaboration of 168 US clinician rheumatologists are enrolling their RA patients (approximately 55000 patients) into a disease population registry based on practice billing records or clinical visits. The majority of physicians collect at least one disease activity (DA) measure including RAPID3, CDAI, PGA or multibiomarker (MB) test. The registry enables real time population reports that track assessment timeliness consistent with treat-to-target recommendations and monitor the disease activity (DA) distribution within each physician's enrolled population. The registry also generates lists of overdue patients.
Another abstract looked at utilizing population management tools in the treatment of gout. Bublin et al (Abstract no 1029) reported on a pilot initiative to improve gout outcomes in family practice using a disease management program within an integrated health care system. The intervention consisted of live and online CME, electronic medical record reminders and nursing staff protocols. In addition, a monthly "report card " for each provider compared their performance with their peers. This was piloted on a primary care group with 11 primary care providers and 441 gout patients. Pre and post intervention performance data – in terms of both monitoring of serum uric acid (SUA) levels and number of gout patients who had achieved target serum uric acid (<6.0) were compared. The intervention site was also matched to another primary care group – who formed the "usual care" control. The study reported significant outcomes in both monitoring of SUA and achieving goal uric acid levels following the intervention (OR 3.76 and 2.44 respectively). In addition, gout outcome measures improved significantly in the intervention site compared with the usual care site in both monitoring of SUA and achieving target SUA levels (OR 2.32 and 1.94).

Key points:

- Population management approaches may improve delivery of care to rheumatology patients. Whilst current practice EMR systems can already track disease activity measurements, these population management tools can be a source of data collection and Quality Improvement initiatives and may be worth exploring.

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