

Pediatric Committee

By Rosie Scuccimarri, MD, FRCPC

The Pediatric Committee of the CRA (Ped-CRA) has grown tremendously over the years; we now have close to 50 members representing eight of the 10 provinces of Canada. The Committee is led by an Executive, comprised of: myself (chair), Dr. Susanne Benseler (chair-elect), Dr. Lori Tucker (past-chair) and Dr. Janet Ellsworth (secretary/treasurer). The Executive has regular teleconferences to assure that the objectives of the Committee are met. The objectives are:

- to promote awareness of childhood rheumatic diseases;
- to promote optimal models of care for children with these diseases;
- to promote education of health professionals to optimize the recognition and treatment of childhood rheumatic diseases; and
- to provide advocacy for these children.

We are very fortunate to have been invited by the CRA to prepare documents for pediatric rheumatology on the “Wait Time Alliance” and “Choosing Wisely” projects of the Canadian Medical Association (CMA). These projects are aligned with the objectives of our Committee and work towards promoting optimal models of care for children with rheumatic diseases. These projects will allow for better advocacy for our patient population.

We are currently establishing working groups for these projects. The “Wait Time Alliance” project will establish medically acceptable benchmarks for wait times for juvenile idiopathic arthritis (JIA). The “Choosing

Wisely” project aims at educating physicians, patients, and other health care stakeholders on the medical tests and procedures that may be unnecessary for the pediatric rheumatology patient population.

Lastly, Dr. Lori Tucker will be submitting the triamcinolone hexacetonide statement to the Access to Care Committee this fall. This statement was prepared with the input of the members of the Ped-CRA. Pediatric rheumatologists have used this intra-articular corticosteroid for more than 30 years for joint injections in children with arthritis. For over two years, this drug has been under restricted access through Health Canada’s Special Access Program; this causes unacceptable delays to treatment and necessitates an application to be made each time this product is used. The endorsement of this statement by the CRA will allow us to advocate further on this issue.

The Ped-CRA will be busy working on these projects. We hope to give each of these the time, dedication and leadership needed to enable fruitful discussions and ultimately yield finalized documents that can allow pediatric rheumatologists to advocate for improved care for their patients.

Rosie Scuccimarri, MD, FRCPC

Pediatric Rheumatologist, Department of Pediatrics

Assistant Professor, McGill University

*Program Director, Division of Pediatric Rheumatology
Montreal, Quebec*

Access to Care Committee

By Viktoria Pavlova, MD, FRCPC; Henry L. Aaverns, MBChB, FRCP(UK), FRCPC;
and Nilg Haroon, MD, PhD, DM

We are pleased to update you on the key activities that the Access to Care Committee (ATCC) has been involved with over the past year. Our primary interests and focus were on improving care for the Aboriginal population, developing wait-time benchmarks for patients with rheumatic diseases, creating a new approach to comprehensive patient care, and collaborating

with the Arthritis Alliance of Canada (AAC) and the Ontario Rheumatology Association (ORA).

Dr. Henry Aaverns took the lead in improving care for Aboriginal people, noting, “the ATCC has embraced the challenge of exploring the provision of rheumatologic services to the Aboriginal population. In late 2013 a survey was sent to members of the CRA, revealing some

important themes, repeated across all provinces, around the healthcare challenges unique to the Aboriginal population in both urban and remote communities.

We have focused on working with the Non-Insured Health Benefits (NIHB) program, first to review the Limited Use Criteria for provision of biologic therapy and, as a longer-term project, to discuss and improve the process of applying for required medications, which most physicians feel lends itself to improvement. Finally, many members of the CRA are continuing to explore models of care, including telehealth and liaison with trained nurses in remote communities. In 2014, we are hoping to build on these initiatives and generate future strategies to improve rheumatologic healthcare to the Native population.”

Dr. Nigil Haroon has been involved with the Wait Time Alliance (WTA), working on developing wait-time benchmarks for rheumatic patients, reporting “the WTA was formed out of concern among Canada’s doctors over delayed access to care for their patients. The WTA is comprised of several national medical specialty societies who work in collaboration with stakeholders. The initial focus was on five priority areas: cancer, cardiac care, diagnostic imaging, joint replacement, and sight restoration. Benchmarks were set for these in 2004. Over the years, more specialties and areas of medical care have been brought under the WTA umbrella. This year the CRA was invited to participate in the process and come up with medically acceptable wait times.

We were charged with identifying the threshold wait-time for rheumatic disease beyond which the best available evidence and clinical consensus indicate that the patient’s health is likely to be adversely affected. These benchmarks will be considered as health-system performance goals that can be used to assess performance, wait times, and differences among services, hospitals, and provinces.

Over the past year, the CRA has been working to set up rheumatology benchmarks with the help of expert committees. The WTA benchmarks being set in the first round include rheumatoid arthritis (RA), ankylosing spondylitis (AS), psoriatic arthritis (PsA), and lupus. A pediatric sub-committee has been formed to assist in the process.

The first CRA wait-time benchmarks will appear in the 2014 WTA report, after addressing comments from the CRA membership.”

The ORA Models of Care (MoC) Committee has been exploring new models of care that would deliver greater value for patients living with inflammatory arthritis (IA), their health care providers, and those that fund their care. This project was initiated and has been guided by Dr. Vandana Ahluwalia. The MoC committee has been considering the gaps in current care and whether or not resources are readily available, along with examining successful care models across Canada in different disciplines. The MoC committee is working on a model that optimizes all existing resources and promotes their sharing, and coordinates quality care for patients with IA. It was strongly felt that one piece of such a model must include the provision of patient support throughout the disease management continuum.

The first interactive meeting that brought together arthritis stakeholders took place on October 4, 2013. The purpose of the meeting was to initiate an open dialogue among stakeholder groups currently offering patient support programs, identify unmet needs, explore strategies to improve coordination and effective delivery of services, and enhance the comprehensiveness of support programs, especially in the early phases of the disease diagnosis. Stay tuned for more updates on this!

Viktoria Pavlova, MD, FRCPC
Assistant Clinical Professor, Department of Medicine,
Division of Rheumatology,
McMaster University
Hamilton, Ontario

Henry L. Aaverns, MBChB, FRCP(UK), FRCPC
Kingston, Ontario

Nigil Haroon, MD, PhD, DM
Assistant Professor of Rheumatology and Medicine,
University of Toronto
Clinician Scientist, University Health Network
Toronto, Ontario