Executive Summary

Introduction

Arthritis is a leading cause of pain, physical disability and health care utilization. It is a serious, chronic, and disabling disease affecting 1.6 million Ontarians. There is no cure for most types of arthritis, but treatments exist that have been shown to prevent disability, maintain function and reduce pain associated with arthritis. Essential components of care in the health care system include access to informed primary care physicians and rehabilitation therapists, prompt referral to rheumatologists for people with inflammatory arthritis, and referral to orthopaedic surgeons for corrective surgery or total joint replacement to alleviate pain and disability. Yet, trends indicate a growing care gap between the number of people with arthritis and availability of and access to relevant and timely services. This gap is likely to continue to grow as the population ages and the number of people with arthritis increases. Consequently, there is a critical need to explore alternative models of health care delivery in order to ensure that Ontarians have timely access to quality care.

Goal and Objectives

The purpose of the overall study is to explore care models for arthritis using existing research, knowledge of experts in the field, and perspectives of individuals living with arthritis. This report builds on previous work documented in the Arthritis Community Research and Evaluation Unit working report *An Exploration of Comprehensive Interdisciplinary Models for Arthritis* in which key informant interviews were conducted with health care providers, educators, and administrators in Ontario.

The specific objectives are:

1. To identify best practice models of care and alternative models of service delivery from the perspectives of key informants working in the arthritis field as well as current research,
2. To identify important components of arthritis management from the perspectives of individuals with arthritis,
3. To explore the acceptability of various models of care with individuals with arthritis, and
4. To make recommendations to the Ontario Ministry of Health and Long-Term Care that include processes required to implement and evaluate proposed models.

Methods

Semi-structured interviews were conducted with two groups a) health care providers, academics and administrators and b) individuals living with arthritis. Data were analyzed using a constant comparative approach.

Results

Key Informants (Health care providers, Academics and Administrators)

Innovative models of health service delivery have been developed within Canada and abroad to deliver care to people with arthritis in primary health care, secondary care and the community. Four main models of care emerged from the key informant interviews with health care providers, including:

- Specialized arthritis programs,
- Models using health care providers in expanded clinical roles,
- Models promoting access in remote and rural communities, and
- Community-based care.

These models evolved to meet at least one of two main purposes: 1) to deliver comprehensive interdisciplinary services for people with arthritis or 2) to promote access to quality services. While specialized arthritis programs focus on delivery of comprehensive, specialized, multidisciplinary team care for the arthritis population, community-based services tend to focus on a broader population and offer community support and resources. Models using health professionals in expanded roles and models promoting remote and rural access evolved, at least in part, to overcome gaps in care and address access issues such as waiting lists and shortages of health care providers, such as rheumatologists and orthopaedic surgeons. Clearly, there is no one model that will work in all populations and all circumstances. Although further evaluation of these models of care is warranted, the models are promising.

Individuals Living with Arthritis

In dealing with the associated daily challenges, individuals who were interviewed adopted strategies and utilized a range of health system and community resources to varying degrees. Some participants were primarily “self-managers” and were less likely to rely on formal supports. When discussing health care delivery, participants identified health care provider characteristics such as empathy, concern, trust and being a team player as being important. Emotional support, shared decision-making and education (for patients, health care providers and the public) were also important aspects of health care delivery. Access issues related to waiting, financial eligibility, coordination and continuity of care, location and accessibility, health care utilization, scheduling of services, follow-up care and referrals were important health care issues from the perspectives of people living with the disease. The models discussed, including team care, non-physician care and telemedicine, were generally favourably received by participants as long as health care providers were knowledgeable, skilled and trusted.

Conclusion

In this research, health care providers and people with arthritis identified common elements of quality health care delivery. These include health care provider knowledge and skills in arthritis, coordination of services and continuity of care. People with arthritis were generally accepting of proposed models of care delivery as long as they felt trust in the health care providers. Given the significant impact of arthritis on the lives of Ontarians and health care system pressures, innovations such as those demonstrated in this report are critical to ensuring that the population as a whole has equitable access to services when needed. Next steps should include further evaluation of models of care for arthritis, integration of arthritis into broader chronic disease prevention and management, and collaboration amongst key stakeholders in arthritis to further develop models of care for arthritis.