Practice Support Program for BC Physicians

By Delia Cooper

It was with great excitement and anticipation that I arrived at the BC Provincial Practice Support Program (PSP) for physicians in Richmond April 4th. I was thrilled to be invited as a Patient Voices Network Ambassador because this PSP focused on the musculoskeletal (MSK) problems of Rheumatoid Arthritis (RA), Juvenile Idiopathic Arthritis (JIA), Osteoarthritis (OA) and Low Back Pain (LBP). Since I had battled with JIA since I was 12, the discussions would be very pertinent to me.

Practice Support Programs (PSP's) have been developed for a variety diseases in BC. In the case of MSK conditions, the goal is to improve the quality of care and support for patients living with RA, JIA, OA and LBP in family practitioner (GP) offices. This two day conference on April 4th and 5th was "Train the Trainer – Session 1". Leading GP's from around the province converged on the Richmond hotel to learn best practice for MSK conditions and to be introduced to numerous clinical tools which will be available on-line for the doctors' reference.

This two day session will be followed with two more meetings which first, will address any problems which the doctors may have had using the new tools and second, will assist the doctors to disseminate the information related to the new MSK tools to the other physicians in their local areas throughout the province.

On Day 1, I was particularly pleased to encounter one of the Ministry of Health officials, Sherry Barr, who I had worked on Guidelines for RA, OA, and OP (Osteoporosis) in the Guidelines and Protocols Advisory Committee during 2007-8. She announced to me, "Well this is the culmination of all our work", - all the work of reviewing every piece of research done in the area of MSK for the past ten to fifteen years as well as all best practice guidelines that existed in the world. These two days were about "Getting the information out to the doctors."

Day One

Each day began with a patient that spoke about their journey with their MSK condition. Megan spoke about her trials trying to be diagnosed with RA and to receive adequate care following fracturing her knee at age 35. The key message that she brought the doctors was that arthritis seems to have never-ending complications and that doctors need to refer their patients to self-management programs sponsored by the Arthritis Society. She wondered how she as a nurse could have been unaware of these programs for so many years while she struggled to manage her condition alone.

Day 1 focused on arthritis and featured Dr. Dianne Lacaille in the morning. Dr. Lacaille stressed using a comprehensive approach to deliver care for people with arthritis. The program hoped to address the needs, fill the gaps and eliminate the barriers to care. She presented the acronym **EARLY** which emphasized the need for aggressive treatment for newly diagnosed RA patients (or other possible inflammatory arthritis such as Psoriatic arthritis). The acronym means that physicians need to treat RA patients **Early** and **Aggressively** with **Remission** as the goal, using **Long** term DMARDS, and **Yes**,

DMARDS are safe. Dr. Lacaille stressed that RA is not a benign disease, it causes joint damage, loss of function, work disability, cardiovascular disease and premature mortality. New onset RA requires URGENT care and GP's must not be afraid to use DMARDS (disease modifying anti-arthritis drugs) such as Plaquenil, Sulphasalizone and Methotrexate because RA is more responsive to treatment early on and that is the window of opportunity for remission. In BC a GP's referral marked "new diagnosis of RA" will be seen by a rheumatologist within 4 weeks. We all worked through the clinical support tools that would help GP's determine the difference between RA and OA including the homunculus depicting the high frequency and lower frequency joint involvements. I was particularly interested in the lists of co-morbidities for each of the arthritis diseases. For RA, this included Cardiovascular disease, Osteoporosis, Depression and an increased risk of Infections. In fact, RA patients should be treated as though they are immuncompromised. There were a number of tools that indicated Red Flags which may need immediate care for sepsis , cancer or other conditions and there were also a number of tools to help GP's recognize and address depression in their patients. This is important because all people who develop a life changing chronic disease experience various levels of depression at some level and GP's are now being encouraged to deal with this problem. The package also included a number of patient surveys to indicate the severity of pain and the impact on function and daily work. For OA, the management regime included patient education, weight management, self-management, exercise (range of motion, strength, aerobic) physiotherapy, occupational therapy, walking aids, braces, orthotics, as well as medications such as acetaminophin and the NSAIDS (non-steroidal anti-inflammatory drugs). Intra-articular steroids were suggested but such lubricants as Synvisk was not recommended. Of course, replacement surgery for knees and hips is the final stage for OA.

Dr. Lori Tucker discussed Juvenile Idiopathic Arthritis. I was surprised to realize that there were members of this audience who still were not aware that children can develop inflammatory arthritis. Dr. Tucker stated that there are four children under the age of sixteen per every 1000 children who develop arthritis so if the GP's in the room haven't found any children with arthritis in their practice, perhaps they should look again carefully because they could possibly have four of such children just as most GP's should have at least four people with RA in their practice. I think these statements made a few doctors start to squirm. The doctors were informed about how to refer a child with a potential JIA diagnosis to the Childrens' Hospital for a Pediatric Rheumatologist workup.

The large conference group then broke up into smaller workshops where pairs of GP's and specialists leaders would work through various tools with videos and allow for more questions. We first had a Rheumatologist and then an orthopedic surgeon.

The orthopedic specialist in our smaller group workshop was Dr. Gredanus who distinguished between OA in the hip and knees and problems with low back pain which is referred. He suggested that it was easy to diagnose when there was a preceding accident or injury to the joint, but more difficult to distinguish OA because it is a more diffuse pain. If there is an antalgic gait(limp) or the joint in misaligned (valgus or varus), it is clearly OA but when there is tingling and numbness it could possibly be lower back pain problems which are referred to the hip or leg. I asked Dr. Gredanus about the recent research which indicates the amount of pain experienced is frequently unrelated to the amount of joint space on the x-rays. He agreed that if a patient is "optimized", that is, if the patient has had

physiotherapy, occupational therapy, weight management, pain management, etc. and is still in severe pain, then the replacement surgery would go forward because when you open up a joint, there is frequently all sorts of different anomalies which may have been causing the problems. When it comes to RA and joint replacements, Dr.Gredanus mentioned Dr. Kayler who suggests that surgery should move forward when the inflammation is so bad that medications are not sufficient to enable a patient to function in life. He also mentioned that RA patients must consider the risks (such as infections and loosening) and benefits of the surgery and must sign an informed consent form because they tend to be younger and may need revisions sometime during their lifetime.

There was a panel at the end of the day where several important questions were answered. Some of the gems from this discussion included:

- Cortizone injections were recommended for a single flared joint only,
- Platelet rich plasma injections are not beneficial.
- Stem cell injections are not beneficial either at this time because local anaesthetics are toxic to cytokines,
- Episodic disability is a huge problem in Canada for people with RA who are at high risk of losing jobs and ending up on disability. This is an aspect that is currently being reviewed by Health Canada and the federal government.
- It was suggested that RA patients need to have a ten year plan for downsizing because they are usually not able to live independently in a single family home unless they are so wealthy they can afford to hire everyone to do the upkeep and maintenance.

I think that most impressive message of the day for BC physicians was that they are not alone in dealing with the various forms of arthritis. They can access the RaCE line (Rapid Access to Consultative Expertise) and have a rheumatologist in BC respond to their questions within two hours guaranteed and usually within 15 minutes of their call. They can also refer patients to the Arthritis Society's Self-Management Programs and Pain Management Workshops as well as have their patients access the on-line Arthritis Resource Guide for BC and the many other free workshops that are available from the Arthritis Society. Additionally, they can go on-line and find PT`s and OT`s who have been trained in arthritis in their local area and they can make referrals to the Mary Pack Center in Vancouver and be assured that their patient will be seen within four weeks if they have an urgent new onset RA case.

Day Two

Mary was the patient who spoke on the second day about her journey through the system trying to address her low back pain. She spoke of pain that Tylenol 3 and muscle relaxants did not address, of her efforts to use ice packs, hot packs, massage therapy, occupational therapists, physiotherapists, chiropractors, exercise such as swimming and walking, acupuncture, etc. Mary had tried everything to escape from the daily headaches, back pain, knee pain, hip pain, and disturbed sleep. She described having to reduce the sound of her alarm clock because it would jolt her in the morning and how

sneezing was **terrible**. Her hope for the future would be that doctors would listen more carefully and screen their patients and refer their patients to the Pain Clinic.

Dr. Julia Alleyne, the Bone and Joint Institute's Chair, spoke next. She explained that Low Back Pain (LBP) is the number one MSK complaint and that it is also sixth in the world when compared to the entire list of diseases that exist. Yet, GP's still have only 1 to 2 percent of their training focused on MSK conditions while in their practices in their work life, at least 40 percent of their patients have MSK problems. Acute LBP makes it difficult to sit or carry on your daily activities. Apparently as long as the red flags indicating serious problems are ruled out, it is unnecessary to order images. Dr. Alleyne's acronym was **NIFTI** which means you must rule out **Neurological** factors, **Inflammatory** issues, **Fractures**, **Tumors**, and **Infection**. These symptoms would include numbness, tingling, weakness, fevers night sweats, trauma and Osteoporosis.

Most LBP will resolve within four to six weeks and it is important that patients with LBP remain active and medications will help this. Dr. Alleyne listed a number of evidence based treatments including: lumbar traction, spinal manipulation, heat/cold, bed rest, therapeutic ultra sound, lumbar support and orthotics. However, the only treatments that actually had proven positive results were spinal manipulation with exercise (6-12 treatments only) and heat/cold treatments. None of the other treatments were helpful or at least had no evidence to support them.

When patients present with persistent and recurrent LBP for more than 6 weeks and over the course of a year, treatments such as education, an exercise prescription, self-management strategies, manual therapy, acupuncture and analgesics must be tried. Additionally psychological referral may be necessary in order to ensure the patient is able to remain working. The only medications which are recommended are Tylenol and the NSAIDS (non-steroidal anti-inflammatory drugs). If LBP becomes chronic or lasts longer that a year, the red and yellow flags must be reviewed again. (Yellow flags deal with psychosocial issues.)

The final session on LBP involved Opioid Strategies and the tools to help doctors determine whether a patient is addicted as well as what appropriate dosages of such narcotics and pain medications would be.

In the afternoon of the final day, the doctors and healthcare providers learned more about self-management strategies and brief action planning strategies. The action plans must be SMART: Specific, Measurable, Achievable, Relevant and Timed. Of course, any of the Arthritis Self-management leaders who may read this will recognize the action planning which is included in the Arthritis Society's ASMP courses.

There were many algorithms included in the tool kits for the physicians. I used to recognize these as computer flow charts, but the current word is algorithm. We ended the day with another video of a patient possibly needing surgery. One of the surgeons suggested that the spine is like operating on 30 knees. It is only appropriate if there is radiculopathy or neurogenic claudication evidenced by bilateral leg pain and difficulty walking. Of course at this point I finally felt that I needed google and was glad

that the two day workshops were close to an end. Apparently there will be a Practice Support Program on Pain rolled out in 2013-14. This will likely be a welcome relief to many people with MSK conditions.

A patient who was attending this conference with me, Lois North, asked a very pertinent question. Because of our work with a program called “Taking With Your Doctor”, we are aware that patients are concerned that their doctors are not listening to them, but are busy looking at and using their computers during their appointments. With these new tools encouraging physicians to use the computer more frequently, how would the doctors address this communication problem? It is even exacerbated when the computer is facing the same direction as the patient and the doctor can’t see the patient or when it is placed between them. I think this question gave a number of people some serious thought. I know that when I went into my doctor this week the computer had been moved so that he could easily see me and I could see him. Patients make a difference in these events and sometimes the changes can be made overnight.

I felt very privileged to be part of this wonderful program which is helping physicians in BC to diagnose and treat arthritis, low back pain and various MSK conditions more effectively. I will look forward to future Practice Support Program workshops with the hope that I might be invited again.