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Summary Report on the Workshop

Research Gaps for Primary Care in Musculoskeletal Health

Hosted by the Institute of Musculoskeletal Health & Arthritis

CIHR Primary Healthcare Summit: 'Patient-Oriented Primary
Care – Scaling Up Innovation'

January 18-19, 2010, Toronto, Ontario

CIHR Primary Healthcare Summit: ‘Patient-Oriented Primary Care – Scaling Up Innovation

Workshop - Research Gaps for Primary Care in Musculoskeletal Health

Research Gaps for Primary Care in Musculoskeletal Health was hosted by CIHR’s Institute of Musculoskeletal Health & Arthritis and was one of twelve afternoon concurrent workshops held at the CIHR Primary Healthcare Summit on January 19, 2010 in Toronto. Twenty-nine people, including principal investigators, health professionals, trainees, IMHA partners, government representatives, and NGO representatives, met to discuss research issues with respect to primary care for people with MSK conditions in Canada. Richard Birtwhistle, Director of the Centre for Studies in Primary Care, and a Professor in the Departments of Family Medicine and Community Health and Epidemiology at Queen’s University, moderated a Q&A between participants and four speakers who gave presentations to facilitate a discussion on MSK conditions in the primary care setting and to identify research gaps on optimal patient care management. The speakers included:

Dr. Gillian Hawker, Physician-in-Chief, Women’s College Hospital, and Professor, Dept. of Health Policy, Management and Evaluation, Faculty of Medicine, University of Toronto

Dr. Linda Li, Harold Robinson/Arthritis Society Chair in Arthritic Diseases and Assistant Professor, Department of Physical Therapy, University of British Columbia; Arthritis Research Centre of Canada

Dr. Carlo Marra, Associate Professor, Canada Research Chair in Pharmaceutical Outcomes, Michael Smith Foundation for Health Research Scholar and Director, Collaboration for Outcomes Research and Evaluation (CORE) Research Scientist, Centre for Health Evaluation and Outcome Sciences, Providence Health

Michael Hillmer, Manager of the Chronic Disease Unit in the Health System Policy and Relations Branch in the Health System Strategy Division, Ontario Ministry of Health and Long-Term Care

Dr. Gillian Hawker’s presentation “Research Opportunities for Primary Care in Musculoskeletal Health” outlined the barriers to quality of care for patients living with arthritis in Canada. There are currently 4 million Canadians affected by arthritis, which is estimated to increase to 6.4 million by 2026. Dr. Hawker believes these rates will rise due to: increasing longevity, increasing obesity and decreasing physical activity at high costs to our healthcare system (1998 stat - \$4.4 billion). Arthritis is associated with significant pain and functional disability, and commonly occurs with other chronic conditions (e.g., cardiovascular disease, diabetes mellitus).

Dr. Hawker indicated that people with MSK conditions are experiencing gaps in primary care where treatments often focus on the other chronic conditions and a lack of comprehensive management

(physical activity, weight loss, etc.) to care for the whole person. Findings from an Ontario Hip/Knee Cohort indicate that only 50 percent of patients are receiving “comprehensive care,” that is exercise, weight loss, and pain management. There are low rates of referral to a physiotherapist (PT) (18.7 percent in past year) and under-referral for total joint arthroplasty. Some of the barriers to quality of care include: lack of confidence in MSK evaluation, patients and physicians’ perception of arthritis as “a natural and expected consequence of aging,” comorbidity – contradictions to safe use of arthritis therapies, and costs for uninsured services (eg. PT/occupational therapists (OT)).

Primary care physicians play a key role, stated Dr. Hawker. They are the gatekeepers in providing patients secondary care referrals to other health professionals (OT, PT, etc), as well as referrals for consideration of joint replacement or medical emergencies for inflammatory arthritis. Dr. Hawker suggested the need to move away from “condition specific” research in chronic diseases towards examining conditions comprehensively. Implementation of strategies to improve care requires valid, reliable measures to evaluate quality of care. She stated that there are tremendous opportunities to improve charting (electronic medical records, etc.) and validating diagnostic/procedure coding to enhance use of administrative data.

In “More than a gatekeeper: Primary care in the management of rheumatoid arthritis,” Dr. Linda Li discussed interventions to improve referrals for rheumatoid arthritis (RA) patients needing secondary care with a rheumatologist. Some of these included continuing medical education activities for primary care physicians (eg. “Getting a Grip” program), shared-care, and triage by rheumatology nurses or orthopaedic physiotherapists. In addition to being the gatekeeper for secondary care, she also illustrated the impact of patient-primary care physician relationships in patients’ subsequently decisions to seek help for early joint symptoms. Finally, she pointed to the study by Dr. Diane Lacaille that showed more than 50% of people with RA were managed by primary care physicians in BC. Only 10% of these patients used disease-modifying drugs within in a 5 year period, illustrating the challenges in RA management in the primary care setting.

While primary care physicians play an important role in the continuum of RA care, affirmed Dr. Li, other health professionals appear to be willing and able to off-load some of the work of primary care physicians and contribute to RA care. The “Falling through the Cracks” project (Marra, et al., 2010-2011) is assessing whether community pharmacists, together with PTs, can accurately identify people who have a RA diagnosis but are not receiving disease modifying drugs. Dr. Li suggested more “investment in research on health services interventions that aim to improve appropriate help-seeking, referral and treatment.” She commented on one CIHR funded team (Badley, Davis, et al. 2008-2013) that is conducting an environmental scan on supply and demand for arthritis care and developing a framework and toolkit for making decisions about models of care that suit local needs. Finally, she described a third CIHR-funded study that aims to evaluate a web-based animated patient decision aid on methotrexate. The goal is to promote shared-decision making and it has great potential to improve communication about treatment decisions in the primary care setting.

In the presentation “How can pharmacists participate in primary care for OA?” Dr. Carlo Marra discussed a study his team is working on to determine how community pharmacists can contribute to

multidisciplinary care in osteoarthritis (OA). The goals of OA management, stated Dr. Marra, are to reduce pain, improve function, improve quality of life, and prevent progression of disease. Care gaps include the identification of knee OA and provision of care, including inadequate pain management, medication safety, and comprehensive care.

Dr. Marra explained how pharmacists are highly accessible health practitioners. Through legislation in most provinces, pharmacists have initiated interventions to improve care in hypercholesterolemia, diabetes mellitus (both Type 1 and 2), emergency contraception, and anticoagulation. People visit their pharmacist at least eight times more than their family doctor, which indicates that there are opportunities for pharmacists to provide triage services. One new study called the “Pharmacist Identification of New Diagnostically – confirmed, OA) is assessing whether community pharmacists, using a simple screening questionnaire, can identify individuals with previously undiagnosed knee OA and whether an intervention initiated by pharmacists can improve quality of care and outcomes. Another study called the Pharmacist-initiated Intervention Trial in OA is determining whether a pharmacist – initiated, multidisciplinary intervention can improve quality of care and outcomes in knee OA.

Dr. Michael Hillmer, the Manager of the Chronic Disease Unit in the Health System Policy and Relations Branch of the Ontario Ministry of Health and Long-Term Care, suggested that primary care gaps for MSK patients are similar to those with patients experiencing other chronic diseases. The big policy question is “what are the effective models of care?” Excellent assessments on models of care are being carried out in various regions across Canada, but Dr. Hillmer suggested that there may be specific regional models needed for different populations. “Finding a way to implement a model of care for a whole range of conditions would be exciting work,” stated Dr. Hillmer.

Overall Message: To improve the quality of care for MSK patients, we need more research on assessing, designing and implementing comprehensive care models. It is important to get MSK issues on the primary care agenda by bringing other health professionals to the table to develop inter-professional care models and improve the continuum of care.

Summary of comments from participants on primary care gaps for people with MSK conditions which might lead to a research agenda include:

- People are waiting too long to seek help for MSK conditions
- Pain management and understanding of medication safety are inadequate
- Educational interventions are needed for both the public and primary care physicians
- Train and recruit primary care physicians who have an interest in inclusive chronic disease management, so that MSK conditions are treated along with cardio-vascular diseases, diabetes, etc.
- Need multiple health professionals at the table to design models of inter-professional care

- Need to stop examining conditions individually and start using a comprehensive model to treat the whole patient
- Get MSK issues on the primary care agenda including bone and joint health, arthritis and related chronic diseases
- Cross-pollinate research priorities across MSK conditions, cardiovascular diseases, diabetes, and others
- Tremendous opportunity to look at issues of comorbidity
- Models of comprehensive care may need to be region specific
- Review the research priorities developed from the 2004 Summit on Arthritis Models of Care

Workshop Evaluation

Seven of the twenty-nine participants completed and returned a workshop evaluation form. The evaluation was overwhelmingly positive with participants indicating that the workshop was a useful or very useful experience, and provided stimulating discussion and ideas for future collaborative opportunities to identify potential research areas in primary care for MSK patients. Due to the lack of time, many participants also commented that they would like to see a continuation of the workshop to fully articulate a research agenda. When asked to comment on next steps, participants indicated the need to:

- Identify priorities for research
- Plan a workshop to discuss and identify a research agenda and possibly partner with other CIHR institutes in relation to other chronic diseases
- Move directly into funding research to push care / management of arthritis & reduce the psychosocial burden of the disease
- Strongly support primary care initiative & engagement of psychologists
- Research MSK and impact of comorbidities
- More get togethers
- A think tank

Participant List

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