Arthritis is the most prevalent chronic condition in Aboriginal populations, and is associated with increased rates of disability relative to the general population; yet arthritis is not addressed with a national strategy to support awareness or self-management from an Indigenous perspective. Discrepancies in arthritis-care access and outcomes between Aboriginal and Caucasian patients were readily apparent in the cities I have trained and now work in. Dr. Christine Peschken has documented increased disease severity in the Cree and Ojibway population of Manitoba. The same appears to be true in my experience in Alberta, which has a diverse population of tribal ancestries (Blackfoot, Stoney, Nakoda, Dene, and Cree) and the only recognized Metis settlements in Canada. I have observed ludicrous situations such as bands paying for patient transportation to get gold shots in a primary-care setting, but not approving travelling the same distance for a rheumatology appointment or biologic treatment. These experiences confirmed the need for enhanced access and delivery of rheumatology services in southern Alberta, with the added bonus that the communities and health services leadership of the Treaty 7 Nations also wanted better arthritis outcomes for their people.

At the time I moved to Calgary in 2006, Dr. Liam Martin and Dr. Sharon LeClercq serviced communities two to three hours away from the city with tele-rheumatology. I pursued “commutable” on-site clinic options, and was introduced to the leadership at the Siksika Nation, a Blackfoot community of 3,700 people located 100 kms east of Calgary. Assisted by Dr. LeClercq and Dr. Dianne Mosher, a monthly clinic for established rheumatology patients from that nation was started in 2010. Shortly thereafter, we received funding from the Canadian Initiative for Outcomes in Rheumatology Care (CIORA) to implement an arthritis screening program to improve early arthritis detection and treatment. This program enabled nearly 200 community members to be assessed, diagnosed, and treated for a variety of musculoskeletal conditions without needing a referral through primary care. During the program, 27 new cases of inflammatory arthritis (IA) were diagnosed, and over 20 rheumatology patients who had been lost to follow-up were re-engaged in arthritis care. Building on epidemiologic research into disease prevalence and health services utilization funded by the Canadian Institutes of Health Research (CIHR), and a qualitative study to understand facilitators and barriers to care funded by CIORA and Alberta Innovates–Health Solutions, we are developing a picture of the current burden of arthritis in the Aboriginal population of Alberta and how health services are being accessed. The outreach sites I work at have expanded to include the urban Aboriginal Health Centre and the Elbow River Healing Lodge, while Dr. Mosher conducts clinics at the Morley reserve.

The issues surrounding access to care are complex in the Aboriginal community. Particular to arthritis, awareness of
the disease is one aspect: it is so common in Aboriginal communities that it is seen as a normal phenomenon and not necessarily as a modifiable disease with severe functional consequences. There are widely-held beliefs regarding disease pathogenesis, specifically related to residential schools and generational trauma from the colonialization process. These beliefs need to be heard, acknowledged, and worked through with the patients. Accessing care is difficult without consistent primary-care provision, or when child and elder care or transportation is not otherwise available to attend appointments. Despite my diligent attempts to complete Limited Use (LU) forms for access to biologic therapies, they are still frequently left sitting somewhere along the fax line to Ottawa.

The other key issue is trust within the community and health leadership for our intentions. I encourage readers of the CRAJ to read a new report by the Health Council of Canada, which explores some facets of this. A long-term and consistent commitment to providing care in the community is absolutely necessary. The connection with the community’s primary-care providers is critical; they are extremely motivated to understand rheumatology better, and will be managing medication side effects or disease flares when we are not on-site. I am constantly impressed with the dedication of the local care-providers and how they problem-solve creatively. Overall, it is extremely rewarding to work with others who are not only targeting access to care, but also achieving better health in the community.

References:

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Exterior view, Siksika Health and Wellness Centre.

Entrance to the Siksika Health and Wellness Centre.