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6. Scientific evidence shows a higher frequency of predisposing shared-epitope (SE) alleles in many North American First Nations populations. However, this alone does not explain their high prevalence of RA.
 7. Researchers know of biomarkers relevant to predicting imminent RA. Science is in a position to apply RA-risk models, and do so in communities willing to engage prevention strategies.
 8. Prevention strategies provide a vehicle to employ and educate individuals in First Nations communities; at the same time, they sensitize researchers to health needs in these communities. Such models engage First Nations as co-researchers within Community Participatory Action Research.

In order to break the pain and suffering of RA, stemming from delayed diagnosis and inadequate treatment of First Nations peoples, all attendees of this conference

realized that the scientific and medical community holds knowledge that can influence early detection of RA and establish early RA-prevention strategies within local communities.

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Mary Pack Arthritis Program: Outreach to First Nations People in British Columbia

By Alice Klinkhoff, MD, FRCPC; Angela How, MD, FRCPC; and Paul Adam, MSW

The Mary Pack Arthritis Program (MPAP) operates under the auspices of the Vancouver Coastal Health Authority with a provincial mandate to provide outpatient and inpatient services in British Columbia from standing clinics in Vancouver, Victoria, Penticton, and Cranbrook. Communities with limited access to care are serviced through separate travelling occupational therapy and rheumatology services that provide care to 13 and 26 communities, respectively (see map on next page).

As arthritis places a disproportionate burden on First Nations people in Canada, MPAP has intentionally focused on outreach to aboriginal communities. Using Ministry of Health annual funding for physician, nursing, and allied health services, there has been an expansion from the first travelling consultation trip in 1951, to a network of physician and occupational therapy trips, and

nascent tele-health and distance nursing support services. In 2012, there were 14 British Columbia rheumatologists funded by two full-time salaries and four part-time occupational therapists engaged in outreach to all patients in the province, including those of First Nations descent, at an approximate cost of \$1,100,000.

In one example, in the last 18 months Dr. Angela How instituted tele-health services from Vancouver to the Gitksan community of Hazelton. The First Nations people in this community experience a high prevalence of multiple inflammatory autoimmune diseases. Dr. Jenny Lee, who has spent time in Dr. How's practice, facilitates the service at that site. Exit interviews have shown the service to be well received and the wait list has been dramatically reduced. Expansion of this tele-health program to other isolated communities will allow more people living

NORTHERN (HIGH)LIGHTS

with arthritis access to appropriate rheumatologic care.

In the past decade, a team including a nurse, physical and occupational therapists, and a rheumatologist has provided contracted travelling and/or tele-health clinics to the Namgis and Carrier Sekani First Nations communities. While this service offered a satisfactory short-term solution, there were few lingering benefits when contract funding ended. Future contracts will ideally build on pre-existing community services, such as adapting community exercise programs, gardens, or kitchens to be arthritis-friendly, with the aim of developing long-term community capacity.

Over the last 15 years infrastructure for inpatient arthritis rehabilitation has been impacted primarily by reduced demand, which we interpret as related to improved and earlier drug treatment. Demand fell from 36 full inpatient arthritis rehabilitation beds in 1997 to an average of 11 beds currently, half of which are typically occupied by First Nations patients with rheumatoid arthritis (RA), ankylosing spondylitis (AS) and psoriatic arthritis (PsA) coming to Vancouver for rehabilitation.

In British Columbia there is manifest pride in these outreach successes, but more needs to be done. There remain small First Nations communities with few or no services, including a black hole in the downtown Eastside where city-dwelling First Nations people often live in substandard housing and poverty, often with coexisting mental illness and addictions. For complex reasons these individuals remain disadvantaged despite having close proximity to care. If there were more rheumatologists in British Columbia there might be an opportunity for extending service to the poorest postal code in the country, as other specialties, including HIV medicine and B.C Women's Hospital, have established local clinics to develop relationships, and improve care and outcomes.

Recommended Readings:

1. Browne, A.J., McDonald, H., Elliott, D. First Nations Urban Aboriginal Health Research Discussion Paper. A Report for the First Nations Centre, National Aboriginal Health Organization. National Aboriginal Health Organization.



OT = occupational therapy; AHP = allied health professionals; TCS = travelling rheumatology services.

Ottawa, Ontario. 2009. www.naho.ca/documents/fnc/english/UrbanFirstNationsHealthResearchDiscussionPaper.pdf

2. Health Council of Canada. Empathy, dignity, and respect: Creating cultural safety for Aboriginal people in urban health care. Health Council of Canada. Toronto, Ontario. 2012. www.healthcouncilcanada.ca/tree/Aboriginal_Report_EN_web_final.pdf
3. Reading, C.L., & Wien, F. Health inequalities and social determinants of aboriginal peoples' health. National Collaborating Centre for Aboriginal Health. Prince George, British Columbia. 2009. www.cahr.uvic.ca/wp-content/uploads/2012/02/NCCAH-report-LoppieWein-download11.pdf

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