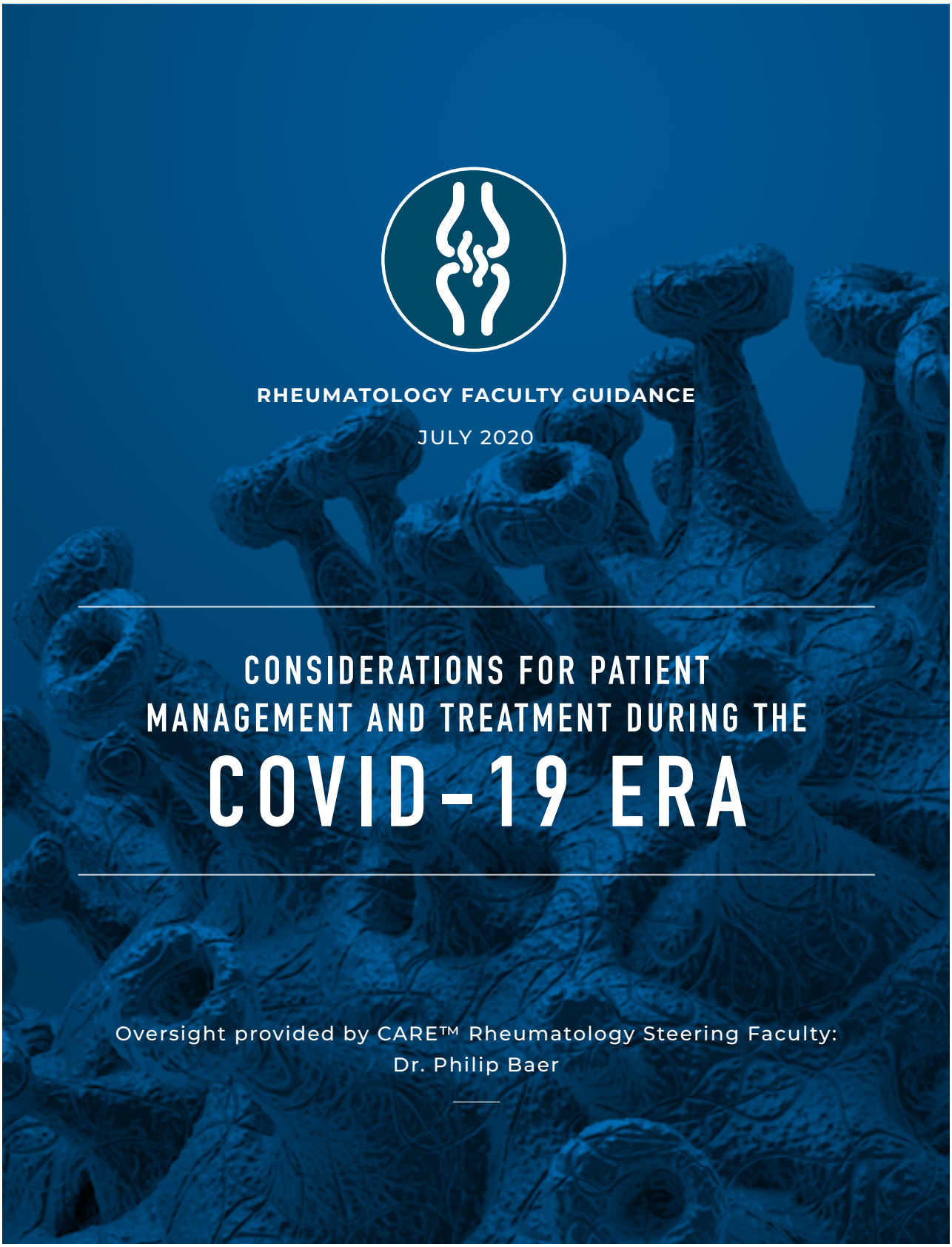

RHEUMATOLOGY FACULTY GUIDANCE

JULY 2020

CONSIDERATIONS FOR PATIENT MANAGEMENT AND TREATMENT DURING THE COVID-19 ERA

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CARE™ 20/20 VISION AND BEYOND

WHY GUIDANCE FOR TREATING PATIENTS DURING COVID-19 IS IMPORTANT

Goal for Rheumatology Practice in Canada – protect rheumatology patients from potentially fatal infection without jeopardizing treatment goals.

- Rheumatoid arthritis and other rheumatological diseases create an inherently immunodeficient, vulnerable state
- Immunosuppressive therapy may further increase the risk of infection
- The long-term outcomes of COVID-19 in patients is not fully understood
- The timing and impact of future waves of infection and delivery of a vaccine are unknown
- Without effective and sustained containment measures, COVID-19 outbreaks can lead to a patient load that exceeds the capacity of the healthcare system

CARE™ EFFORTS TO DATE- STATEMENT OF NEED FOR GUIDANCE

On May 4th, 2020, a survey was distributed by email and mail to 448 rheumatologists across Canada. The 10-item survey covered 3 areas: approaches to medical therapy; overall patient management; and future clinical education.

Key Takeaways

The response rate was 79/448 (17.6%), with 31 (39.2%) from academic centres and broad geographic representation across Canada.

Approaches and needs related to delivery of therapy at clinic

90% respondents agreed that their patients' access to healthcare providers has changed and 100% agreed that the provision of ambulatory services has changed.

Impact on patient outcome

91% acknowledging that approaches to clinic will need to be re-evaluated, with 92% indicating the impact on patient outcomes in the near-term (2 years) is not fully understood. 81% of responders agreed that changes will become institutionalized and 78% considered these to not be optimal for patient outcomes.

Approaches for clinician education in near-term (<2 years)

While 76% of respondents indicated that national and international congresses provide the highest yield in terms of education value, the majority also agreed that on-line education will become the preferred method of knowledge transfer in the near-term (2 years). Respondents indicated reduced interest in attending national and international congresses, small group sessions and rounds.

Conclusions

The COVID pandemic has had a profound impact on both clinical practice and continuing medical education. Changes to clinical practice may become permanent and require careful consideration. Future education may rely more on online curricula, but national and international congresses will also continue to provide value.

What Follows In This Report

Areas of Focus:

- Pre-clinic/consult at clinic
- Post-clinic
- Specific treatment considerations for RA

MANAGEMENT OF RHEUMATOLOGY PATIENTS DURING COVID-19 AND NEAR-TERM

Overarching approach - Consider that all patients may have COVID-19, minimize visits, and maximize outcomes when patients are at clinic.

Clinicians should acknowledge:

- Every patient who engages with the traditional rheumatology care delivery system significantly disrupts the tactic of physical distancing, resulting in innumerable potential ripple effects
- COVID-19 symptoms may overlap with disease or treatment-related manifestations or associated opportunistic infections
- Many standard treatment strategies that bring patients into care centers for laboratory testing, physical assessments, radiographic imaging, and office visits should be thoughtfully revised

Each clinic/centre should ensure:

- Appropriate follow-up during and after the pandemic
- Any delays in assessment and treatment should not be excessive
- No progression of disease, even if treatment or testing is delayed
- Patients have the ability to access a member of the rheumatology care team if there is any change in their clinical status
- Psychosocial support for patients to reduce patient anxiety as much as possible
- Communication with patients about the level of care, the therapeutic options being considered, and risks associated with treatment during COVID-19

Mitigating Exposure of COVID-19 to Patients and Healthcare Professionals

Use of Telemedicine and Virtual Care

- Patients should be offered virtual care appointments where feasible and appropriate (e.g. phone or video)

Visitor limitations reduce the number of personal contact points and potential opportunities for viral transmission

Strategies and Considerations for Assessment and Patient Management

Before a Clinic Visit

Assess whether an in-clinic visit is warranted

- Consider local rates of COVID-19 transmission, overall practice preparedness (staffing PPE, processes), and availability of broader community resources (hospital capacity)

Advance plan for in-clinic visits

- Share protocols with patients before coming to clinic (masking of all patients, physical distancing, hand and surface hygiene, and identification of upper respiratory infection symptoms)
- If possible, organize tests, procedures and face-to-face consultations such that the patient spends as little time as possible in the clinic
- All new patient consultations to be done virtually to gather information on symptoms, medications, allergies, family and social history; in-clinic time can then focus on targeted physical examination, necessary procedures such as joint aspirations and injections, and initiation or adjustment of therapy
- Serology testing to assess previous infection is not available at this time – the significance of antibody levels and protection remains unclear

Advance planning for telehealth or virtual consult

- Obtain informed consent prior to the visit
- Provide educational material about the use of the communication platform
- HCPs should acquire secure email and WIFI, good quality speakers or headphones, high definition video camera with microphone, and adequate screen space
- Excellent material on conducting a video examination of arthritis patients is available online from the Arthritis Society; see Virtual Arthritis Physical Assessment at: **https://arthritis.ca/healthcare-professionals/tools-and-resources**

At a Clinic Visit

Re-working the clinic format and structure

- Screen for symptoms at the entrance to facility/clinic/ lab. Ensure access to COVID-19 screening centers and urgent care centers if required for evaluation of screen failures
- Require masks to be worn by all patients and any accompanying caregivers
- Ensure physical distancing in waiting room(s)
- Explore options such as remote lab monitoring and imaging where applicable
- Allow patients to check in by phone and remain in their vehicles until an exam room is ready
- Joint visits with a multi-disciplinary team should have one healthcare provider in the room at a time

Rearrange facility/clinic/ lab space

- Arrange exam rooms to allow for proper physical distance
- Put markings on the floor to control flow of traffic
- Consider installing a plexiglass barrier at reception
- Keep doors open if appropriate to eliminate the need to touch knobs and handles
- Remove non-essential items such as waiting room magazines
- Rethink patient questionnaires to avoid sharing of tablets, clipboards, and pens unless they can be cleaned after each use
- Designate an isolation space

Provide necessary resources

- Set up hand hygiene stations
- Establish a daily schedule to disinfect both office and patient care areas
- Put up screening posters, public health posters and reminders on PPE safety

Patient consult considerations

- Only order investigations that are critical for decision-making and anticipate delays
- Consider earlier referral or intervention where markers of progression are concerning

Staffing considerations

- Limit team members in room
- Respect physical distance
- Take proactive approaches to staff emotional and physical well-being
- Screen employees daily for fever and other symptoms of COVID-19
- Provide masks and other PPE including eye protection, face shields, safety glasses, masks, and gowns to be worn by employees depending on their risk of exposure

Occupational health and safety considerations

- Develop an infectious disease response plan
- Prepare and respond appropriately to staff illness and absences (obtain insurance)

Consider innovative ideas for preserving PPE

- Canadian patients and healthcare workers are dependent on extended global supply chains' being uninterrupted both for PPE and drug therapy
- If you are experiencing difficulties sourcing PPE connect with provincial resources

After a Clinic Visit

- Prioritize virtual care for follow-up
- Extend follow-up intervals for both visits and lab monitoring
- Limit in person follow-up to patients requiring joint examination or procedures
- In the presence of concerning symptoms, face-to-face consultation may be necessary
- Encourage home delivery of prescriptions and self-isolation. Many pharmacies offer home-delivery
- Essential imaging to assess disease status will still proceed, but these may be reduced in frequency

When is it safe for staff and patients to return to the clinic after a confirmed case of COVID-19?

- **Test based strategy:** individuals may return when their fever has resolved, their respiratory symptoms are improved, and they have tested negative twice consecutively (at least 24hrs apart) by PCR
- **Symptom based strategy:** individuals may return when they have been afebrile (without the use of antipyretics) for a minimum of 72 hours, and their respiratory symptoms are improved, and at least 10 days have passed since the onset of their symptoms
- **Asymptomatic patients** who have tested positive for COVID-19 may return 10 days after their first positive test or following 2 consecutive negative RNA tests collected at least 24hrs apart

Caveats/Requirements for Strategies and Considerations for Assessment and Patient Management

- There is a risk to the patient of being exposed to COVID-19 as part of travel to and attending a clinic visit
- Limitations need to be acknowledged and allowances made. Telemedicine does not replace need/benefit of physical exam and testing
- Patients may find virtual care challenging or may not have access to virtual tools/resources
  - If a patient is uncomfortable using virtual care technology, it can hinder their ability to participate fully in healthcare decisions
- Patient reported outcomes (PROs) may under or over estimate disease activity and progression
- Clear, consistent, and simple language must be used with patients
- Privacy and security concerns must be met
- Informed consent and confirmation of patient identity must be secured at the beginning of each virtual visit
- Ancillary virtual care services can be accessed (e.g. interpreter services in the event of a language barrier)
- Documentation standards must be maintained. Additional technology-related specifics (i.e. video-enabled visit or a phone visit, start and end times) should be recorded
  - If the visit involved multiple care providers, it is important to document who was present and who is the most responsible clinician
- As more patients begin to go back into clinic, anticipate challenges with coordinating patient load and testing

Strategies and Considerations for Treatment

- Initiate or delay therapy?
  - The decision to proceed with systemic treatment must take into account the risk to the patient of contracting COVID-19 according to the burden of illness in the local environment, particularly for people at increased risk of serious consequences
  - Treatment can be initiated or continued in SARS-CoV2-positive patients if they are still fit and willing to be treated after proper risk/benefit discussion
  - Patients with active or high-risk disease should not be denied effective treatment
- Clinical trials are considered standard of care for many patients. Most trials require additional appointments and tests, further increasing the potential exposure of both patient and provider
- A non-medical biosimilar switch policy for people with RA at this time should be weighed against increased time required for patient education and counselling at clinic, and increased vigilance associated with the initiation of a new therapy, and closer follow-up assessment/monitoring requirements. These steps increase patient contact and risk for contracting COVID-19

Considered Actions for Patients with COVID-19

- Phone triage for patients with mild COVID-19 symptoms
- For patients who test positive for COVID-19 or who have symptoms, the examination should be done in a negative pressure room with appropriate protective equipment. Unnecessary involvement of learners and ancillary team members should be avoided
- If a patient develops COVID-19, therapy may have to be interrupted or delayed

Reinitiating Treatment Following COVID-19

- As of July 13, 2020 the American College of Rheumatology has added two new recommendations to its **COVID-19 Clinical Guidance for Adult Patients with Rheumatic Diseases**
  - For patients with uncomplicated COVID-19 infections (characterized by mild or no pneumonia and treated in the ambulatory setting or via self-quarantine), consideration may be given to re-starting rheumatic disease treatments (e.g., DMARDs, immunosuppressants, biologics and JAK inhibitors) within seven to 14 days of symptom resolution. For patients who have a positive PCR test for SARS-CoV-2, but are (and remain) asymptomatic, consideration may be given to re-starting rheumatic disease treatments (e.g., DMARDs, immunosuppressants, biologics and JAK inhibitors) 10 to 17 days after the PCR test is reported as positive (H)
  - Decisions regarding the timing of reinitiating rheumatic disease therapies in patients recovering from more severe COVID-19-related illness should be made on a case-by-case basis (H)

(H) at the end of both of these statements stands for "high" and is related to the consensus during voting by the task force on these two new recommendations

Choice of Therapy: RA Specific Considerations

- Therapeutic decisions should be individualized based on disease phenotype, prognosis, age and comorbidities
- All healthcare facilities including clinics must develop appropriate protocols to minimize risk of exposure
- Protocols to reduce time required for infusions, or preference for use of self-administered oral or subcutaneous options should be considered
- Virtual care should be used when available and appropriate
- In-person care should be targeted to patients where physical examination is critical to clinical decisions
- Patient support services should be engaged to provide patients with flexible means of communication
- Use of systemic steroids should be avoided if other alternatives exist
- Patients should not stop therapy to avoid infection, and should be encouraged to discuss any concerns with their physician or nurse
- Patients who develop COVID-19 (either suspected or confirmed) should contact their physician or nurse before stopping or altering their therapy
- Effective therapy should not be denied, or delayed, as uncontrolled disease activity puts patients at risk
- Global Rheumatology Alliance has identified prednisone use at 10mg/d or more, but not antimalarials, NSAIDs or conventional DMARDs, alone or in combination with biologics or JAK inhibitors, as a risk factor for hospitalization in rheumatology patients with COVID-19
- Rheumatology drugs have been tested as treatments for COVID-19, with overall negative results for hydroxychloroquine, mixed results for IL-6 inhibitors (negative for sarilumab, positive for tocilizumab) and pending results for JAK inhibitors and IL-1 inhibitors. Colchicine and dexamethasone are also being tested, with both showing positive results

Closing Comments

- Our understanding of COVID-19 and its impact on management of RA and other rheumatological diseases continues to evolve
- The full impact of COVID-19 on patients is not fully understood
- Therapy for rheumatology patients needs to continue, balancing the need for effective disease control that may decrease the chance of acquiring COVID-19 infection against any risks of therapy or the need for monitoring, which may increase the chance of acquiring COVID-19 infection
- Centres across Canada should adopt procedures and policies that are reflective of their size and needs. Multidisciplinary input from healthcare providers, administrators and patient advocates is required
- Policies and processes should be re-visited and revised on an ongoing basis

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