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Guiding Principles from the American College of Rheumatology for Decision Making Around In-Person Urgent versus Virtual Non-Urgent Medical Care

Background

The American College of Rheumatology (ACR), and the rheumatologists and rheumatology health professionals that it represents, recognize the importance of physical (also known as "social") distancing in an attempt to minimize our patients' risk of exposure to SARS-CoV-2, the virus that causes COVID-19. Indeed, many rheumatology patients, by virtue of immune compromise, advanced age, or complex medical conditions, may be at increased risk of complications should they contract COVID-19. Nevertheless, many of our patients also have diseases or take medications that require intensive monitoring and make their medical care essential. These same factors increase their risk of urgent complications independent of COVID-19. These considerations heighten the need for careful discernment of urgent from non-urgent medical problems and complicate efforts to achieve the safest balance between measures aimed at physical distancing (delayed office visits, evaluating patients by telehealth, delayed laboratory monitoring, etc.) versus advising a patient to seek face-to-face medical care.

Several groups have offered advice about how to maximize patient and provider safety when face-to-face visits are required. The AMA and CDC detail best practices and highlight disparate triage approaches required for hospitals compared to ambulatory clinics. Clinical guidance from the ACR for the treatment of rheumatology patients during the COVID-19 pandemic is available here. The ACR also has guidance for the safe management of infusions when they are necessary. Rheumatology experts have weighed in, but guidance from government authorities outlining the circumstances when in-person versus virtual encounters are allowable varies. Some state health departments have released strict rules precluding in-person medical evaluations that do not qualify as urgent or emergent and some suggest that urgent is defined by the expectation for an adverse outcome if care is not provided within 30 days. When virtual encounters are medically appropriate, their execution, especially across state lines, is complicated by variable and sometimes conflicting regulations around licensing, certification, and malpractice coverage.

Guidance from the ACR

A. Authority

The ACR holds that rheumatologists and rheumatology health professionals are in the best position to determine what defines routine, urgent, and emergent care for

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rheumatology patients. Regulatory bodies, who may not be familiar with the unique needs of rheumatology patients, should defer triage decisions to professional healthcare providers. Rheumatologists and rheumatology health professionals consider a host of factors related to a patient's individual circumstance (severity of illness, risk of short-term complications related to disease or treatment, risk of complications related to COVID-19, prevalence of COVID-19 in the local community, local capacity for ensuring measures to prevent the spread of SARS-CoV-2 in the healthcare setting, etc.), when advising patients on the safest methods for delivering care. But accurate assessment can be hindered in the absence of a face-to-face encounter. Thus, any provider who, in good faith, brings to the clinic a patient when the provider, in collaboration with the patient, believes the need may be urgent should not be subject to *post-hoc* regulatory audit of urgency.

Flexible policies will be paramount as practices and providers transition from early quarantine efforts, to partial re-opening, to resumption of "normal" activities in the post-COVID era. It is to be expected that re-opening procedures will (and should) vary over time, from region to region, and even from practice to practice. This is because the factors (related to individual patients, local prevalence of SARS-CoV-2, local capacity for testing and physical distancing, the ability of individual practices to accommodate a resumption of normal activities, etc.) that determine when and how to safely and feasibly re-open will vary. As in the early stages of the pandemic, the individuals best suited to evaluate local conditions and coordinate a transition to "normalcy" are providers who, in shared decision making with their patients, staff and local authorities, can devise and follow plans to maximize patient safety and deliver high quality care.

B. Urgency

The following scenarios, common in day-to-day rheumatology practices, might reasonably be considered urgent, based on an individual patient's unique situation. These examples are in no way intended to be comprehensive or proscriptive.

- Infusions and administration of medications in the office.
    - The potential risks versus benefits of infusions must be ascertained for each individual patient and will change over time as the COVID-19 pandemic continues. Forced non-medical switching to a different drug or to home infusions, by a payer solely based on cost considerations and without the consent of the patient and the patient's rheumatologist or rheumatology health professional, is always inappropriate (1) and remains inappropriate during the COVID-19 pandemic.
    - Many patients are prescribed powerful subcutaneous and infusible medicines precisely because their rheumatologic disease is active and/or high-risk. For these patients, withholding therapy increases the risk of a flare which in some cases (as in patients with ANCA-associated vasculitis, for example) can be life threatening.

  - In certain cases, delaying an infusion or an in-office injection may be reasonable. For instance, when a patient's disease is well controlled, a drug holiday is deemed low risk, and measures to promote physical distancing in the infusion center are not feasible, it may be in the patient's best interests to delay therapy. For instance, rheumatologists and rheumatology health professionals may reasonably consider delaying treatments with zoledronic acid. In contrast, interruptions in therapy with denosumab have been associated with poor outcomes (2) and therefore extending dosing intervals beyond eight months should be avoided if possible.
  - Some clinics may be equipped to offer curbside treatment with injectable medications (such as certolizumab and denosumab) in order to maximize physical distancing and patient safety.

- Acute flare or ongoing disease activity of a known disease, or adverse effect due to a medication, for which the patient and rheumatologist or rheumatology health professional estimate that the benefits of immediate face-to-face evaluation and/or treatment outweigh the risk.

- Joint aspirations and injections. Based on the severity of pain and/or functional limitation or concern for septic arthritis, face-to-face evaluation for aspiration and/or injection of a joint may well be urgent. In contrast, rheumatologists and rheumatology health professionals, in shared decision making with the patient, may consider delaying routine joint injections if the patient's condition is stable and/or local conditions dictate.

- New patient evaluations when the consulting or referring provider indicates urgency (suspected rheumatoid arthritis, systemic lupus erythematosus, vasculitis, etc.).

C. Lab Monitoring

Routine lab monitoring, which is the standard of care for patients on a variety of medicines used by rheumatologists and rheumatology health professionals, also requires individualized decision making. Extending the interval between routine lab monitoring tests may be reasonable if local environmental factors (adequacy of physical distancing at the site where labs are drawn, access to alternative sites, access to off-hours testing) preclude safe testing on schedule and patient factors (dose and duration of therapy, prior abnormalities in lab testing results) are favorable (3).

D. Telehealth

The ACR supports the use of telehealth for appropriate patients during the COVID-19 pandemic. Due to widespread shortages of rheumatologists and rheumatology health professionals, patients routinely travel across state lines to receive rheumatologic care. The use of telehealth technologies in these scenarios is complicated by state and regional regulations around licensing, certification, and malpractice that vary

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widely in terms of their allowance for medical professionals to provide care across state lines. The ACR applauds efforts at the federal and state levels, as has been done with HIPAA regulations, to clarify and loosen, when necessary, regulations covering licensing, certification, and malpractice coverage to allow rheumatologists and rheumatology health professionals to provide care at a distance in states where they may not hold a license during the COVID-19 pandemic. We urge all states to update regulations immediately to allow appropriate care at a distance in accordance with federal guidance. Otherwise health professionals are left without a viable telehealth option for their patients who reside out-of-state. Lastly, policies by government payers to provide payment parity for telehealth (audio-only as well as video) and face-to-face visits are necessary and appropriate and should be adopted by commercial payers. We urge commercial payers to implement payment parity during, and beyond, the COVID-19 public health emergency.

References:

(1) https://www.rheumatology.org/Portals/0/Files/Complexity%20of%20Biologics.pdf

(2) https://www.ncbi.nlm.nih.gov/pubmed/?term=30659428

(3) https://www.ncbi.nlm.nih.gov/pubmed/?term=31012257

1 April 2020
Revised 12 April 2020
Revised 26 April 2020
Revised 9 May 2020