

Advice from the American College of Rheumatology: Reopening Strategies During the COVID-19 Pandemic

Background

As COVID-19 stay-at-home orders have been revised and repealed, businesses across the US have begun to reopen. The timing and the degree of reopening efforts have varied from state to state and even from region to region within a state. Rates of new infections are being monitored closely in an attempt to correlate specific reopening policies with the risk of resurgent COVID-19 cases.

Rheumatology practices have also started to reopen. The degree to which rheumatologists and rheumatology health professionals reduced the number of face-to-face visits and other services has varied. This is entirely appropriate as local circumstances, including regional prevalence of SARS-CoV-2, local capacity for testing and tracking, physical (also known as “social”) distancing, and supplies of personal protective equipment have varied from region to region.

Similarly, policies and procedures for phased reopening should be tailored to local conditions as well as the capacity for individual providers to accommodate best practices. The ACR holds that the individuals best suited to evaluate local conditions and coordinate reopening efforts 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.

The following information is intended for rheumatologists and rheumatology health professionals to consider as they evaluate local conditions, design reopening procedures, monitor progress, and advise patients during the transition to this new phase of patient care during the COVID-19 pandemic.

Quick Reference Guide for this Document		
Question:	Summary:	See:
Return to workplace?	<ul style="list-style-type: none"> • Work from home if possible • Avoid group interactions • Wear a mask • Careful hand hygiene 	Section I
Reopen clinic?	<ul style="list-style-type: none"> • Phased approach • PPE, physical distancing, sanitization, staff education, etc. 	Section II
Return to clinic after SARS-CoV-2 infection?	<ul style="list-style-type: none"> • Symptom-based strategy (10d after symptom onset) • Test-based strategy no longer recommended 	Section III
Restart medicines?	Please see separate ACR guidance document “COVID-19 Clinical Guidance for Adult Patients with Rheumatic Diseases”	

I. Suggestions for addressing patient questions about re-entry: “Is it safe to go back to the workplace?”

The simplest advice for patients inquiring about workplace safety might be: 1) work from home if possible, 2) avoid group interactions, 3) wear a mask*, and 4) practice careful hand hygiene.

When possible, a more nuanced discussion that includes an assessment of the factors below can help a patient better understand their personal risk, identify and plan strategies to mitigate risk, and arrive at decisions that are as informed as possible.

Factors influencing a patient’s decision to return to the workplace will evolve over time and depend on future therapeutic advances and the availability of vaccines, as well as individual circumstances including:

- The patient’s ability to tolerate ongoing and future quarantine and isolation
- Conditions in the workplace
- The patient’s underlying health
- Local incidence and prevalence of SARS-CoV-2 and local testing rates

Accordingly, advice to patients about reentry into the workplace should start with an assessment of their current circumstances and the patient’s tolerance for continued restrictions. Is the patient unemployed? Working from home? Does the patient have access to other sources of financial support? How long are the current conditions sustainable? What will be the impact of schools reopening (or not reopening) in the fall?

Information about the workplace is also helpful, including measures being taken by the patient’s employer to ensure a safe work environment. To what degree is physical distancing possible? Are masks, eye protection, and hand hygiene feasible? Permitted? Required? To what degree are CDC recommendations regarding employee daily health checks and workplace ventilation being followed? Is travel required? If so, to locations with high prevalence of SARS-CoV-2? To what degree can face-to-face encounters continue to be replaced by virtual meetings?

An individual patient’s co-morbidities and attendant risk of severe disease if infected must also be taken into account. Previously identified risk factors for severe COVID-19 in China and the UK include advanced age, diabetes and chronic heart disease. Recent data from the Global Rheumatology Alliance have identified prednisone use at 10 mg/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. Guidance for the management of adult and pediatric rheumatology patients, including risk assessment, during the COVID-19 pandemic has been published by the ACR. A potentially useful two-dimensional framework (occupational risk and risk of death) for discussions with patients has been outlined by Larochelle.

An individual's risk of contracting SARS-CoV-2 is highly dependent on the incidence and prevalence of the virus in the communities where the patient resides, works and engages in activities outside the home. Thus, advice for returning to the workplace should take into account local prevalence of COVID-19, new infection rates, and the extent to which testing is being performed in the region. If these are favorable, then the odds of contracting the virus are less, and the ability of local health authorities to quickly detect subsequent waves of disease is enhanced. Ongoing monitoring of the extent of local testing and new infection rates, via local (usually county) health department outlets, is critical for rapid adjustments to physical distancing policies and minimizing resurgences.

Health professionals are encouraged to keep in mind both employee and employer rights, as codified by the ADA and interpreted and enforced by the EEOC, around reasonable accommodation when writing letters to employers on behalf of patients. Supporting claims of disability can be problematic. In general, it is appropriate for health care providers, with signed consent from the patient, to disclose a patient's medical condition(s), explain why reasonable accommodation is necessary, and make suggestions (which may or may not be adopted by the employer) as to specific accommodations that may be helpful.

Is it safe to go out in public? To visit my family?

Similar factors must be taken into consideration when advising patients about the safety of returning to public spaces beyond the workplace. A general rule of thumb is "time, space, people, place." In general, short exposures (less than 15 minutes) are safer than prolonged ones. Outdoor activities with abundant sunlight and ventilation are thought to be safer than indoor activities. Small gatherings with people who otherwise remain largely isolated are safer than activities that result in exposure to large numbers of people. Proximity to people who are shouting (such as at a sporting event) or singing appears to pose excess risk. As in the workplace, the capacity for physical distancing, hand hygiene, masks, and eye protection in different venues and settings impacts the safety of different activities outside the home. Patients should be counseled that strategies that rely on identifying infectious individuals based on symptoms (including fever) alone are not likely, in isolation, to be sufficient to prevent further outbreaks.

Patients should take into account not only their personal risk, but the risk to those around them. Even if the patient's risk of severe disease from COVID-19 is minimal, the risk to others, especially the elderly and those with co-morbid conditions, could be high. The case fatality rate in individuals over 80 years of age ranges from 13-20%.

A concept of potential interest to patients as they contemplate various activities during the reopening process is the relative risk of death from COVID-19 compared to other risky activities. Semi-quantitative assessments of risk, individualized and contextualized for patients, can add value to these discussions between health care professionals and patients.

II. Strategies for Reopening a Clinic

The CDC and others have made specific recommendations for reopening medical facilities. Potential measures, above and beyond routine hand hygiene and sanitation procedures, for consideration by rheumatologists and rheumatology health professionals who are reopening practices and rethinking standard protocols are listed below. These suggestions are not comprehensive nor intended to be prescriptive.

- Proceed in phases, inviting select patients back for face-to-face visits based on risk factors and using telehealth when it is a viable and appropriate alternative.
- Screen employees daily for fever and other symptoms of COVID-19. Temperature checks may be performed at home by employees before arrival at the workplace. Screening of patients for symptoms prior to clinic visits is also recommended. However, as noted above, strategies that rely on identifying infectious individuals based on symptoms alone are not likely, in isolation, to be sufficient to prevent further outbreaks.
- Require masks to be worn by all patients. Provide a mask to any patients who arrive without a mask.
- Provide masks and other PPE including eye protection (face shields or safety glasses) to be worn by employees depending on their risk of exposure according to CDC guidance.
- Arrange exam rooms to allow the patient and provider to maintain a distance of six feet during the visit (except during the physical exam) if possible.
- Arrange check-in, check-out, and waiting rooms to allow for physical distancing. Limit visitors accompanying patients to no more than one person and only when that person is essential (mobility, communication, parents of young children, etc.)
- Consider plexiglass barriers at check-in and check-out.
- Allow patients to check in by phone and remain in their vehicles until an exam room is ready if feasible.
- Sanitize exam rooms between patients and disinfect high-touch surfaces.
- Provide ample supplies of hand sanitizer.
- Consider arranging foot traffic through the clinic to allow one-way flow.
- Clinic employees without patient contact should follow general return-to-work guidelines including daily screening for symptoms of COVID-19, use of masks, arranging work spaces to limit proximity to colleagues, and staggering lunch and other breaks to minimize crowding in shared spaces.
- Educate staff and patients regarding correct procedures to don/doff PPE.
- Educate staff and regularly emphasize the importance of strict infection control measures in the workplace, precautions including hand hygiene and physical distancing outside the workplace, and staying home if any symptoms possibly related to COVID-19 develop.
- We strongly recommend offices develop a plan of action in case an asymptomatic patient tests positive *after* visiting your clinic. Policy considerations include whether providers or staff will need to be isolated and/or tested. Local and state department

of public health officials may be helpful in planning and responding to such circumstances.

As above, the risk to patients and employees is related to the local incidence and prevalence of COVID-19. Constant monitoring of local testing and new infection rates will be critical to controlling outbreaks as reopening proceeds. Clinics should be ready to scale back again.

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

Two separate but related questions govern the return of patients, following infection with SARS-CoV-2, to rheumatology clinics and infusion centers:

1. When, following documented or suspected COVID-19, is it safe for a patient to resume DMARD and/or biologic therapy (if such therapy was interrupted during the infection)?
2. When, following documented or suspected COVID-19, is it safe for the *other* patients and staff to invite a patient back to the clinic or infusion center?

Studies that address the first question, the timing of safe resumption of biologics and other therapies in patients who have recovered from COVID-19, are lacking. However, expert advice about when to resume DMARD and/or biologic therapy following infection with SARS-CoV-2 has been put forward by the ACR.

In contrast, data are emerging regarding the second question: infectivity in the post-COVID-19 convalescence period. While some patients have tested positive for SARS-CoV-2 RNA for prolonged periods, cultures have by and large failed to detect viable virus beyond 8-10d despite continued detection of viral RNA. (There may be exceptions: at least one example of prolonged culturable viral shedding for 18d after symptom onset has been reported). Seroconversion takes place between 5-14d after onset of symptoms. As of this update, re-infection with SARS-CoV-2 has not been convincingly demonstrated. Antibody titers appear to correlate with clinical severity but their appearance does not clearly correlate with an abrupt decline in viral load. Also, in some cases, IgM/IgG levels decline rapidly. There is wide variability in the quality of commercially available kits used to measure antibody responses against SARS-CoV-2. Thus, patients and staff recovering from COVID-19 should be counseled that prior infection and measurable IgM and IgG responses may not confer reliable or durable protection from reinfection.

Pending further studies, strategies for safe return of staff and patients to the clinic for a visit or to work following suspected or confirmed infection with SARS-CoV-2 may be based on CDC recommendations designed to prevent transmission:

Symptom-based strategy: Individuals may return when they have been afebrile (without the use of antipyretics) for a minimum of 24h, and their symptoms are improved, and at least 10d have passed since the onset of their symptoms. The 10d interval should be extended to 20d for patients who had severe or critical COVID-19 or who are severely immune compromised. Severe immune compromise does not necessarily apply to most rheumatology patients, but does include patients taking prednisone at doses higher than 20 mg/d for more than 14d.

Asymptomatic patients who have tested positive for SARS-CoV-2 may return 10d after their first positive test (assuming they don't develop symptoms in the interim). As above, the 10d interval should be extended to 20d for patients who are severely immune compromised.

There are circumstances where a test-based strategy may still be useful. However, in general due to the high incidence of prolonged shedding of (non-viable) viral RNA, a test-based strategy for return to work (or for patients to return to clinic) is no longer recommended.

*A discussion of the merits and weaknesses of various masks and face coverings and their proper use is beyond the scope of this document. The ACR acknowledges that some masks are ineffective at blocking aerosols, and that SARS-CoV-2 may be capable of spreading via aerosols. The degree to which community spread of SARS-CoV-2 occurs via aerosols versus droplets remains unknown. Thus, even if a portion of community spread depends on droplets, masks are warranted as a precaution until definitive data regarding their efficacy becomes available.

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26 July 2020