Virtual Care in Rheumatology: The Sequel – *Thoughts as of March 2020*

By Philip A. Baer, MDCM, FRCPC, FACR

"Never let a good crisis go to waste."

– Variously attributed to Winston Churchill, Rahm Emanuel and Saul Alinsky.
(M. F. Weiner Medical Economics 1976: "Don't Waste a Crisis — Your Patient's or Your Own")

I didn't think I would be revisiting this topic so soon, but COVID-19 has changed many plans. Amid all the bad news, the restrictions on face-to-face interaction have upended our working world, potentially with some longer-term benefits to us and our patients.

Fresh off a typically excellent CRA Annual Scientific Meeting, extensively covered in this issue of the *CRAJ*, I had high hopes for March 2020 in real life. My wife and I were booked to speak on a continuing medical education (CME) tour of Morocco for two weeks: that was cancelled with three days to go, preventing us from being stranded in Casablanca when Morocco closed its airspace. I pivoted to attend a medical meeting in Vancouver: cancelled again, after I already had checked in for my flight online. No problem: I obtained a cancellation slot for needed cataract surgery. Again, that was cancelled with less than 24 hours notice due to COVID-19.

Meanwhile, every booked medical meeting, Journal Club, CME, and industry contact has been postponed, cancelled or moved online. With social distancing the new norm, our local Disaster Psychiatry interest group did remind us that emotional connectedness was even more important than usual. In this wired world, that is easier than ever, even when physical separation is necessary. In Ontario, it was gratifying to see our tight-knit rheumatology community working together, in small groups and through the ORA, to support each other in this very unfamiliar environment.

While helping each other, we also were confronted with how to meet the needs of our patients with rheumatic diseases. While many of us are not thrilled with our electronic medical records (EMRs) on a day-to-day basis, the benefits of having one over paper charts in this situation are clear. We can work from anywhere, at least as long as the electricity keeps flowing and the internet is functioning. Provincial governments moved quickly to enable billing for telephone visits, which we last used during SARS in 2003, and expanded the options for video visits to more platforms. With some medical buildings closed, and some physicians healthy but in self-isolation after travel, care could continue to be delivered.

Of course, adjustments are needed in any new work environment. EMR adoption is not synonymous with EMR optimization, as I quickly learned. We had never favoured emailing with patients because of privacy and timeliness of response concerns. Now, we suddenly wanted everyone's emails in order to scan and send them lab requisitions and other documents, as most patients do not have fax access, and snail mail could be eliminated at any moment. E-prescribe options look better than ever when available; for everyone else getting a virtual visit, recording their pharmacy's name and fax number was a new requirement.

My first few telephone visits included this new administrative work, but otherwise went surprisingly well. Routine follow-up visits of stable patients work well in this format, saving some patients long commutes to my office. We also handled patients who were in self-isolation after travel, who would have had to delay their visits. Video visits for the tech-savvy will manage other patients: rashes and obviously swollen joints can be seen; home blood pressure readings can be obtained from patients; but subtler findings will clearly go unrecognized. Patients proved quite adept at doing their own tender joint counts, and our paper Multidimensional Health Assessment Questionnaires (MDHAQs) were replaced by verbal versions.

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Issues do persist. Joint injections and biologic infusions cannot be done virtually. Patients who are not doing well require in-person examination in many cases. New consults also are difficult to handle virtually, other than those related to incidental abnormalities on imaging and lab tests, many of which should not have been ordered in the first place. Patients with new-onset vasculitis, rheumatoid arthritis and systemic lupus erythematosus (SLE) must be seen and treated urgently. Lab monitoring intervals can be spaced out, but those tests are still required.

For those visiting the office, there are new realities: Locked office doors, social distancing in the waiting room, restrictions on accompanying persons and drop-in visits, and the use of personal protective equipment when necessary. All patients are now screened based on travel history, contacts with COVID-19 patients, fever, and other worrisome symptoms. My secretary has a new script for reminder phone calls, and the signage on our front door and throughout our medical building is ever evolving.

Tantalizing therapeutic questions remain to be answered. Should ibuprofen be avoided? Will the promise of anti-malarials, baricitinib and IL-6 inhibitors as COVID-19 treatments be realized? Will there be a vaccine? Will this be the last ever pandemic? That one is easy, the answer is NO. What will the new normal look like after this pandemic runs its course? I predict virtual medicine is here to stay. As Canada's chief public health officer Dr. Theresa Tam stated: "People are using innovations to try and get care to people in different ways. That includes . . . having billing codes for physicians who are doing these consultations remotely. So what you're trying to do is increase the maximum . . . capacity for the health system to treat those who have more serious presentations of the COVID virus. They are using telemedicine in a way that I feel to be maybe a legacy of the outbreak itself."

If you have COVID-19 tips, experiences or stories to share, feel free to send them to us at the *CRAJ* for possible publication in print and/or online in future issues.

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Congratulations to the Inaugural CRA Master Award Recipients!

The Canadian Rheumatology Association (CRA) has introduced a new *Master* Award in 2020, bestowed upon members aged 65 and older who have made outstanding contributions to the field of rheumatology and excelled in one or more of the following ways: outstanding service to patients, outstanding administrative service, excellence in rheumatology teaching and education, and/or excellence in rheumatology research.

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