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Ask the Expert: Optimal IBD Management for Ulcerative Colitis During COVID-19

Announcer:
Welcome to CME on ReachMD. This activity, entitled “Ask the Expert: Optimal IBD Management for Ulcerative Colitis During COVID-19” is provided by Prova Education in collaboration with The Crohn’s and Colitis Foundation and is supported by an independent educational grant from Pfizer.

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Dr. Russell:
As the COVID-19 pandemic continues, practice gaps continue to emerge for many clinicians who provide care for patients with inflammatory bowel disease, or IBD. For those living with IBD, specifically, ulcerative colitis or UC, stress and anxiety can be part of everyday life. Clearly, during the COVID-19 pandemic, there is an additional layer of concern as both patients and their providers must navigate a host of questions related to ensuring the continuity of care. This is CME on ReachMD, and I’m Dr. John Russell. Joining me is Dr. Uma Mahadevan, who is co-director of the UCSF Colitis and Crohn’s Disease Center in San Francisco, California. She’s here to answer key questions related to ensuring the continuity of care for patients with UC not only during the COVID-19 pandemic, but also as we reopen our offices and clinics. Dr. Mahadevan, welcome to the show.

Dr. Mahadevan:
Thank you for having me.

Dr. Russell:
So, let’s start off by setting the foundation for our discussion today. What is the impact of COVID-19 pandemic on patients with UC, especially as it relates to ensuring continuity of care during this time of high stress?

Dr. Mahadevan:
So, the COVID-19 pandemic has been difficult for everyone, but for patients with inflammatory bowel disease, they have to deal with a multitude of concerns. There’s a lot of anxiety about whether it’s safe to continue their medication, it’s safe to stop their medication, whether they can go to work, whether they need to have more isolation precautions than the average person, and of course the data has really been rolling in, and so, recommendations have changed as more data come in. Access to information may be more difficult for older patients or those with limited resources. There’s a lot of concerns about what happens in the workplace, both for working from home and when they need to go back in.

So, it seems like patients with IBD on IBD medications are not doing worse than the general population. There’s also a great registry – the SECURE-IBD registry – which is an international registry, and you can look at that at covidibd.org. And what they found were risk factors for having more bad outcomes were similar to what you would see in the general population. There was no difference between ulcerative colitis and Crohn’s disease for having bad outcomes and getting COVID. For the patient with IBD, there are a lot of things that have changed. For example, they can’t go into the clinic as easily to see their provider. They need to be able to and have access to telemedicine. There’s limited endoscopy. So we’re using a lot more surrogate markers of inflammation than we did before. And then of

course, there's a concern with nonadherence to medication, which can be the worst outcome because then they get sick, have to go into the hospital, and go on steroids, all of which may increase their risk of COVID.

Dr. Russell:
So you mentioned adherence to therapy, maintaining a treat-to-target focus during these times. So in your office, what strategies have you found to be successful in maximizing patient adherence to therapy?

Dr. Mahadevan:
Communication really is key, so we have educated everybody on our team, our administrative assistants, our nurses, our nurse practitioners, our GI trainees, our, faculty about the impact of COVID on IBD, about the importance of continuing medication, so that at every point, when a patient comes into communication with someone from our office, they are able to get a consistent message. We have scripting to tell people what to do about going to work, what to do about their medications, what to do about their bloodwork. So all of that really increases adherence. We've also worked with organizations such as IOIBD and AGA to put out information, with guidance for patients and have put it on social media and on the Crohn's Colitis Foundation website; other places where patients may go if they don't communicate with their provider directly. Where before, we may insist people come in in person, we are now very happy with just doing telemedicine. So where before, we may say, "Well, you must get your labs every three months." If patients have been stable, we haven't made them go into the labs necessarily as often just for their own protection.

Dr. Russell:
There are a number of foundations, organizations, and societies that have provided for recommendations for ensuring the continuity of care for patients with UC during this COVID-19 pandemic. These include the International Organization for the Study of IBD, and especially the Crohn's and Colitis Foundation, which has a wide range of IBD resources for physicians and patients. What guidance has been provided by these organizations and foundations, and are there any resource links that you would recommend?

Dr. Mahadevan:
So, those are the two that I would recommend: the crohnscolitisfoundation.org website has written information as well as a video featuring Dr. David Rubin and Dr. Andrew Grossman talking about the impact of COVID and what patients should do. The International Organization for the Study of Inflammatory Bowel Disease is an organization that is essentially that – the leading experts in IBD around the world. And we all got together and had a consensus panel – a RAND panel – where we asked questions that were relevant to the patient with IBD Based on what data is available, which is limited, there was an expert consensus statement that came out, and you can read that on the ioibd.org website, and it was a publication in gastroenterology as well. Some of the highlights from that panel, were that we felt the risk of infection with SARS-CoV-2 is the same, whether the patient has IBD or does not. And it's uncertain if active inflammation from IBD increases the risk of getting SARS-CoV-2 or COVID, and that all IBD medications should be continued during the pandemic. If a patient is on steroids, we always want them to taper their steroids, so that recommendation continues. Now, if a patient develops COVID, in most instances we would hold the medication and then restart it, 14 days after symptoms resolve, or if they're asymptomatic but diagnosed with SARS-CoV-2, then restarting 14 days later. That again is an expert consensus, and we're trying to collect data to support that, as well. And then, in terms of procedures and surgeries, at the beginning of the pandemic in February, everything was halted, but now most institutions are starting to do procedures and surgeries and so, those should not be deferred at this time. It is safe for patients to come in for infusions and go to the infusion center, assuming the infusion center has appropriate protocols in place, as they do at our institution at UCSF. And I think most major infusion centers will have that. Endoscopy units as well have protocols in place, including social distancing, testing of patients before they come in, screening of staff, appropriate cleaning. And then, finally, I think the biggest, change, and the biggest recommendation, that globally has been stopping in-person visits and going to telemedicine as much as possible. There was an IOIBD survey – an international survey –prior to the pandemic, 75% of visits were face-to-face, and video was just a small fraction. But after the pandemic, in the world, 20% was face-to-face, 15% was video, and 50% was telephone. So you went from 75% face-to-face to about 75%, telephone/video, or other types of non-face-to-face communication. In the U.S., it was much more marked with 10% face-to-face, 30% phone, and 60% by video.

Dr. Russell:
For those just joining us, this is CME on ReachMD. I'm Dr. John Russell, and I'm joined by Dr. Uma Mahadevan to discuss the continuity of care for patients with ulcerative colitis during the COVID-19 pandemic and beyond as we reopen our offices and clinics. So I'd like to follow-up on some things you just said. It appears that the provided guidance incorporates telehealth visits as well as the establishment of safety protocols to protect both the healthcare team and the patient. Could you please go into greater detail on these recommendations and how they're maximizing outcomes for your patients?

Dr. Mahadevan:
As part of IOIBD, we came up with best practices, which is currently in press, but you can read our best practices on the ioibd.org website. With respect to telemedicine setup, you need to choose a platform that can provide a secure and private connection and is

compliant with local government regulations of telemedicine. And that can be easily implemented by both patients and providers. Now, in the United States, this has been relaxed somewhat, where in some instances, you can use FaceTime or other ways such as WhatsApp, etcetera. However, in general, if you have a more secure connection, for example, a Zoom connection that has appropriate security and privacy protocols in place, that's better. Many people do it through their EPIC, which is another way of doing it. Prior to the visit, you need to have a workflow with your staff that can identify patients who are appropriate, provide instructions to the patient on how to access the platform. Sometimes, if the patient has difficulty with it, the staff should be able to perform a dress rehearsal with the patient. If you can, do things prior to the visit, like collect, questionnaires, etcetera, that can help expedite the visit, clinic staff can pre-chart and input clinical information. And then it's important that both the provider and the patient have a space that's quiet and private. During the visit, the medical assistant can "room" the patient like they normally would in your office, taking vitals such as height and weight, and putting in their medications or pharmacy, etcetera. You do need to obtain verbal consent to perform the video visit. You can obtain history. You can actually do a full physical exam with eight elements over a video visit. And then after the visit, make sure you provide an electronic copy of the after-visit summary to the patient, route the prescriptions and laboratory orders electronically so they can just walk into the lab or walk into their pharmacy, and then you can instruct your staff for whatever follow-up is needed.

Dr. Russell:
So, unfortunately, it appears that our time is about up for today's discussion, Dr. Mahadevan. So, in the time remaining, could you provide any key take-home messages for our learners to help ensure continuity of care for patients with UC during the COVID-19 pandemic?

Dr. Mahadevan:
So, the key takeaways is that communication between the provider and the patient is really important. There needs to be trust, and there needs to be knowledge so that the patients feel comfortable continuing medication, making decisions about work, and childcare. We do want patients to continue their IBD medications. We do want them to report concerning symptoms – both of flare as well as of COVID infection. In those settings, you should have the protocols in place to have them go to the lab and get appropriate testing. And you want to use remote resources as much as possible – this is telemedicine, trying to do as many of the orders and everything else electronically as much as possible. And finally, we all need to prepare now for the recovery phase, for when we will start doing more procedures; we will start seeing patients in office. And for many of us, that has already started. We will continue to use telemedicine so that – so that many of the providers will be doing telemedicine, alternating with providers doing in-person care to limit the number of patients that are physically in the office and the number of staff you need physically in the office.

Dr. Russell:
An excellent way to end today's discussion. I want to thank my guest, Dr. Uma Mahadevan, for helping us to better understand how to ensure the continuity of care for our patients with ulcerative colitis during the COVID-19 pandemic, and additionally as we reopen our offices and clinics. Dr. Mahadevan, it was great speaking with you today.

Dr. Mahadevan:
It was great speaking with you as well.

Announcer:
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