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Hello my name is Claire Barber and I am a rheumatologist and researcher at the University of Calgary in Calgary, Alberta, Canada. Today I will be presenting an abstract on behalf of my co-authors of our recent publication entitled: Best Practices for Virtual Care: A consensus statement from the Canadian Rheumatology Association.

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The Canadian Medical Association had adopted the following broad definition of virtual care which defines virtual care as “any interaction between patients and/or members of their circle of care, occurring remotely, using any forms of communication or information technologies with the aim of facilitating or maximizing the quality and effectiveness of patient care”.

The COVID-19 Pandemic has led to a rapid increase in virtual care worldwide.

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The use of virtual care in rheumatology poses several unique challenges including:

- Difficulty assessing affected organ systems by telephone or video call
- Lack of appropriateness criteria for deciding if a visit can be conducted virtually
- Lack of long-term data on the impacts of virtual care on patient outcomes

Slide 3:

To begin to address these challenges, the Canadian Rheumatology Association convened a Telehealth working group. This work was conducted by this working group to support CRA members during the pandemic. The objective was to develop best practice statements to support rheumatology care teams in delivering high quality virtual care to patients with rheumatic diseases.

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There were four phases to this project. In the first phase, a core working group of rheumatologists representing adult and pediatric rheumatology met to define the scope and approach for the project. This was approved by the Canadian Rheumatology Association’s Telehealth working group. An initial list of topics was developed based on group discussion and based on results from a previously conducted virtual care survey. The scope of the project included the provision of virtual care in adult and pediatric rheumatology populations.

Secondly a rapid review was conducted to define the evidence for the best practice statements. Various sources were in the rapid review including systematic reviews, best practices, guidelines, and policy documents from organizations in Canada, the United States, Europe and Australia, recent abstracts from major rheumatology meetings. A search was also conducted of the PubMed database and the Cochrane library.

In phase 3, an initial draft of the best practice statements was compiled by the core working group. The Canadian Quality and Patient Safety Framework for Health Services and the PROGRESS-PLUS framework were considered during statement development. PROGRESS-PLUS is an acronym which can be used to understand which populations may face inequities in social determinants of health.

Lastly a three Round modified Delphi Consensus Process was used to finalize the statements. The Delphi panelists included rheumatology healthcare team members, individuals with rheumatic disease, and parents of children and adolescents with rheumatic diseases. Panelists voted on the importance and feasibility of each best practice statement based on a Likert scale from 1-9 where 9 denoted statements that were “very important” or “very feasible”. During Round 2 discussions, panelists also provided feedback on the scope and wording of the statements. In Round 3, a median final vote between 7-9 with no disagreement was required on both importance and feasibility criteria for final inclusion.

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There were 22 panelists who agreed to participate in the Delphi including representatives from 10 Canadian provinces and territories. Fourteen were healthcare providers and 9 were persons with a lived experience with a rheumatic condition with some overlap between groups.

There were seven candidate best practice statements in Round 1 and all but 1 met criteria for inclusion in the final set. Following revisions to wording made during Delphi Round 2 all statements met criteria for inclusion.

The final seven statements are shown on this slide and address adherence to existing virtual care recommendations and provincial standards, considerations for determining the appropriateness of virtual care, consent, the standard for virtual physical exam, collection of patient-reported outcomes, the use of virtual care to enhance care in addition to in-person follow-ups and in complex co-management of disease to enhance provider communication. Further details on each statement are available in our online manuscript.

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This work represents the first set of best practice statements in Canada to guide virtual rheumatology care. This is a starting point for future research and practice advances. We look to updating these statements over time as additional evidence becomes available.

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