Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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Multidisciplinary telemedicine and the importance of being seen

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To the Editor,

We write in response to DiGiovanni et al.'s recent article outlining the transformation of the SOCARE clinic into a telehealth format [1]. Given the impact of COVID-19 on healthcare, telehealth has been pivotol to care delivery for geriatric oncology. We seek to share and expand our experience to help facilitate telehealth options for older adults with cancer. At The Ohio State University – James Comprehensive Cancer Center, the Cancer and Aging Resiliency (CARE) clinic is a multidisciplinary team featuring a hematology/oncology physician, physical therapist, dietician, nurse case manager, nurse cognitive evaluation, audiologist, and pharmacist. A routine CARE clinic schedule includes six patients with providers rotating between patients over the course of the half-day clinic. Patient visits last approximately 2–3 h. This is a consultative clinic with a verbal hand-off provided to the primary oncologist regarding implemented changes to care plan and recommendations requiring follow-up.

In response to the COVID-19 pandemic, we have adapted the CARE clinic to a virtual telemedicine platform (Table 1). All members of our team continue to participate in the virtual clinics with the exception of our audiologist. Under guidance from the Office for Civil Rights within the United States Department of Health and Homeland Security, telemedicine visits can be conducted via any non-public facing platform as long as reasonable measures are employed to safeguard protected health information. Breaches of the Health Insurance Portability and Accountability Act resulting from the good faith provision of telehealth services during the COVID-19 nationwide public health emergency will not be pursued for enforcement of penalties [2]. We preferentially conduct visits using videoconferencing, but also utilize phone call visits for patients who do not have a webcam-enabled device.

In support of DiGiovanni et al. and their modified SOCARE model, including plans to expand their telehealth clinic to videoconferencing, we offer our experience as it relates to the benefits of videoconferencing and the "web-iquette" with which we have found success.

1. Videoconferencing "Web-iquette" for Multi-Disciplinary Clinic

In preparation for our virtual CARE clinic, our scheduler contacts each patient to obtain consent for proceeding with a videoconference visit. The scheduler confirms that a patient has a webcam-enabled device and a preferred e-mail address. This typically occurs within 1 week of the appointment. The day prior to scheduled appointment, our clinical nurse creates the teleconference meeting and sends the invitation to the preferred email address as well as all of the participating CARE providers for the given week. We request that patients log in 10 minutes prior to the scheduled appointment time and perform a test run in advance if new to the process. The e-mail also contains suggestions about identifying appropriate home settings to limit distractions, ensuring that Wi-Fi signal is strong in the selected setting, and encouraging sharing of the visit hyperlink with support people outside of the home who patients would like to include.

On the day of a virtual CARE clinic, all CARE providers join the teleconference meeting prior to the scheduled appointment time. Providers halt their video feed and mute their microphone for the start of the visit. The team is present throughout the duration of the call. A preestablished order of interaction with patient is set. The visit concludes with the physician returning to active video feed to summarize findings and answer any follow-up questions. After the visit, a written summary of recommendations organized by domain is sent to the patient either through the electronic medical record patient portal or via e-mail. When neither is an option, the summary is printed and mailed by US Postal Service.

2. Time Constraint

We have condensed our assessment into a 1-h format with 4 appointments scheduled back-to-back. We have found that active listening by all providers during the virtual visit has cut back on redundancy of history-taking. We utilize a secure communication application within our electronic medical record to facilitate efficient communication among team members about potential medication changes and need for testing or referral orders. There are some patients who have greater need in specific domains and this format does not allow for more in-depth evaluation and formulation of treatment

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Table 1
Structure of Virtual and In-person CARE Clinic.

Domain	Responsible Provider & Time	Virtual CARE Clinic	In-person CARE Clinic
Co-morbidities	Physician 10 min + 5 min summary at visit conclusion	-CARG Chemotoxicity Calculator -Common geriatric syndromes (bowel or bladder symptoms, insomnia, decubitis ulcers) -Likert scale depression and anxiety -Alcohol and substance use	Same as virtual CARE clinic PLUS -Audiometry (performed by audiologist)
Cognition	Nurse 5 min	BOMC	MOCA
Pharmacy	Pharmacist 10 min	Medication reconciliation, education, and recommendations	Medication reconciliation, education, and recommendations
Nutrition	Dietician 10 min	-MNA (with recent BMI if possible)	-MNA -Diet recall -AND/ASPEN Malnutrition
Physical Function	Physical Therapist 10 min[a]	-Falls history -SF-36 PFS -Follow-up with PT as needed	-TUG, SPPB, 5× sit to stand -Falls history -SF-36 PFS
Social Support	Nurse case manager 10 min[a]	-Needs assessment (home safety, financial toxicity, caregiver support) -Advanced directives review -IADL/ADL -COVID-19 impact on access to food, medications, healthcare	-Needs assessment -Advanced directives review -IADL/ADL

Abbreviations and references: CARG: Cancer and Aging Research Group Chemotoxicity Calculator [3]; BOMC: Blessed Orientation and Memory Concentration Test; MOCA: Montreal Cognitive Assessment; MNA: Mini Nutritional Assessment; AND/ASPEN: Academy of Nutrition and Dietetics/American Society of Parenteral and Enteral Nutrition Malnutrition Criteria [4]; TUG: Timed Up and Go test; SPPB: Short Physical Performance Battery; SF-36 PFS: Short Form-36 Physical Functioning Scale; IADL: Instrumental Activities of Daily Living; ADL: Activities of Daily Living.

[a] Providers may jointly interview patient due to time constraints.

plans which has led to scheduling follow-up appointments with specific providers, usually within one week of the initial virtual CARE appointment.

3. Physical Therapy Virtual Visits

Our physical therapists are the providers most frequently scheduling follow-up visits after the initial virtual CARE appointment. When transitioning to video visits, the physical therapy team considered which parts of the evaluation can be safely completed using this platform. The evaluation consists of collecting subjective information as outlined in the table. Clinical reasoning based on subjective report is needed to determine appropriate objective assessments for each patient. If the patient is determined to be safe, objective measures are performed [3]. These include posture and transfer assessment, range of motion screening, and 5 times sit to stand test. Education on exercise recommendations based on the physical therapy assessment is given to each patient.

Many patients have benefited from additional follow up virtual physical therapy visits to ensure proper and effective performance of exercises. Screening questions are asked at the beginning of each video visit to assess safety and barriers to performing a virtual physical therapy visit. The questions are as follows:

- Are you experiencing any shortness of breath, chest pain/tightness?
- Are you experiencing any new pain today
- Is your front door unlocked or anyone home with you today?
- Is your phone charged and located near you?
- Where are you currently located?
- Are you sitting in a stable chair?
- Are you on a non-slip surface?
- Have you had any issues with exercising at home?

During the COVID-19 pandemic, many geriatric oncology patients have experienced decreased activity levels, placing them at risk for muscle atrophy and falls. Through video visits, the physical therapist provides specific cueing for each exercise and is able to safely instruct and progress an individually tailored exercise program, making any accommodations in real time. An additional benefit over a telephone visit or an in person assessment is that the physical therapist is able to ensure the patient has a safe home set up, which is vital to decreasing fall risk in this population.

4. Non-Verbal Communication

The importance of non-verbal communication cannot be underestimated. Non-verbal cues are important for turn-taking behavior allowing for a smoother, more efficient interview. The quality of psychosocial care and patient satisfaction have also been linked to higher amounts of patient-directed gaze in the in-person clinical setting [4]. Research examining incorporation of technology through electronic health record review on patient-provider relationship reveals that some approaches are better than others. In a recent review, Wolfe et al. find that physically configuring clinic space for screen sharing and limiting use of electronic health records during difficult or emotional discussions are best practices [5]. A paradoxical finding of our use of video technology to conduct multi-disciplinary clinic visits is that we have transformed the triad of computer-patient-provider back to the fundamental patient-provider relationship by shifting the computer to a simple means of communication. In this consultative clinic, we frame our discussion on patient-directed goals of care for living with cancer, in line with evidence supporting limited use of electronic health records during emotional discussions.

Non-verbal communication is also important for our hearing impaired patients. We have identified hearing loss in the majority of patients completing audiometric assessment during in-person clinics. Many would qualify for hearing aids but do not obtain them due to lack of communication difficulty, stigma, or cost. The importance of speechreading as a “third ear” for patients with presbycusis has been established [6]. Use of video telehealth visits allow us to most closely approximate the in-person interaction allowing for both auditory perception and speechreading. We anticipate that not all communication difficulties can be overcome by the use of video alone and have also explored the use of the closed captioning feature within Zoom but have not yet had occasion to use it in a patient encounter. A further advantage of all team members remaining in the teleconference meeting is that we can serve as typist for closed captioning for each other.

In summary, we have transitioned our multi-disciplinary geriatric oncology clinic to a virtual telehealth format, primarily utilizing video

visits which we feel is important to promoting patient-provider relationships, facilitating clear communication, and enabling our patients to continue and progress through home-based exercise programs. Patient feedback has been largely positive thus far and we hope to report on this more formally in the future as we anticipate that this virtual modality for the CARE clinic will remain useful after physical distancing guidelines are lifted.

Disclosure

Dr. Rosko is a member of the editorial board for the Journal of Geriatric Oncology. None of the other authors have any relevant disclosures.

Authorship Contribution

Writing - original draft: S.W. & B.K.; Writing - review & editing: All Authors

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