

Report from West Virginia University Cancer Institute: Short-term and Long-term Changes in Care Delivery for our Immunocompromised Patients

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Consistent with our Consult-Liaison colleagues across the country, our psychiatry services quickly adapted in order to continue to provide meaningful care across our hospital system while managing the safety of all involved. Caring for patients with cancer during this time has presented unique challenges and led to both short-term and long-term changes in care delivery.

Due to temporary restructuring of our general psychiatry consult service in an effort to streamline care, we were able to increase our physician time in psycho-oncology, which has been essential to meeting the needs of the cancer center. Team members have participated in biweekly meetings with nursing leadership to assess the needs of nursing staff and respond accordingly. There have been weekly check-ins with the hematology/oncology fellows to provide opportunities for reflection and debriefing. We have actively served as liaisons between the cancer center staff and faculty and the peer support program that was developed through the Department of Behavioral Medicine.

The request for new patient evaluations in the outpatient and inpatient settings have both continued to rise since the onset of the COVID-19 pandemic. Given the ability to flexibly adjust schedules, we have been able to meet this need thus far. As patients with cancer are immunocompromised, most are already practicing above-average hand hygiene and social distancing in an effort to avoid illness. Early in the pandemic, we saw that most patients with standing cancer diagnoses coped relatively well with fears of infection- many experiencing very few changes to their daily routines and lives. However, the number of outpatient referrals for patients with new cancer diagnoses increased substantially as the fear of COVID-19 compounded cancer-related fears and the strict hospital-wide policies related to visitors limited access to in-person supports through friends and family. Outpatient visits continue to be transitioned to telemedicine video visits whenever possible. In this rural and mountainous location, there have been many challenges in delivering care with patients in their homes. Internet services are not available in many parts of the state. Cell service can be unpredictable. Many struggle with understanding and using new technologies and are often uninterested or even outright resistant to trying it. Given these factors, many patients have preferred to continue with in-person visits despite long travel distances to the cancer center. In addition, many cancer treatments must be delivered in-person at a medical facility, so the majority of patients in active cancer treatment have continued to present to the center at regular intervals. Based on these factors, we have maintained a higher than average number of in-person visits despite the COVID-19 pandemic.

All providers wear an N-95 mask covered by surgical mask as well as protective eyewear during all patient encounters. We are provided with new PPE once a week. Many new protocols and procedures have been put into place to increase the frequency of sanitizing surfaces throughout the building. Efforts are made to limit patient movement around the cancer center throughout the

day. Now, patients typically stay in one room with providers moving around rather than the prior approach to having our providers assigned to specific treatment rooms and patients moving between them as needed. This has limited the need for patients to return to the waiting rooms between visits. We continue with a “no visitor” policy. However, there have been some exceptions made to help facilitate patient care. For example, patients may now have one visitor present during their first oncology appointment and those with cognitive impairments are permitted a visitor at each visit.

Regarding psycho-oncology consults for hospitalized patients, we provide direct services to the oncology medicine service. Since all patients with suspected or confirmed COVID-19 are admitted to a designated hospitalist service, we have not yet been asked to care for a patient with COVID-19. We initially attempted to adapt all consults to utilize phones and iPads in order to limit face-to-face exposure risks. However, it quickly became apparent that the majority of consults were driven by patient loneliness and isolation. We also saw a trend of increased distress in patients near the end of life, even when anticipated, in the setting of limited visitor access. Following discussions with oncology, the decision was made to return to in-person consults very quickly. Our service has also expanded our role at times to offer a simple familiar face during new treatment initiations or prior to procedures. Clinic nursing staff have been eager to help in this way.

We are grateful to have significantly lower numbers of those infected with COVID-19 than what was predicted and what our colleagues around the world have faced. Fortunately, we have seen much less change in our day-to-day operations than we anticipated. This crisis has provided an opportunity for our mental health programming to shine and make a significant difference in the lives of our patients and our colleagues across disciplines. We have shown that utilization of telemedicine services is not only possible but very helpful in reaching our patients across the state. We are currently developing a plan to initiate formal telemedicine services to our largest community oncology program at the request of our administration. We have also been able to demonstrate a clear need for increased mental health services on our campus and are in discussions with administration to increase physician and therapist time in the cancer center for the coming academic year.

The author reports no relevant conflict of interest.