Outpatient Telehealth in Oncologic Palliative Care: Breaking Paradigms and Transforming the Current Reality

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Teleatendimento Ambulatorial em Cuidados Paliativos Oncológicos: Quebrando Paradigmas e Transformando a Realidade Atual

Telesalud Ambulatorio en Cuidados Paliativos Oncológicos: Romper Paradigmas y Transformar la Realidad Actual

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INTRODUCTION

With the pandemic of the coronavirus disease 2019 – COVIV-19[1], many health services were required to change their routines to match with a completely different and unknown reality. These changes needed to be implemented rapidly and effectively to preserve the consultation of the patients[2]. In this challenging context, medical and nurse telehealth were incorporated to the outpatient service of the Cancer Hospital IV (HC IV), Palliative Care Unit of the National Cancer Institute José Alencar Gomes da Silva (INCA).

The HC IV/INCA provides treatment to patients with advanced neoplasms and in progression who have no indication for disease changing treatments, only treatments to control the symptoms for better quality of life[3].

The objective of this article is to describe the process of implementation of the outpatient telehealth of HC IV/INCA.

DEVELOPMENT

Telemedicine

According with the World Health Organization (WHO)[4], telemedicine

> consists in the delivery of health care services, where distance is a critical factor, by all health care professionals using information and communication technologies for the exchange of valid information for diagnosis, treatment and prevention of disease and injuries, research and evaluation, and for the continuing education of health care providers, all in the interests of advancing the health of individuals and their communities"[4].

Worldwide in the last decades it was noticed the increasing use of Information and Communication Technologies (ICT) as complementary strategy in attention to health[5]. It started with medicine (called telemedicine) and from the decade of 1990, its broadening to health professions is transforming ICT in tools to improve the coverage of services, facilitate communication and information exchange among professionals and patients[6].

There are references distinguishing telemedicine and telehealth, the first would be limited to physicians and the second to other health professionals[6]. In addition, the term telenursing is coined when nurses consult remotely[5,6]. Regardless of this, these terms are used interchangeably as WHO suggests[4].

Telemedicine/telehealth was already utilized before the pandemic in other services and there is vast material published about its use in palliative care[7,8]. A study conducted by Hennemann-Krause et al.[9] in Rio de Janeiro (Brazil) between 2011 and 2013 noticed better control of symptoms when telemedicine was associated with in-person consultation. Salem et al.[10], in a study performed between 2015 and 2017 described the perception of correct clinical orientation, well-coming and emotional support of caretakers and relatives. Although with positive results and encouraged use, it is consensual that it does not substitute in-person consultation.

On March 2020 in the context of the pandemic, the Federal Council of Medicine (CFM) and Federal Council of Nursing (COFEN), as well as the Ministry of Health recognized the possibility and ethics of medical and

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nursing telehealth[1-13]. For the CFM[11], telemedicine can be conducted in the following manner:

- **Teleguidance:** for medical professionals who consult and refer patients in isolation;
- **Telemonitoring:** remote action performed under medical supervision and guidance for monitoring or validity of disease and/or health parameters;
- **Tele-interconsultation:** exclusively to exchange information and opinions among physicians for therapeutic and diagnostic support.

Telehealth as strategy to cope with the pandemic

With the beginning of the COVID-19 pandemic of and the increased exponential risk of infection of patients, family, and professionals it was necessary to reduce in-person consultations to a safe number to avoid unnecessary exposure of patients and their families in and out of the hospital environment (transportation) to avoid agglomeration[14].

At the same time, it was mandatory to keep control of patients' symptoms in home care to ensure quality of life and to avoid spontaneous demand at the HC IV prompt care unit and consequently, at the unit's[15] Hospital Admission.

Former well succeeded experiences associated with the orientation of the respective authorities encouraged the elaboration of a structured strategy for correct and safe use of medical and nursing telehealth in the unit's outpatient.

The strategy emerged as a proposal to cope with the current scenario with the following objectives to be met:

- Keep monitoring and correct control of the patients' symptoms.
- Reduce the number of in-person consultations avoiding agglomeration and unnecessary travels to the hospital.
- Identify patients and caretakers/family with clinical suspicion of COVID-19 and determine the required isolation to reduce the spread to the community.
- Identify and monitor patients with suspicion of COVID-19 and instruct the referral for in-person consultation, reducing the risk of the virus spread in the hospital.

Structuring the telehealth

Telehealth at the unit started on April 2020. A flow to manage the cases and referral for in-person consultation was created only for those patients where teleconsultation was unable to meet the current demands, being necessary the physical evaluation.

The administrative staff is assigned the logistic organization of the agenda which is sent to the health professionals responsible for the patients' evaluation (physician and nurse).

First-time patients, that is, recently referred from INCA units and who still haven't received the first consultation at HC IV are consulted in-person always by the multi-disciplinary team. In this case, the professionals call in the eve of the appointments just to screen possible COVID-19 symptoms.

Telehealth occurs through voice or video call. After this contact, the patients have access to a commercial phone number for contact with the professional during working hours if needed.

An initial card was created to standardize the procedures of telehealth with items that are mandatory to be evaluated (Table 1). The card is filled at every consultation informing worsening factors and/or uncontrolled symptoms and to determine whether telehealth will continue, or an in-person appointment will be scheduled. With the experience acquired along the time it was noticed that the in-person consultation is not indispensable for the correct follow up of patients and its use became optional according to the decision of the professional in charge of what is better in each case. The history of each consultation is recorded in electronic chart.

The professional in charge defined the schedule for the upcoming consultation (remote or in-person) according to the demands. Based in the telehealth, the necessity of changes/adjustments of the medication in use was identified, their continuation or necessity to attend the prompt care service, in-person consultation or even hospital admission. In addition, the nurse identifies the demands carefully and provides the necessary guidance. Once identified that the patient did not need an in-person consultation, the responsible physician would prepare its prescription for the family or designee to go to the hospital and have access to the medication and other materials that the nurse had requested.

Initial evaluation of telehealth

Initially, either the patient or its family were concerned they would be left adrift, although they understood the actual necessity of telehealth. Some patients were contrary to go to the hospital fearing COVID-19 and were eager for the virtual consultation.

Between April and December 2020, 1,535 medical telehealth and 2,205 nursing telehealth were performed. An initial subjective evaluation of the outpatient telehealth of the unit was performed, pondering advantages and disadvantages.

The relevant negative aspects were: lack/difficulty of access to technology by patients and relatives, hampering the communication; patients with

Chart 1. Telehealth Card

Date of the last visit:
KPS of the last visit:
Estimate KPS through phone contact:
Date of the last blood test:
Any significant alteration: ( ) No ( ) Yes, Describe _____
Have you been at the PCU since the last visit?: ( ) No ( ) Yes, motive:_____
Have you been hospitalized since the last visit?: ( ) No ( ) Yes, motive: _____

Symptoms:
Pain: ( )no ( )mild ( )moderate ( )severe
Dyspnea: ( )no ( )mild ( )moderate ( )severe
Somnolence: ( )no ( )mild ( )moderate ( )severe
Nausea: ( )no ( )mild ( )moderate ( )severe
Mental confusion: ( )no ( )yes
Vomit: ( )no ( )yes
Others: _____
Observations:
Vesico-intestinal function: Diuresis: _____
Defecation: _____

Any ostomy/drain/catheter/invasive device? ( ) No ( ) Yes, which one? _____
Observations:
Any wounds? ( ) No ( ) Yes, location:
Observations:
Any bleeding episode? ( ) No ( ) Yes, location:
Observations:
Fever with respiratory symptoms (dry cough, runny nose, dyspnea, sore throat, respiratory effort etc.)? ( )No ( )Yes

Conduct/guidance:
Phone contact made with: ( ) Patient ( ) Family
Conduct:
( ) Patient stable, has medication for more _____ days. Reschedule next visit.
( ) Patient stable, but medication/material for dressing at home is nearly ending. Only the responsible should come to the outpatient at the scheduled date.
( ) Patient with some uncontrolled symptoms, but possible change of medical prescription. Only the responsible should come to the outpatient.
( ) Patient with uncontrolled symptoms/necessity of in-person evaluation. The patient and responsible should come to the visit.

Captions: KPS = Karnofsky Performance Scale; PCU = Prompt Care Unit.

difficulty of communication via tele/videoconference (tracheostomized, hearing deficit, neurologic deficit, among others); difficulty of transportation among municipalities during the pandemic (transportation out of the household and collective transportation); difficulty of access of the primary attention/health team.

The positive aspects perceived were: possibility of continuing to provide care to the patients; strengthening of the caring team; confidence of the patients and relatives in the work that the team provided; possibility of creation of network with other closer health services to the patient and preparation of prescriptions and reports by the Regional Rio de Janeiro Medicine Council (identified as facilitator for the patients who were unable to go to the hospital to pick up the prescriptions and medications).

In despite of the disadvantages perceived, the advantages and benefits of the method were successful. This strategy continues and probably will be incorporated in the unit definitely.

No increase of the emergency calls or hospitalization in the same period was observed according to the indicators investigated. Certainly, telehealth favored the

maintenance of these indicators since the number of in-person consultations reduced drastically.

CONCLUSION

Although more thorough studies need to be performed for the benefit of the work conducted at HCIV/INCA, telehealth has been shown a key strategy the COVID-19 pandemic created. Even after the end of the pandemic and the possibility of resuming in-person unrestricted consultation, the continuation of telehealth will help patients with difficulty or unable to go to the hospital because of clinical and/or social situations.

The possibility of training Primary Attention teams was evaluated as they could potentially act as consulting instance to discuss cases of definition of conducts and broaden the supporting network for patients in need of palliative oncologic care.

CONTRIBUTIONS

The authors participated of all the stages of the manuscript and approved the final version to be published.

DECLARATION OF CONFLICT OF INTERESTS

There is no conflict of interests to declare.

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