

This is Tammy McCausland bringing you SROA Soundboard. I'm joining today by Dr. Bisham Chera, Associate Chair of Clinical Operations and Improvement, and Director of Patient Safety and Quality in the Department of Radiation Oncology at the University of North Carolina School of Medicine. We're speaking about radiation oncology in the time of the pandemic. Welcome, Dr. Chera.

Tammy:

What actions did your facility take, and what has been the hardest since the coronavirus took hold? (0:28)

Bisham:

Yeah, so in our department, like many other radiation oncology departments, what we've done is try to have as many staff members work remotely from home as possible. And what that means is that if you can work from home, we want you to work from home. And that's all staff. Now that's really hard for our therapists to do that, obviously because they are front line workers treating patients. Another thing that we've done is try to do more physical distancing even at work. And all of our conferences are remote, Webex, where we're all in our offices, but we're all dialed in. And also when we're working in the clinics we try to practice physical distancing between ourselves.

We've moved to more telehealth work for our patients, so we're doing more tele-visits, that's telephone calls and also video visits with the government deregulating this now, it's allowed us to do more of this, and this reduces the ... The goal is to reduce the number of patients coming through our clinic to minimize them being exposed and also to create physical distancing for the patients and the providers. And so, I think that that's going to change the way medicine is practiced. And I think after the COVID-19 epidemic this telehealth is going to be a main part of medical care for patients in the United States.

Tammy:

And what about the patients when they actually have to come for treatment? What kind of measures are you taking, and what have you been telling the patients to do either before they arrive and after they leave? (2:23)

Bisham:

Yeah, so we are, and this is a standard practice among all clinics, is to screen patients. So, our admin staff when they call patients, for the few that come in for follow-ups or consults they're screened on the phone with a set of hospital administration approved screening questions to try to see if they may be at risk of having COVID, they get screened before their visit, the day before, a couple of days before. When they come, to check-in, our front desk staff has set up physical barriers to create physical distancing between the front desk staff and the patient checking in. At least six feet. But the front desk staff also screen them with the same questions.

For patients who are on treatment what we do is that our therapists every day screen the patients with questions. The screening question changes every week or even faster than that. One day it's fever is the screening question and then the next day it's not, so we've been trying to keep up with the hospital guidelines. So, there's a lot of screening questions, screening with questions. And if a patient is positive per the screening question then there's a whole procedure of getting the patient tested for COVID-19. So, if a patients screens positive and they're at home and they call in as coming in for visit, and they screen positive by the admin person, the admin person gives them a COVID-19 hotline to call which is run by our UNC hospital systems and there's someone who does a telehealth visit with them and determines whether the patient needs to stay home or come into our drive through COVID-19 testing.

If a patient's in a clinic and they screen positive they immediately get put into an isolation room, given a mask, and we call infection control or we also can get them over to get tested for COVID-19 at our walk-in facility.

Tammy:

Have you had any patients test positive? (4:40)

Bisham:

We have not. We've had several patients who screened positive to the question and then they have a COVID-19 test done and they're a person under investigation, and we've had several of those kinds of patients where they're on treatment, or they're about to start treatment and they have to have a COVID-19 test performed. And usually, the test result comes back in 24 to 48 hours, but it depends on who's doing the testing. Sometimes it can take up to two weeks, so once the patient is identified as possible COVID-19 infection and they get this test, we tell the patient that we're not able to, per hospital policy, treat you or have you come into the clinic until we get the test result.

So, we had several patients had to have their radiation delayed somewhat, that had to go into radiation break for a couple of days while we waited, the COVID-19 results to come back. So far they've always been negative, and we're able to resume treatment for these patients.

Tammy:

What about the facilities themselves, in terms of the physical keeping ... If you have a patient that's been on the table, what kind of sanitization practices are you using to make sure, just in case somebody may have been exposed to COVID and they don't show symptoms? (5:39)

Bisham:

Yeah, so even before this COVID-19 issue it's standard practice for our therapists in the vault to wipe down treatment devices and the table couch top with sanitizing wipes that specifically disinfect for SARS and other viruses and bacteria. And in fact, I actually went and checked all these wipes and looked at their labels and the labels say that it does disinfect for coronavirus and SARS, so even before we had this issue our therapists were doing this standardly. Since the coronavirus epidemic has occurred, or pandemic rather, we have just reinforced strict

sanitization in between patients and the big issue is that we would love for our front line staff to have masks, surgical masks to wear every day, but currently, with the low supply of the personal protective equipment, and also in radiation oncology we are not a high-risk clinic for having a lot of patients come in with COVID, we don't have the supplies to give our therapists to wear a mask every day.

Tammy:

So, what are you telling the staff that you wish you could give those supplies to, but you can't because of the shortage? (7:23)

Bisham:

Yeah, I mean, so we ... They're screening patients with questions, and so hopefully that will help them identify patients sooner rather than later that possibly having the COVID-19 infection. We've reinforced proper policy and procedure with taking care of patients. We continue to advocate at the hospital level that once personal protective equipment is available and if there's enough supply we want to have that for our staff, our nurses, our therapists. I mean, it's somewhat controversial depending on who you talk to, whether masks are protective or not, but it appears that there may be some protection and also prevention of spreading the virus if you're a carrier and asymptomatic. Something else that we've done is that we've instructed every treatment patient about the coronavirus and what they need to be looking for, what they should be doing.

So, in our on treatment status checks, I know I do it and now my colleagues do it, we educate the patient almost every status check and we talk about the virus and the fact that they're somewhat immuno-compromised, so they have a higher risk of getting the infection. And if they get the infection because they're immuno-compromised and a cancer patient they have a higher risk of a complication, a bad outcome rather, from the virus meaning a higher chance of being intubated or dying. Being hospitalized. And so part of that education is we tell them, "If you develop cold-like symptoms, do not come in. Give us a call and we will triage you to the right clinic or to get tested for COVID-19." We tell them not to go to the ER, we say, "Give us a call, don't come in and we'll work with you over the phone to get you tested or whatever needs to be done."

Tammy:

You mentioned at the beginning, that more delivery of services through telehealth is going to change the way medicine is practiced even after the pandemic. Could you elaborate a little bit on why you think that is the case and how it will change? (9:40)

Bisham:

Yeah, I think access to care has always been an issue, so with the deregulation and the loosening of ... Deregulation not in a bad way, I mean they've removed a lot of red tape so that we can do this more freely and more readily for patients. So, I think what's going to happen is

patients are going to be able to get more specialty consultations without having to come in and drive four or five hours, so I think that they'll get better consultative services.

Also, and I think in surveillance, the cost of cancer care is expensive, but a good chunk of the cost comes from surveillance, following patients after treatment and all the visits and the imaging studies and whatnot, laboratory studies. And I can definitely see for patients who have projected excellent outcomes after treatment and patients who also known to have minimal long time side effects, depending on their cancer and type of treatment, those patients could be surveilled and monitored through telehealth. I'm going to propose that for that low risk, that prostate cancer patient who's in follow up, really the major thing in follow up is to check the PSA, so you can easily get your PSA done locally and you could have a telehealth visit for survivorship issues.

And so, I think that maybe it'll improve patient's compliance with follow up, it'll reduce the cost of follow up, better access to good surveillance follow up care, and the diagnostic world is changing so quickly where there's a lot more blood-based biomarkers that are being developed. For example, circulating tumor HPV DNA can be used to detect cancer recurrence, so you can imagine that warfarin cancer patient who received chemoradiation, five years out they still need to be seen, but they get the blood test done locally and have a tele-visit for survivorship care issues over the phone or through the video.

Tammy:

Is the pandemic also going to change the way we look at patient's safety and quality in radiation oncology? (12:07)

Bisham:

Our profession is by nature more ... It's easier for us to be focused on quality and safety, part of it because of the engineering kind of fashion of our work, and so our think our specialty does naturally focus on that and with this coronavirus pandemic, how's it changed what we do? Well, I mean, I think that we will continue to focus on quality and safety, it's definitely made us more attuned to infection control things and issues, but I think that we will continue to have a strong interest in focusing on quality and safety even after all of this.

Tammy:

Last question. What advice would you have for other radiation oncology administrators and other staff that are involved in radiation oncology to help get through this pandemic? (13:14)

Bisham:

Yeah, I mean this is obviously a very challenging time, and for a hospital administrator, you have to worry about keeping your staff healthy and safe and keeping the patients healthy and safe. And in this time it's hard to plan for what you don't know is going to happen, the unexpected, but the number of COVID emails that I get in a day it's pretty astonishing, and as

an administrator, I'm sure that they get twice as many as I do. Planning for having a quarter of your staff, one day you show up one day and we get told there was a COVID-19 patient that we didn't know about and occupational health or infection control says that you quarter of your staff have to be quarantined for two weeks.

Those are the kind of things that as an administrator, you've got to treat the patients, you've got to have staff to do it. How do you plan ahead for these possible disaster situations? Trying to get people to work remotely, I know people have done creative things, they'll have a team A, team B that never see each other in the department. The team A comes in, and then team B comes in, but team B and team A don't interact to minimize transferring and getting infected or exposed.

I've heard of departments basically setting up a Noah's ark where three weeks ago they picked two physicists, and two physicians, a couple of therapists, dosimetrist, a small selection of everybody from every division of the department, and they said, "You guys leave, don't even come to work. Work remotely, never come in, and we're doing this just in case that all of us get sick then we'll at least have a backup team to come in." So, there's a lot of people doing a lot of creative stuff, but I think that from an administrator side one of the hardest things to plan for, but should be planned for, is you walk in one day and get told by someone, a regulator, a quarter of your staff can't come in for two weeks.

Tammy:

Thanks for those examples, it was a pleasure talking to you today, I really appreciate your time.