



Original Research

Patient and Provider-Reported Satisfaction of Cancer Rehabilitation Telemedicine Visits During the COVID-19 Pandemic

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Abstract

Introduction: The coronavirus disease 2019 (COVID-19) pandemic has accelerated the growth of telemedicine services across the United States. In this study, we examined cancer rehabilitation patient and physician satisfaction with telemedicine visits. We also sought to evaluate the types of provider services that are given during telemedicine visits.

Objective: To assess overall patient and provider satisfaction with telemedicine visits and explore whether satisfaction varied by contact method (phone or video) and encounter type (new problem, worsening problem, stable/improving problem).

Design: Prospective survey study.

Setting: Cancer rehabilitation program at an academic medical center.

Participants: Three cancer rehabilitation providers and 155 unique patients participated in the study.

Interventions: Not applicable.

Main Outcome Measures: Provider and patient satisfaction measured by customized surveys.

Results: One hundred eighty-four encounters with 169 unique patients were scheduled. Of these, 14 were new visits and 170 were follow-up visits. Eighteen encounters (9.8%) were either no shows or rescheduled, making for 166 encounters with 155 unique patients. Patient and provider responses comprised the following: 94.8% of patient responses reported “quite a bit” or “very much” for the telemedicine visit being a good experience; 63.1% of patient responses reported “quite a bit” or “very much” for interest in using telemedicine visits in the future; and 83.9% of provider responses reported “quite a bit” or “very much” for the patient’s main problem being addressed by the visit. Providers were more likely to prefer an in-person visit for a new or worsening problem versus a stable/improving problem. The most common services provided were medication prescription/titration and education/counseling. The least common services provided were making of new diagnoses, ordering interventional procedures, and making referrals.

Conclusion: Telemedicine visits were well received by both patients and providers in a cancer rehabilitation medicine clinic setting. However, in the case of a new or worsening problem, satisfaction declined. These data support that telemedicine visits should be considered essential as part of comprehensive cancer rehabilitation care, especially during a public health crisis.

Introduction

The coronavirus disease 2019 (COVID-19) pandemic has resulted in hundreds of thousands of deaths and caused significant worldwide economic loss. To manage the influx of COVID-19 patients, health care systems have turned to telemedicine to engage patients and simultaneously reduce in-person contact, conserve personal protective equipment, and redeploy facilities for the care of COVID-19 patients.

Since the onset of the pandemic, many health care systems have increased their proportion of telemedicine

visits, with some increasing from less than 100 telemedicine visits daily to over 600.¹ The level of interest in telemedicine has increased as the number of COVID-19 cases has risen, with medical specialties ranging from otolaryngology to allergy and immunology reporting high rates of satisfaction with telemedicine.²⁻⁴ Within the field of rehabilitation, general recommendations for conducting telemedicine visits have been recently published⁵ and the use of telemedicine in a sports and musculoskeletal practice has previously been well received by both patients and providers.⁶ Telerehabilitation remains

relatively unexplored in other areas of rehabilitation, including cancer rehabilitation.

Cancer patients represent a unique challenge to telerehabilitation. Their rehabilitation needs vary depending on disease type and stage and treatment rendered, and those with active disease may have sudden changes in their symptoms. Although Cheville et al found that virtual physical therapy was effective in improving function and reducing pain in patients with advanced cancer,⁷ it is not clear that the multiple complex problems of cancer rehabilitation medicine patients, which may require a thorough physical examination, can be successfully evaluated through virtual visits. Furthermore, given that patients with active cancer are at increased risk of negative outcomes from COVID-19^{8,9} and potentially from other communicable diseases, having a robust and effective telerehabilitation program for cancer patients is essential for this at-risk population.

Telemedicine may also play a role in helping physiatrists keep up with the growing clinical needs of cancer patients. There are an estimated 16.9 million cancer survivors in the United States as of 2019, with expected growth to 22.1 million cancer survivors by 2030.¹⁰ This is in stark contrast to a growing, yet limited, clinical workforce trained in providing cancer rehabilitation medicine services, many of whom provide care clustered in tertiary centers.¹¹ In addition, many patients must travel a long distance to reach large cancer centers in which many cancer rehabilitation programs reside, and cancer-related impairments may make this travel more difficult.¹² As the need for cancer rehabilitation services continues to outpace availability, it will be vital to use telemedicine to extend the reach of these services to reduce health care delivery disparities.

Given this need, the authors evaluated the effectiveness of physician-based telerehabilitation for cancer patients, including both patient and provider satisfaction, in an outpatient cancer rehabilitation practice.

Methods

This was a prospective, single-institution study completed by patients and providers within a cancer rehabilitation program at an academic medical center in the United States. This study received a status of “not regulated” by the institutional review board as it qualified as a quality improvement project with activities rather than human subjects being the object of the study.

Surveys were sent out to patients and three cancer rehabilitation physiatrists following video or phone patient care encounters from 25 March 2020-31 May 2020. Questions on the surveys were developed through consensus decision based on what information would be useful for rehabilitation providers and was constructed based on prior studies evaluating patients’ perceived utility of telemedicine visits.¹³⁻¹⁵ The patient survey consisted of seven items answered on 5-point Likert scales

from a score of 1 corresponding to “not at all” to a score of 5 corresponding to “very much.” A final space was available at the end for open-ended comments. The provider survey consisted of six items rated on the same 5-point Likert scales. Video visits were conducted using either Zoom (Zoom Video Communications Inc, San Jose, CA), Doxy.Me (Doxy.me LLC, Rochester, NY), or the institution’s native system embedded in the electronic medical record (Epic Systems Corporation, Verona, WI). Survey data were collected and managed using REDCap (Research Electronic Data Capture).^{16,17} Providers logged into REDCap directly and completed surveys for each patient encounter. Providers did not view patient responses until the data were analyzed in total.

Statistical Analysis

The data were analyzed in aggregate using descriptive statistics conducted with SPSS (IBM, Armonk, NY, v27 2020). Each visit was stratified by contact method (phone or video) and by encounter type (new problem, pre-existing worsening problem, or pre-existing stable/improving problem). Chi-square analysis was performed for all responses to the patient and provider surveys stratified by encounter type, contact method, age, and provider. For subgroup analysis in comparing items rated by both providers and patients, nonparametric correlation coefficients with one-tailed significance testing was performed.

Results

One hundred eighty-four encounters with 169 unique patients were scheduled during the study period, which corresponded to a large surge of COVID-19 cases in the institution’s region. Of these, 18 encounters were either rescheduled or the patients did not show up (9.8%), making for 166 encounters with 155 unique patients. The frequency of visits stratified by contact method and encounter type are shown in Table 1. Women made up nearly two-thirds of the study population and ages ranged from 22 to 83 years. Patients were seen for a variety of reasons but were mostly seen for pain symptoms. Patients presented with a wide variety of primary malignancies (Table 1).

Patient Responses

There were 76 patient responses for a response rate of 45.8%, which is consistent with prior telerehabilitation survey results.⁶ Of these, 30 were phone visits and 46 were video visits. Forty-three were for improving/stable problems, 25 were for worsening problems, and eight were for new problems. In response to “overall was the telemedicine visit a good experience,” most of the responses stated “quite a bit” or “very much” (Table 2). Similarly, most responses reported high

Table 1
Demographics and visit characteristics

	n (%)
Mean age	57.6
Gender	Female, 101 (65.2); Male, 54 (34.8)
Treatments received	
Systemic	121 (78.1)
Surgery	116 (74.8)
Radiation	99 (63.9)
Cancer stage	I-III, 59 (38.6); IV, 59 (38.6); Unknown, 35 (22.9)
Bladder/urethral	5 (3.2)
Brain	11 (7.1)
Breast	43 (27.7)
Colorectal	4 (2.6)
Gynecologic	6 (3.9)
Head/neck	12 (7.7)
H/O AlloBMT	10 (6.5)
Lung	6 (3.9)
Melanoma	8 (5.2)
Multiple myeloma	10 (6.5)
Prostate	4 (2.6)
Renal	2 (1.3)
Sarcoma	12 (7.7)
Thyroid	3 (1.9)
Other	25 (16.1)
Contact method	Phone, 73 (47.1); Video, 82 (52.9)
Visit type	New Visit, 11 (7.1); Follow-Up, 144 (92.9)
Encounter type	New Problem, 18 (11.6) Worsening Problem, 54 (34.8) Stable/Improving Problem, 83 (53.5)

satisfaction when asked if their main problem was addressed by the visit (Table 2). When we stratified by contact method and encounter type, satisfaction was

consistently higher for video versus phone visits (Table 3). Patients’ comments ranged from supportive to critical of telemedicine. The comments in support of telemedicine noted the benefits of social distancing and the efficiency and time saved by avoiding travel, which for some patients was noted to be in the range of hours. One patient commented “A great alternative to keep safe at this time.” Another patient noted “... We don’t have to travel to the hospital, valet park...I feel that I am receiving quality time in a video call.” Negative comments included technical difficulties in using video visits (initiating the visit and losing connection), with one comment noting, “Getting to the actual video visit was annoying, repetitive, and time consuming.” Other critiques were the inability to have vital signs checked, and one comment by an out-of-state patient lamented the inability to interface via video due to guidelines mandated by the Centers for Medicare & Medicaid Services prohibiting video visits with providers in a different state.

Provider Responses

There were 155 provider responses for a response rate of 93.4%. In response to “the patient’s main problem addressed by the visit” most responses stated “quite a bit” or “very much” (Table 2). In response to “an in-person physical exam would have changed the treatment plan” the majority of responses stated “not at all” or “a little bit.” When the question asked if the providers would have preferred an in-person visit, a lesser majority of

Table 2
Patient/provider survey responses

	Not at all n (%)	A little bit n (%)	Somewhat n (%)	Quite a bit n (%)	Very much n (%)
Patient survey (N = 76)					
-My main problem was addressed by the phone/video visit	0 (0)	1 (1.3)	5 (6.6)	17 (22.4)	53 (69.7)
-I was able to give my doctor all the important information I wanted to	0 (0)	2 (2.6)	0 (0)	14 (18.4)	60 (78.9)
-I am satisfied about how much time my doctor spent with me	0 (0)	0 (0)	1 (1.3)	11 (14.5)	64 (84.2)
-I would have preferred to see my doctor in person	18 (23.7)	8 (10.5)	24 (31.6)	13 (17.1)	13 (17.1)
-My doctor was paying attention to me	0 (0)	0 (0)	1 (1.3)	6 (7.9)	69 (90.8)
-I am interested in using phone/video visits in the future	2 (2.6)	1 (1.3)	25 (32.9)	15 (19.7)	33 (43.4)
-Overall, the phone/video visit was a good experience	1 (1.3)	0 (0)	3 (3.9)	24 (31.6)	48 (63.2)
Provider survey (N = 155)					
-I would have preferred an in-person visit	60 (38.7)	41 (26.5)	30 (19.4)	14 (9)	10 (6.5)
-An in-person physical exam would have further specified the diagnosis	62 (40)	44 (28.4)	24 (15.5)	17 (11)	8 (5.2)
-An in-person physical exam would have changed the treatment plan	101 (65.2)	29 (18.7)	16 (10.3)	6 (3.9)	3 (1.9)
-The patient’s main problem was addressed by this visit	3 (1.9)	5 (5.2)	17 (11)	28 (18.1)	102 (65.8)
-I was able to convey all important information to the patient	2 (1.6)	2 (1.6)	6 (3.9)	16 (10.3)	129 (83.2)
-The patient was able to convey the needed information for me to give an accurate diagnosis and reasonable treatment plan	2 (1.6)	2 (1.6)	6 (3.9)	19 (12.3)	126 (81.3)

Table 3
Physician and patient visit rating comparisons by encounter type and contact method

		Encounter type				Contact method		
		New problem n (%)	Worsening problem n (%)	Stable problem n (%)		Phone n (%)	n (%)	
Physician ratings (N = 155)								
I would have preferred an in-person visit	Not at all	1 (5.6)	13 (24.1)	46 (55.4)	<i>P</i> < .001	24 (32.9)	36 (43.9)	<i>P</i> = .056
	A little bit	8 (44.4)	13 (24.1)	20 (24.1)		18 (24.7)	23 (28.0)	
	Somewhat	3 (16.7)	16 (29.6)	11 (13.3)		13 (17.8)	17 (20.7)	
	Quite a bit	4 (22.2)	9 (16.7)	1 (1.2)		10 (13.7)	4 (4.9)	
	Very much	2 (11.1)	3 (5.6)	5 (6.0)		8 (11.0)	2 (2.4)	
An in-person physical exam would have changed the treatment plan	Not at all	7 (38.9)	25 (46.3)	69 (83.1)	<i>P</i> < .001	44 (60.3)	57 (69.5)	<i>P</i> = .655
	A little bit	8 (44.4)	15 (27.8)	6 (7.2)		15 (20.5)	14 (17.1)	
	Somewhat	2 (11.1)	9 (16.7)	5 (6.0)		9 (12.3)	7 (8.5)	
	Quite a bit	0	4 (7.4)	2 (2.4)		4 (5.5)	2 (2.4)	
	Very much	1 (5.6)	1 (1.9)	1 (1.2)		1 (1.4)	2 (2.4)	
The patient's main problem was addressed by this visit	Not at all	1 (5.6)	1 (1.9)	1 (1.2)	<i>P</i> = .150	1 (1.4)	2 (2.4)	<i>P</i> = .616
	A little bit	0	3 (5.6)	2 (2.4)		4 (5.5)	1 (1.2)	
	Somewhat	2 (11.1)	9 (16.7)	6 (7.2)		8 (11.0)	9 (11.0)	
	Quite a bit	3 (16.7)	14 (25.9)	11 (13.3)		14 (19.2)	14 (17.1)	
	Very much	12 (66.7)	27 (50.0)	63 (75.9)		46 (63.0)	56 (65.3)	
Patient ratings (N = 76)								
My main problem was addressed by the phone/video visit	Not at all	0	0	0	<i>P</i> = .950	0	0	<i>P</i> = .456
	A little bit	0	0	1 (2.3)		1 (3.3)	0	
	Somewhat	1 (12.5)	1 (4.0)	3 (7.0)		3 (10.0)	2 (4.3)	
	Quite a bit	2 (25.0)	6 (24.0)	9 (20.9)		6 (20.0)	11 (23.9)	
	Very much	5 (62.5)	18 (72.0)	30 (69.8)		20 (66.7)	33 (71.7)	
I would have preferred to see my doctor in person	Not at all	2 (25.0)	5 (20.0)	11 (25.6)	<i>P</i> = .730	8 (26.7)	10 (21.7)	<i>P</i> = .070
	A little bit	0	3 (12.0)	5 (11.6)		4 (13.3)	4 (8.7)	
	Somewhat	1 (12.5)	9 (36.0)	14 (32.6)		4 (13.3)	20 (43.5)	
	Quite a bit	3 (37.5)	3 (12.0)	7 (16.3)		6 (20.0)	7 (15.2)	
	Very much	2 (25.0)	5 (20.0)	6 (14.0)		8 (26.7)	5 (10.9)	
I am interested in using phone/video visits in the future	Not at all	0	1 (4.0)	1 (2.3)	<i>P</i> = .586	2 (6.7)	0	<i>P</i> = .233
	A little bit	0	0	1 (2.3)		1 (3.3)	0	
	Somewhat	3 (37.5)	10 (40.0)	12 (27.9)		11 (36.7)	14 (30.4)	
	Quite a bit	0	3 (12.0)	12 (27.9)		5 (16.7)	10 (21.7)	
	Very much	5 (62.5)	11 (44.0)	17 (39.5)		11 (36.7)	22 (47.8)	
Overall, the phone/video visit was a good experience	Not at all	0	0	1 (2.3)	<i>P</i> = .712	1 (3.3)	0	<i>P</i> = .417
	A little bit	0	0	0		0	0	
	Somewhat	0	1 (4.0)	2 (4.7)		2 (6.7)	1 (2.2)	
	Quite a bit	3 (37.5)	5 (20.0)	16 (37.2)		8 (26.7)	16 (34.8)	
	Very much	5 (62.5)	19 (76.0)	24 (55.8)		19 (63.3)	29 (63.0)	

P-values in the table refer to Chi-square tests of responses to each item by encounter type and contact method, respectively.

responses stated, “not at all” or “a little bit.” Provider responses favored visits for stable/improving problems over new/worsening problems. They also trended towards favoring video visits over phone visits (Table 3). There was a greater number of responses stating that providers would have preferred an in-person visit when problems were new or worsening or when visits were conducted through phone.

Services Provided

Services provided during each encounter included new diagnosis made, medication prescribed/titrated, education/counseling, work-up ordered, therapy ordered (eg, physical or occupational therapy), home exercise program prescribed, diagnostic or therapeutic interventional procedure ordered (eg, epidural steroid injection, nerve block, botulinum toxin injection), referral made

to another medical specialty, orthotic ordered, and other. Frequencies of provided services are listed in Table 4. The most common services provided were education/counseling, medication prescription/titration, and prescription of home exercise programs. The least common services provided were making of new diagnoses, ordering diagnostic or interventional procedures, and making referrals. “Other” services provided included coordination of care with other health care providers, prescription of therapeutic modalities, and provision of physician letters for employment/personal reasons. To our knowledge, no adverse events resulted directly from visits being virtual and not in-person.

Subgroup Analyses

Multiple subgroup analyses were performed. The first analysis looked at age as a variable of patient

Table 4
Services provided

	n (%)
New diagnosis made	8 (5.2)
Medication prescribed or titrated	73 (47.1)
Education and counseling	117 (75.5)
Work-up ordered	18 (11.6)
Therapy ordered (PT/OT/SLP/Neuropsychology)	19 (12.3)
Home exercise program prescribed	46 (29.7)
Interventional procedure ordered	9 (5.8)
Referral made	7 (4.5)
Orthotic ordered	11 (7.1)
Other	18 (11.6)

PT: Physical therapy, OT: Occupational therapy, SLP: Speech language pathology

satisfaction. Multiple cut-off ages were used and ages greater/less than 50, 55, 60, 65, and 70 years were all evaluated. There were no differences in satisfaction rates using any of these ages as cut-off points. Subgroup analysis of results for which both patient and provider responses were available was also conducted. Specifically, analysis of responses for questions that were asked to both providers and patients was performed and included the questions “the main problem was addressed by the visit,” “an in person visit was preferred,” and “all important information was conveyed.” There was a significant, yet weak correlation (Spearman’s $\rho = 0.199$, $P = .042$) for the question of if the main problem was addressed by the visit. There were no significant correlations for the remaining questions. Finally, subgroup analysis was performed to evaluate for interprovider differences. There were significant differences in provider satisfaction for all items except for “an in-person visit would change the treatment plan.” This contrasts with patient satisfaction for which there were no significant differences in responses except for a significant difference for “my doctor was paying attention to me.”

Discussion

The purpose of this study was to assess overall patient and provider satisfaction with telerehabilitation stratified by contact method (phone or video) and encounter type (new problem, worsening problem, or stable/improving problem). We also sought to determine what types of services can be provided through these encounters. As with other telemedicine satisfaction studies, including other medical and surgical subspecialties,^{3,4,6} our study demonstrated an overall high level of satisfaction among patients and providers with both video and phone visits.

From a patient perspective, satisfaction tended to be marginally higher when encounters were for stable/improving problems or were conducted through video versus phone. Because new or worsening problems may require a physical exam, these visits may be considerably

more difficult to conduct via telemedicine, especially through phone. As such, these results were concordant with the expectations of the authors. An unexpected finding was that age did not appear to affect patient satisfaction although, it should be noted that the mean age of this population was 57.6 years. Further study may be indicated for geriatric populations.

From a provider perspective, satisfaction was higher when problems were stable/improving and when visits were conducted through video. Satisfaction with the lack of a physical exam and the addressing of a patient’s main problem was less for worsening problems than for new problems. It is difficult to draw firm conclusions from this, as there were far fewer encounters for new problems than for worsening problems; however, these differences could also be attributed to the wide variation in reasons for new patient evaluations. It is also notable that there was significant variation in satisfaction between providers, indicating the importance of individual comfort level and style in utilizing telemedicine. Although satisfaction varied between providers, the same variation in satisfaction was not observed among patients when stratifying by individual providers.

Given that much of rehabilitation care is dependent on a thorough physical exam, which is considerably limited over telemedicine platforms, our results that provider satisfaction is diminished when evaluating a patient for new and worsening problems was expected. This is also in line with the findings of Tenforde et al that potential uses of telehealth for sports, spine, and pain management may be those that do not require physical exam.¹⁸ This is compounded by the unpredictable nature of cancer patients, who may have acute changes to their symptoms or function, and a full neuromusculoskeletal exam may help determine if the patient needs urgent diagnostic testing or interventions. In these cases, providers may be hesitant to order interventional procedures without being able to perform a physical exam, which may explain the low amount of interventional procedures ordered.

This is not to say that every new patient referred to the cancer rehabilitation clinic has to be seen in-person. There are circumstances in which a telemedicine encounter is entirely appropriate, as with the patient presenting for preoperative counseling or purely cognitive concerns in which complete and clinically valuable assessments can be conducted through phone or video. For example, one of the new encounters was for preoperative amputation counseling, and both patient and provider expressed a high amount of satisfaction with the video visit. This is contrasted with previously known worsening problems, which are typically physical symptoms and frequently require a physical exam. The results of our study suggest that cancer rehabilitation patients with new or worsening symptomatic concerns, especially pain or neurologic complaints, should be seen in person.

Regarding the mode of telerehabilitation, satisfaction was consistently higher among both patients and

providers when visits were conducted through video versus phone. One explanation for this is the greater capacity of video in performing a physical exam. Through video we can assess range of motion, evaluate gait, and to a degree even perform special testing such as straight leg raise or Spurling's maneuver. Although not a perfect substitute, allowance for these physical exam techniques may bolster both physician and patient confidence that problems are stable and treatment plans are working appropriately. On the patient side it is possible that patients may feel that they have more attention from their physician as there was a trend for increased satisfaction with video. It is also possible there are more concrete benefits leading to increased satisfaction. One study evaluating the efficacy of remote video examinations versus telephone consultations for acute stroke found that patients evaluated through video had lower 10-day mortality and greater diagnostic accuracy despite a higher transfer to the stroke center following telephone consultations.¹⁹ However, even though phone visits were not rated as highly in our study, they still had substantial support and are perhaps most adequate for situations in which no physical exam is needed such as follow-up after an intervention, medication titration, or if a patient is unable to use and/or have access to video services.

Telemedicine will be a vital bridge in reaching underserved populations, especially those in rural locations. It is estimated that less than 15% of cancer patients receive their care at tertiary centers, which is where a significant portion of cancer rehabilitation providers are concentrated.¹¹ Frequently patients who do receive their care at such cancer centers live far away and 24% of Medicare beneficiaries have reported traveling more than 1 hour to reach their cancer care sites.²⁰ In addition to its apparent effectiveness in delivering patient care, telerehabilitation can eliminate long commutes for patients and their caregivers and reach patients who live in more remote locations. Unfortunately, there are barriers that telemedicine will not be able to cross. Patients without the financial resources to conduct video visits (eg, phone or computer with a camera, high speed internet) and those with less technologic literacy may not be able to utilize telemedicine. A review by Kruse et al showed the most frequent barriers to include technically challenged staff, cost, age of the patient, and level of education of the patient.²¹ Such disparities could indeed create a greater gap in care received by already marginalized patient populations and will need to be further considered moving forward. Also limiting the reach of telerehabilitation is that many patients cross state lines to receive cancer care and current regulations prohibit video visits from being conducted across state lines.

Our study has several limitations. As a single institution study, findings may not be generalizable to other practices, although the results of overall patient satisfaction are consistent with other telemedicine studies.^{3,4,6} It is also unclear if patients would be as amenable to

telerehabilitation outside of the COVID-19 pandemic. In addition and perhaps most notable, the question in the patient survey regarding preference to see their doctor in person had answers that were more often inconsistent with other answers, possibly due to a reversal in the polarization of the answers for that single question, as a response of "very much" correlates as a negative aspect of the telemedicine visit. It is also possible that some patients may have preferred to see their providers in person but were not able to because of the pandemic. During the initial ramping down of ambulatory services, only those patients with urgent/emergent issues were allowed in-person visits so an element of their autonomy was removed. Finally, this study does not address the potential for technical difficulties during telerehabilitation visits and did not assess patient comfort level with using telerehabilitation platforms.

Conclusion

Patients and providers within a cancer rehabilitation medicine clinic were overall satisfied with telerehabilitation visits during the COVID-19 pandemic, and a comprehensive number of service types can be provided through telemedicine visits. Existing problems can be adequately addressed; however, new problems or worsening problems may require in-person visits. Almost all provider services outside of interventional procedures can be given using telemedicine, although there may be a tendency against ordering interventional procedures and making new diagnoses through telemedicine.

Although not a perfect substitution for in-person visits, telemedicine has demonstrated itself to be more than adequate for the majority of visits in a cancer rehabilitation medicine practice, particularly during a public health crisis. Even after the pandemic subsides, telemedicine will likely continue to have a role in patient care, and follow-up studies will be necessary to determine how to appropriately triage patients to in-person versus virtual visits.

With the ongoing pandemic and an uncertain future, telemedicine visits should be considered essential as part of comprehensive cancer rehabilitation care.

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Disclosure

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