Keynote Session: Effects of the Pandemic on Cancer Care/Future Directions of Cancer Care

Presented by James E. Bachman, MPA; Kim Slusser, RN, MSN; Thomas K. Varghese, MD, MS; Andrew Wagner, MD, PhD; and moderated by Timothy Kubal, MD, MBA

ABSTRACT

A panel of experts in healthcare administration and delivery convened virtually during the NCCN 2021 Virtual Annual Conference to discuss the effects of the pandemic on cancer care and what the future may hold. The discussion ranged from the effects of the pandemic on screening and the implications of missing early cancers to the challenges of telemedicine, the future delivery of more in-home services, and burnout among healthcare workers as hospitals and cancer centers work to rebuild for the future.

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COVID-19 and Decreases in Cancer Screening

As a panel of experts at the NCCN 2021 Virtual Annual Conference explained, hospitals in the Northeast, including Dana-Farber Cancer Institute and Yale Smilow Cancer Hospital, experienced a surge in COVID-19 cases between March and May 2020, with cases diminishing in the summer and surging again in the fall. Most elective procedures were stopped and screening mammography and colonoscopies were deferred. Patient volume at the cancer centers decreased, and telemedicine was implemented for many patient visits.

At Yale, during the first surge of the pandemic, there were more than 400 inpatients with COVID-19, explained Kim Slusser, RN, MSN, Vice President of Patient Affairs, Yale Cancer Center/Smilow Cancer Hospital. Cancer services were displaced from the main hospital, but the patient volume was maintained over Yale's large network across the state. After the second surge, Yale had approximately 100 COVID-19 inpatients and 7 COVID units. Cancer services are currently still displaced.

"Right now we are challenged with access to cancer services," Ms. Slusser said.

Moderator Timothy Kubal, MD, MBA, Moffitt Cancer Center, noted a 60% to 80% decline in screening at Moffitt despite a much smaller number of COVID-positive inpatients (peaking at 15–20 patients or 8%–10% of total bed availability).

"Our experience in Utah is completely different," said Thomas K. Varghese, MD, MS, Chief Value Officer, Huntsman Cancer Institute, University of Utah. "Our catchment area covers 1,200 miles, and there has been a steady climb in the number of cases of COVID-19, but we didn't have as many hospitalizations [as in the Northeast]."

Currently Huntsman Cancer Institute is down to between 10 and 20 patients with COVID-19. "We don't seem to get below that," he noted.

Current State of Screening

The general consensus among panelists is that screening rates are starting to rebound but are still suboptimal. "We are nowhere near where we want to be," Ms. Slusser said. "The issue is backlog. We are trying to extend hours, but this is challenging for staffing across the board."

James E. Bachman, MPA, Chief Administrative Officer, The Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins, expressed similar frustration. "Screening remains challenging, because we still need to keep distance between patients and healthcare workers and we are trying to recover from the backlog. We have to keep pedaling hard. It will take time, but for some [patients], screenings are 'coupled,' so patients only have to come in for one visit instead of two."

Dr. Varghese agreed. "We are all very inefficient, between physical distancing and the need for personal protective equipment."

Andrew Wagner, MD, PhD, Associate Chief Medical Officer, Dana-Farber Cancer Institute, noted that staffing is a big challenge. "People had to take time off for quarantining. We have increased need for staffing at a time when we are short-staffed," he said.

Participants agreed that it can be difficult to get people to come in for cancer screening, due to all the fear

and hesitancy and misperceptions about the safety of a hospital/clinic environment. Several centers have used targeted emails and patient forums to encourage patients to come in for screening. In Utah, because of the large catchment area, the system was ramped up to provide more vans for mobile screenings to address the lag, Dr. Varghese noted.

Panelists agreed that it will take time to catch up regarding screening volume, and that the message needs to be brought home to the public that hospitals and screening centers are potentially the safest places they can be. Communication to the public is key, they agreed.

Studies suggest that the decrease in screening will lead to more cancers detected at advanced, and therefore, incurable stages. Referrals for screening typically come from a primary care physician or the emergency department, but during the pandemic the numbers of those visits have also decreased.

"It makes sense that we will miss some earlier cancers," Dr. Varghese said.

New Wave of Patients

Panelists expect a new wave of patients with more advanced cancers that will require increased capacity—more hours, more staffing. This is coming at a time when healthcare workers are already stressed and possibly traumatized.

A survey at Yale revealed that patients want extended hours and continued coupling of visits. "They prefer to get all their tests in one day," Ms. Slusser said.

"Patients do not want de-coupled visits," Dr. Kubal agreed, although it remains unclear what the patient would choose if the two experiences were offered side-by-side with an understanding of the total wait time associated with coupled versus decoupled visits.

Telemedicine: Pluses and Minuses

Although the experience varies depending on the center, the "sweet spot" for telemedicine visits was between one-third and two-thirds of patient encounters at the peak of the pandemic. Telemedicine currently constitutes approximately 20% of visits at most centers (these percentages include phone visits). However, Drs. Varghese and Bachman find that patients prefer in-person visits.

All participants agreed that a learning curve exists for telemedicine, but that it is probably here to stay in some form or another and that institutions need to establish best practices to provide a standardized telemedicine offering to their patients.

On the plus side, telemedicine has fostered the integration of Zoom and electronic health records. Another benefit is that more patients are encouraged to use patient portals for communication, although patients have had a mixed reaction to this development.

"Telemedicine markedly reduced on-site visits, but it allowed families to join the visit at a time when they could not come in person," Dr. Wagner noted.

The main downside is the safety of a telemedicine assessment, especially for patients being treated for cancer; however, for its current use cases, telemedicine appears to be relatively safe, as the patients understand the need for in-person assessments in the presence of significant symptoms. Another concern is exacerbating disparities in access to care. Patients must have access to broadband, language ease, and a computer, which is not the case for all patients across the country.

"Telehealth is terrible for new patients. It is much better for established patients and for surveillance," Dr. Varghese stated. "It's not just the disparity from socioeconomic status, but also it's harder for elderly people than younger ones."

Dr. Bachman said that telehealth has forced consideration of waste in services. "The downside is that telemedicine limits what we can deliver. A team approach in real time is much more efficient."

"Telemedicine makes a holistic, comprehensive approach to patient care more difficult. We want to keep our patients at the center of care," Ms. Slusser added.

"The value of in-person visits is in the ability for the patient to see the whole team. With telemedicine appointments, you only see 1 or 2 practitioners," Dr. Wagner noted. "We are figuring out how to envelop the whole patient in the telemedicine visit."

"There is no chance for a hug with telemedicine," Dr. Kubal added.

Post-Pandemic: Offering Other Services At Home

"The pandemic made us think creatively about what services could be offered at home. Convenience for patients is important," Dr. Varghese said.

"We can get stuck in our routines. The pandemic showed us that we can quickly adapt within shorter periods of time. To offer other services, we need reimbursement and to ensure quality and safety outside our facility. The administrative burden is enormous, and as we move forward with this effort we will need more staffing," Dr. Wagner asserted.

"For example, with home infusion, we will need to be sure it is safe. We need systems set up to address adverse events. We need to deliver care efficiently and safely. It is hard to replicate the team approach in a home environment," Dr. Bachman noted.

"We will be pushed to offer services at home, but administering hazardous drugs is complicated. We need more nurses and pharmacists, and more time to develop an infrastructure while maintaining safety," Dr. Wagner added.

"There will be consequences. This cannot happen overnight," Dr. Varghese cautioned.

Wellness of Healthcare Workers

"With the expected tsunami of late-stage patients, we need to think about the stress and fatigue among our healthcare workers. I'm very concerned, because we don't have the luxury of stopping the train and letting everyone regroup. There are new graduates now who haven't delivered care with visitors present. We have to offer resources, such as buddy programs," Ms. Slusser said. "Everyone's lives have been affected by the pandemic. We will need strong interventions for our staff. This is not a 'one-size-fits-all' approach," she added.

The other panelists agreed, and each had a perspective on ensuring healthcare worker wellness.

"We need to focus on staff as we extend hours. Each organization needs to address this. We have been working so long at a breakneck clip. We need to find a way to dial it back," Dr. Bachman said.

"In a way, this has brought our staff members closer. We are all tired of the pandemic. We need to make our staff meetings more efficient and find ways to focus on the mental and physical well-being of our staff," Dr. Wagner said.

"There is nothing normal about what we are doing. The tsunami is here. The worry is that with added responsibilities, we will have a crash," Dr. Varghese said, adding, "Surveys have shown us that our staff is hurting. Burnout was always an issue pre-pandemic, and it certainly is now."

Dr. Kubal agreed, noting, "We have all experienced posttraumatic stress disorder."

"I'm very concerned, but the good news is that we are talking about it and making sure that we have mental health resources for our staff," Ms. Slusser said.

Dr. Bachman also brought up the needs of those who had to leave positions. "Healthcare workers who have had to leave their organizations during the pandemic because they could not continue also need services," he said.

Dr. Varghese advised that going forward, healthcare professionals need to "voice [their] concerns, bring ideas to the table, construct solutions, and have the courage to express [them]selves."

Disclosures: Dr. Bachman has disclosed receiving consulting fees from GRAIL, Inc. Dr. Wagner has disclosed receiving consulting fees from Daiichi-Sanyko Co., Deciphera Pharmaceuticals, Inc., Epizyme, Inc., and Mundipharma International. The remaining panelists have disclosed that they have no financial interests, arrangements, affiliations or commercial interests with the manufacturers of any products discussed in the article or their competitors.

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