

The Phoenix of Breast Cancer Care- Emerging from Crisis



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NCBC 2021



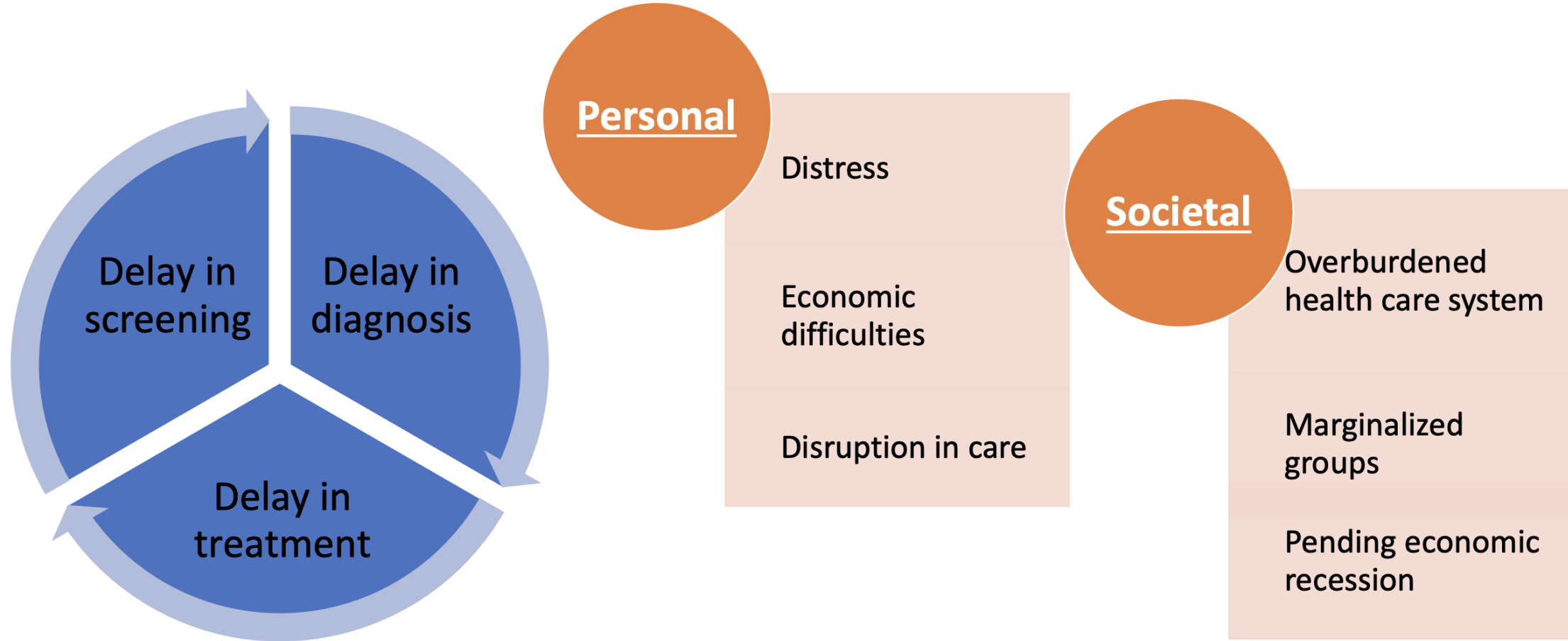
Disclosures

- Grant/Research Support from Genentech and Roche.
- Consultant for Daiichi, Genentech, Immunomedics and Seattle Genetics.

Learning Objectives

- How our world changed suddenly
- Our response to COVID in clinic, research
- The intersection of Social Injustice, COVID and Breast Cancer
- Impact of COVID on imaging, surgery, radiation and medical oncology
- Downstream impact on clinical outcomes of breast cancer
- Disproportionate effects in Black & Brown communities
- Upsides: Cooperation, Research, Telehealth

Cancer & COVID-19 impact



ASCO 2019 McCormick Place, Chicago



ASCO 2020- Virtual McCormick Place- COVID Field Hospital



SABCS 2019



Henry Gonzalez Convention Center SABCS 2020





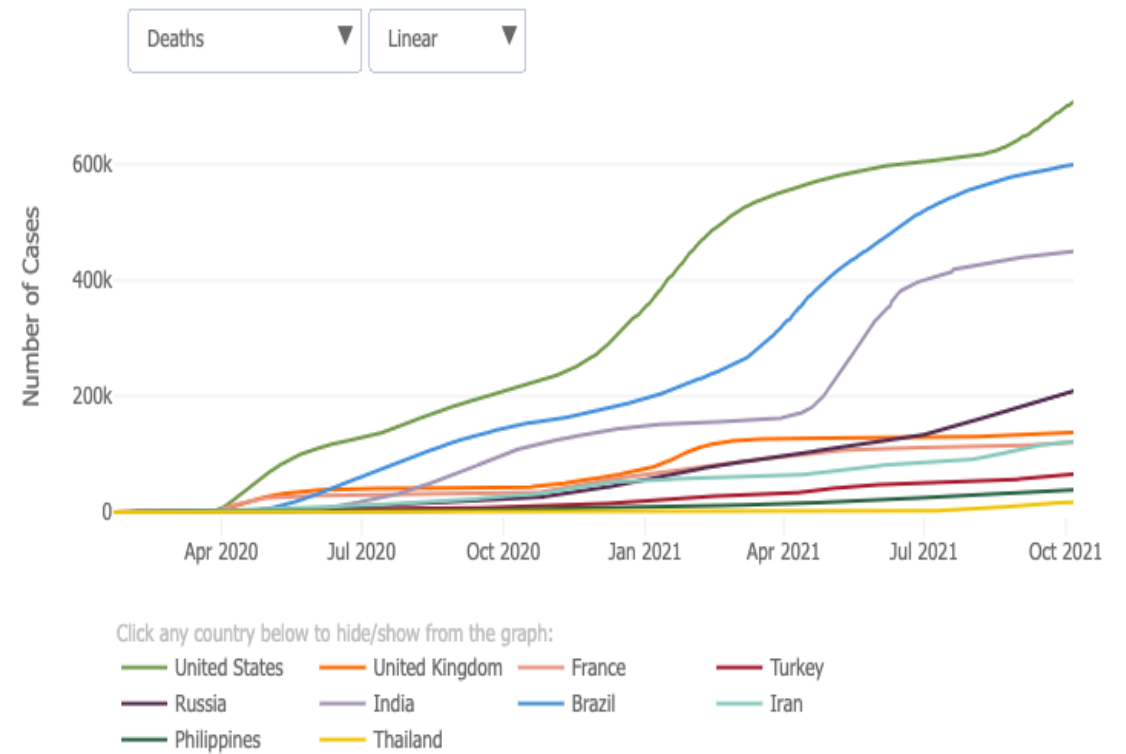
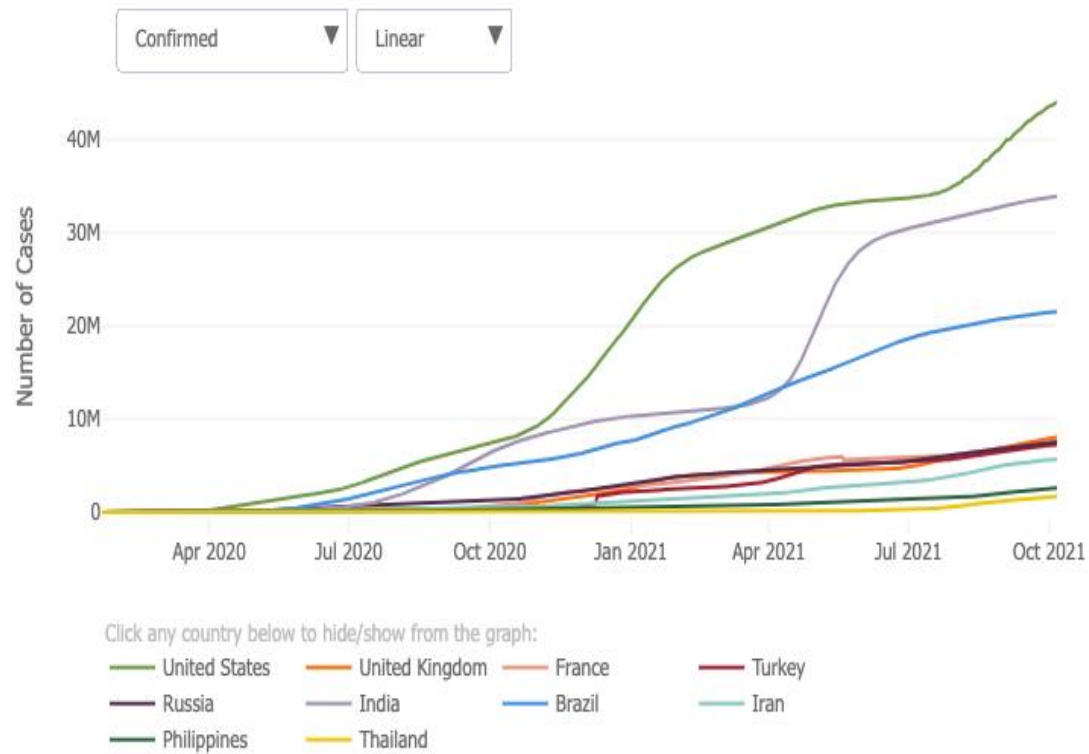
Meetings of the last 2 years

- Virtual ASCO
- Virtual SABCS
 - Virtual ASH
- Virtual ESMO
- Virtual AACR
 - Et al
 - Et al.....

2020: The intersection of a health pandemic and a societal reckoning



Cumulative Confirmed Cases & Deaths /Date



WAR footing mindset emerged!

Breast Cancer Research and Treatment (2020) 181:487–497

<https://doi.org/10.1007/s10549-020-05644-z>

EDITORIAL



Recommendations for prioritization, treatment, and triage of breast cancer patients during the COVID-19 pandemic. the COVID-19 pandemic breast cancer consortium

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NCCN, NAPBC, ASBrS, ASTRO, ACR, CoC

Recommended Priority Schema*

- Priority A Category:
 - Condition that immediately life threatening, clinically unstable, or completely intolerable
- Priority B Category:
 - Treatment or service cannot be indefinitely delayed beyond 6-12 weeks
 - Most BC in this category; often given NAC or NAE
 - Sub-stratified as B1 (higher priority), B2 (mid-level priority), B3 (lower priority)
- Priority C Category:
 - Those for whom treatment or service can be indefinitely delayed until pandemic over without adversely impacting outcomes
- IMPORTANT: Multidisciplinary teleconference take place to review BC patients, document category for surgery and/or neoadjuvant/adjuvant therapy, and maintain close follow-up of these pts to ensure best outcomes

*not intended to supersede individual physician judgement or institutional policies/guidelines

Outpatient Visits

- Majority can be conducted remotely with telemedicine
- Limit in-person visits to minimize patient and provider risk

Category	
A	Unstable postop patients or those with potential medical oncologic emergencies (ex: febrile neutropenia, intractable pain) who need in person assessment
B	Should be evaluated by at least one member of multidisciplinary team either in-person or remotely: newly diagnosed BC, established patients with new problems, those on active IV chemotherapy, patients completing neoadjuvant therapy and preparing for surgery, routine postop visit, being evaluated for chemotherapy or radiation therapy
C	Routine follow up visit for benign or malignant conditions (including those on oral adjuvant agents and those not on active treatment), survivorship visits, or high-risk screening

Breast Focused Imaging

- Limit visits to minimize patient and provider risk

Category	
A	Imaging urgent situations such as breast abscess or for evaluating serious post-operative complications
B	Diagnostic imaging for abnormal mammogram or suspicious breast symptoms, biopsies for BI-RADS 4 or 5 lesions, breast MRI for extent of disease evaluation or pre-chemo
	Biopsies for low suspicious lesions (BI-RADS 4a) may be postponed or biopsied
C	BI-RADS category 3 pts returning for short-term FU diagnostic mammo and/or US should be postponed until after COVID 19
	All screening exams (mammo, US, MRI) should be postponed until after COVID 19

Priority Categories for Surgical Oncology

Priority A	Patient Description	COVID-19 Treatment Considerations
A	Breast abscess in septic pt	Operative drainage if unable to drain at bedside
A	Expanding hematoma in unstable pt	Operative evacuation and control of bleeding

Priority Categories for Surgical Oncology

Priority B	Patient Description	COVID-19 Treatment Considerations
B1	Ischemic autologous flap	Revascularize or remove flap
B1	Revision of mastectomy flap w/exposed prosthesis	Debride and remove expander/implant
B1	Patients completed NAC for Inflammatory BC	Operate (mastectomy without reconstruction) as soon as possible depending on institutional resources
B1	TNBC and HER2+ BC	NAC or HER 2 targeted therapy. In some cases and depending on institution and patient, may operate first.
B2	Neoadjuvant: finishing RX or progressing on RX	Operate if feasible or extend/change neoadjuvant RX
B3	Clinical Stage T2 or N1 ER +/-HER2 neg tumors	Consider hormonal RX, delay operation
B3	Discordant BX likely malignant	Perform excisional biopsy when feasible
B3	Malignant or suspect local recurrence	Staging first when feasible. Excision when conditions allow and no distant disease

Priority Categories for Medical Oncology

Priority A	Patient Description	COVID-19 Treatment Considerations
A	Oncologic emergencies (e.g. febrile neutropenia, hypercalcemia, intolerable pain, symptomatic pleural effusions or brain metastases, etc.)	Initiate necessary management

Additional Considerations for Medical Oncology

Agent	Dosing and Scheduling Considerations
Chemotherapy	<p>Chemotherapy schedules may be modified to reduce clinic visits (using 2- or 3-week dosing, e.g.) or to reduce infection risk (using weekly dosing) for selected agents when appropriate.</p> <p>For low risk febrile neutropenia, outpatient regimens may be used.</p> <p>Selected pts (particularly with ER+ disease), can consider radiation before chemo if this facilitates pt safety.</p>
Targeted Therapy	<p>Oral targeted agents (CDK 4/6, mTOR, or PIK3CA inhibitors) to endocrine RX may be delayed in first-line RX, or in situations where endocrine RX alone is providing or is likely to provide effective tumor control.</p> <p>Cardiac monitoring (Echo, nuclear) during HER2 therapy can be delayed or discontinued if clinically stable.</p> <p>Consider reduced dose of oral targeted agents to optimize tolerability and minimize treatment related toxicities.</p> <p>Trastuzumab and pertuzumab for met HER2+ BC may be administered at longer intervals (e.g. 4 weeks).</p>
Endocrine Therapy	<p>Oral endocrine agents (e.g. tamoxifen, AI's) are not immunosuppressive and can be safely continued.</p> <p>Fulvestrant is not immunosuppressive but requires monthly clinical administration.</p> <p>AI's are preferred over tamoxifen for NAE (and LHRH agonists should be used for premenopausal women).</p>
Supportive Care	<p>Extend venous access device (port) flush to 12 weeks or longer</p> <p>Consider periph venous access for IV RX if patient has sufficient veins and no port if institution policies allow</p> <p>Administer G-CSF growth factor support to minimize neutropenia.</p> <p>Limit dexamethasone when possible to reduce immunosuppression.</p>

Priority Categories for Radiation Oncology

Priority A	Patient Description	COVID-19 Treatment Considerations
A	Bleeding/painful inoperable local-regional disease, Symptomatic metastatic disease	Consider palliative HF* regimens
A	Progression of disease during NAC	Consider definitive HF regimens

*HF=Hypofractionated

Priority Categories for Radiation Oncology

Priority B	Patient Description	COVID-19 Treatment Considerations
B1	Inflammatory BC s/p mastectomy	Consider PMRT HF regimens
B1	Node positive: TNBC or HER2+ disease s/p BCT or mastectomy	Consider WBRT or PMRT HF regimens
B1	Post mastectomy with 4 or more tumor positive nodes	Consider PMRT HF regimens
B1	Residual node positive disease after NAC	Consider WBRT or PMRT regimens
B2	PMRT with 1-3 tumor positive nodes	Consider PMRT HF regimens
B2	Node negative: TNBC or HER2+ s/p BCT	Consider WBRT HF regimens
B2	If tumor positive margin after BCT for invasive BC with <u>no</u> alternative therapy options*	Consider WBRT HF regimens
B3	If tumor positive margin after BCT for invasive BC <u>with</u> alternative therapy options	Consider WBRT HF regimens
B3	Young age (≤ 40 years) s/p BCT, node negative with ≥ 1 additional high-risk features (LVI+, PNI+)	Consider HF regimens
B3	ER- DCIS with a positive margin	Consider HF WBRT regimens

*TNBC with tumor positive margins should be given priority over TNBC with negative margins

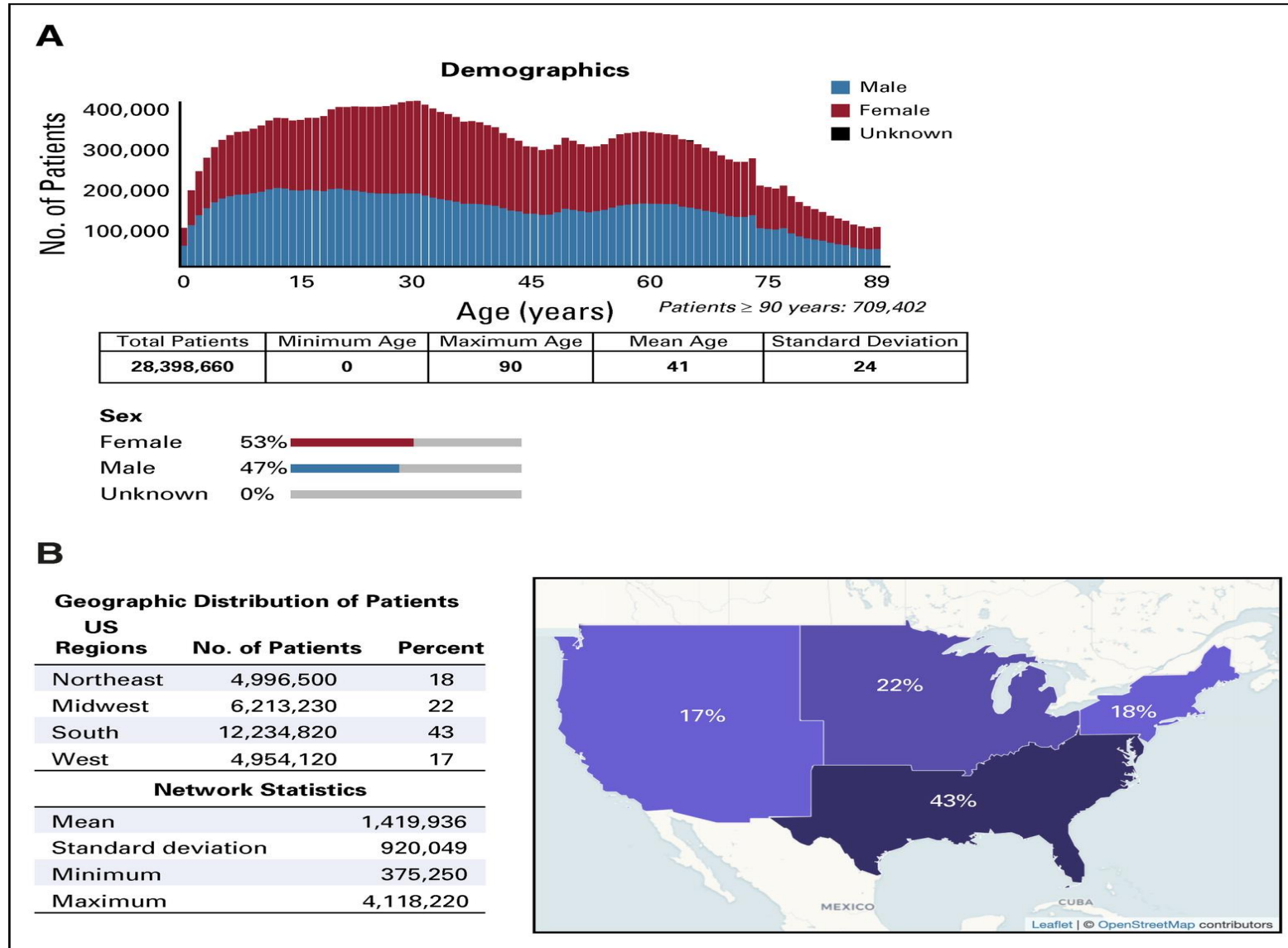


FIG 1. COVID and Cancer Research Network descriptive statistics and demographics. (A) Distribution of patient age and sex within the network. (B) Geographic distribution split into Northeast, Midwest, South, and West. Network statistics represent the distribution in sizes of individual institutions included in the network.

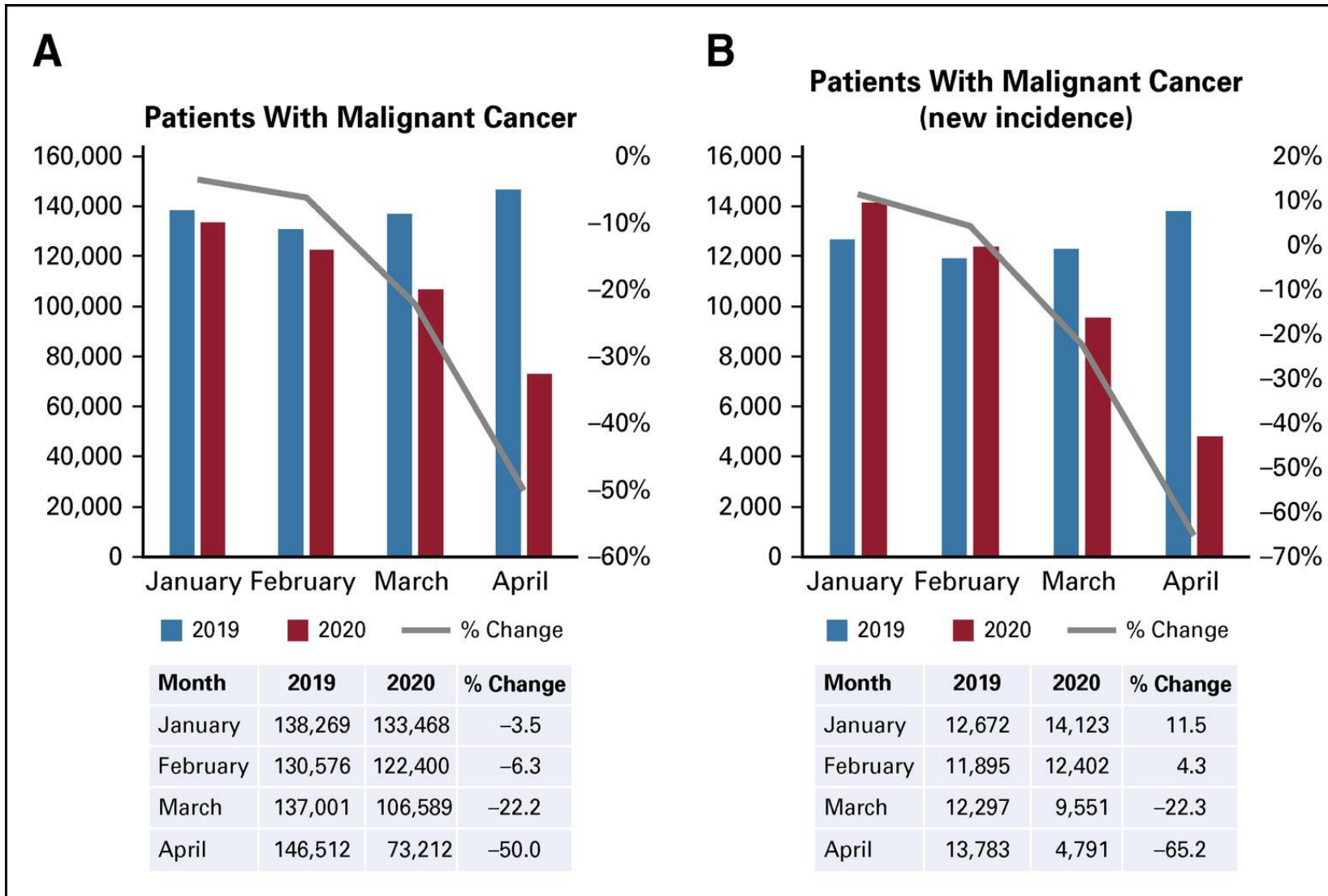


FIG 4. The effects of COVID-19 on patients with a malignant neoplasm-associated encounter. (A) Patients identified by month as previously described, using International Classification of Diseases, Tenth Revision, diagnosis codes for any malignant neoplasm (C00-C96, D37-D49). (B) Counts of patients with new incidence malignant neoplasm diagnosis.

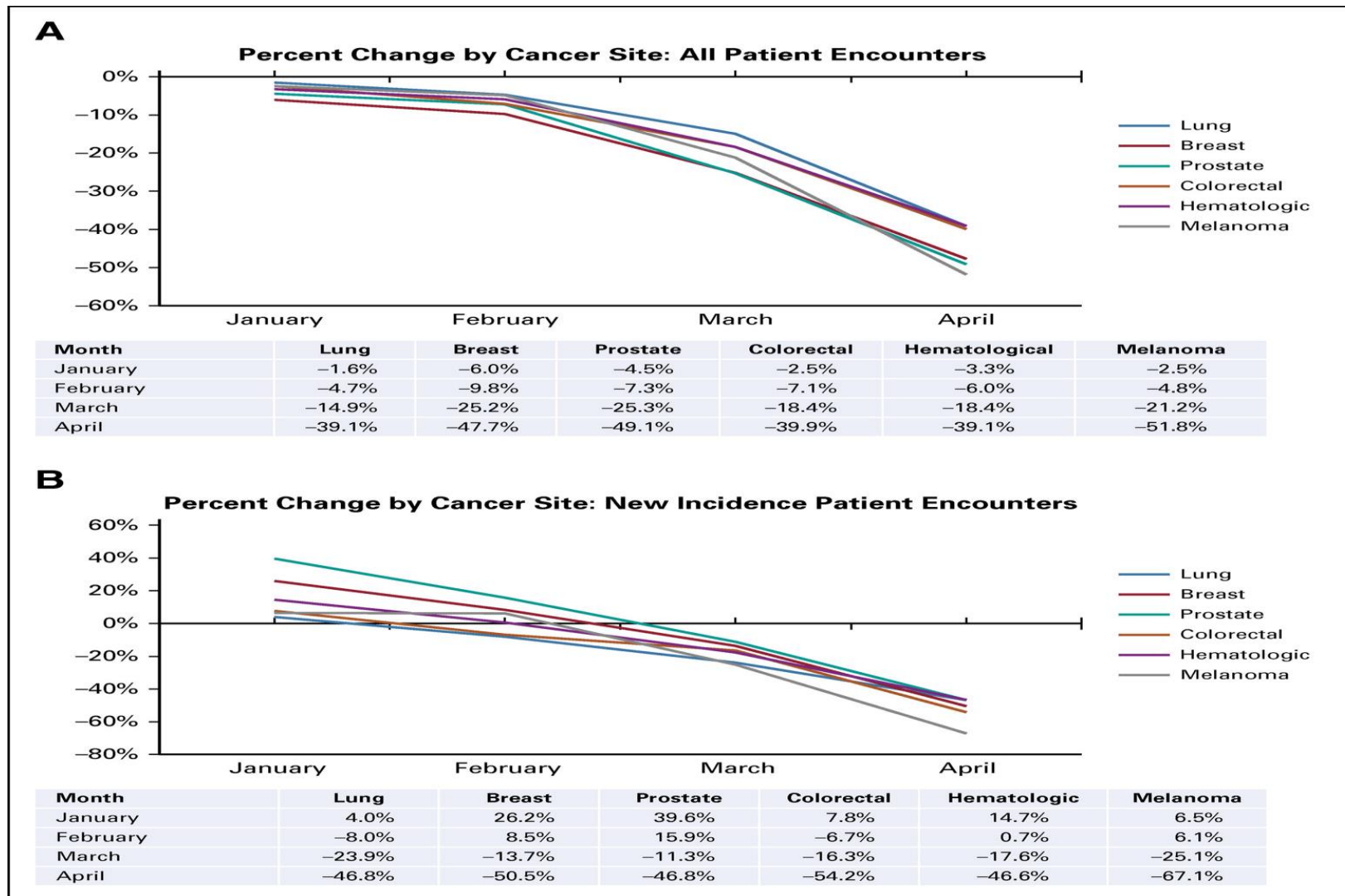


FIG 5. The effects of COVID-19 among cancer types. (A) Patient counts were generated for the indicated month for each cancer type in 2019 and 2020 using International Classification of Diseases, Tenth Revision, diagnosis codes: breast cancer (C50), lung cancer (C34), prostate cancer (C61), colorectal cancer (C18-21), hematologic cancers (C81-96), and melanoma (C43). Percent change from 2019 to 2020 is shown. (B) Patient counts were generated using the diagnosis codes indicated in panel A, filtering on patients with new incidence encounters.

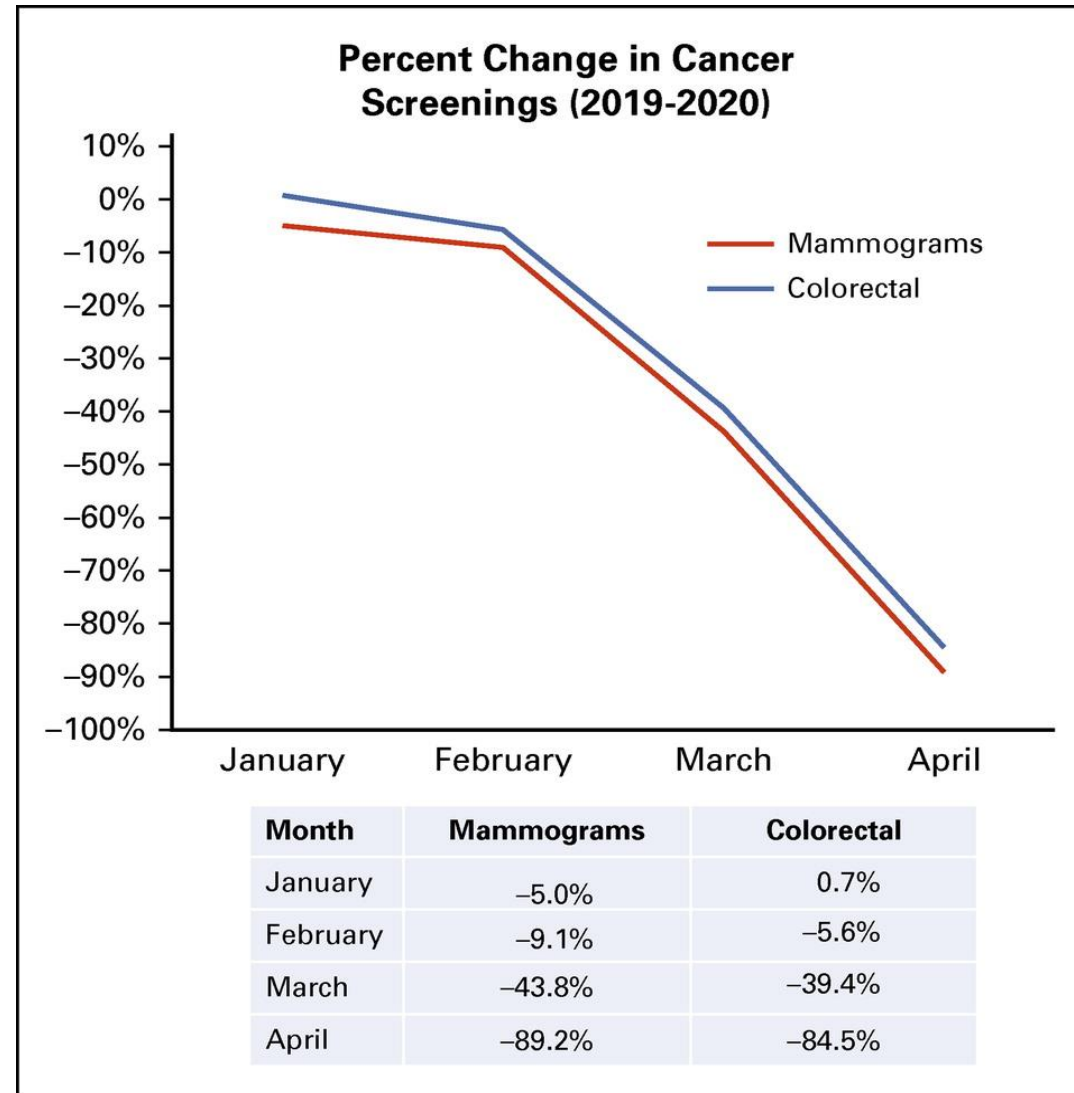
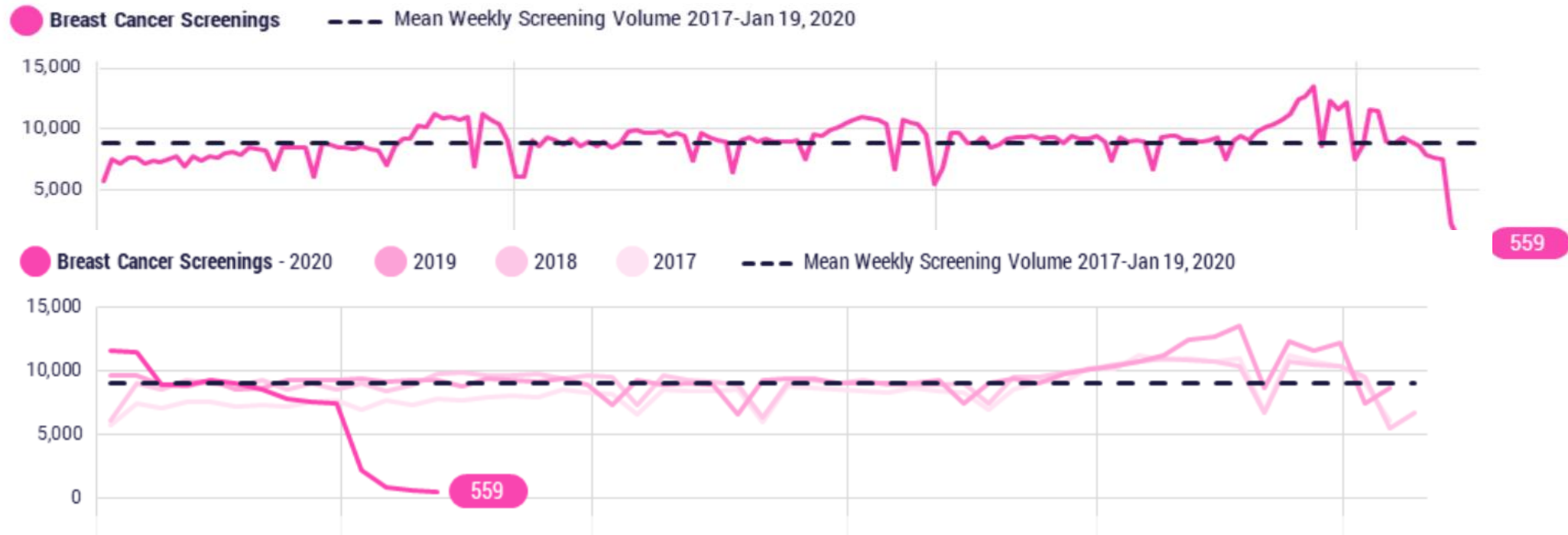


FIG 6. The effects of COVID-19 on cancer screening. Patient counts were generated for breast cancer screening encounters using International Classification of Diseases, Tenth Revision (ICD-10), codes R92.0-R92.2 and Z12.31 and Current Procedural Terminology (CPT) codes 77067 and 1029705 and colorectal cancer screening encounters using ICD-10 code Z12.11 and CPT codes 1022231, 1007534, and 1020217. Percent change from 2019 to 2020 is shown in the indicated months.

Early Signs of COVID on Breast Cancer Via EPIC EHR

Cancer Screenings in the U.S.

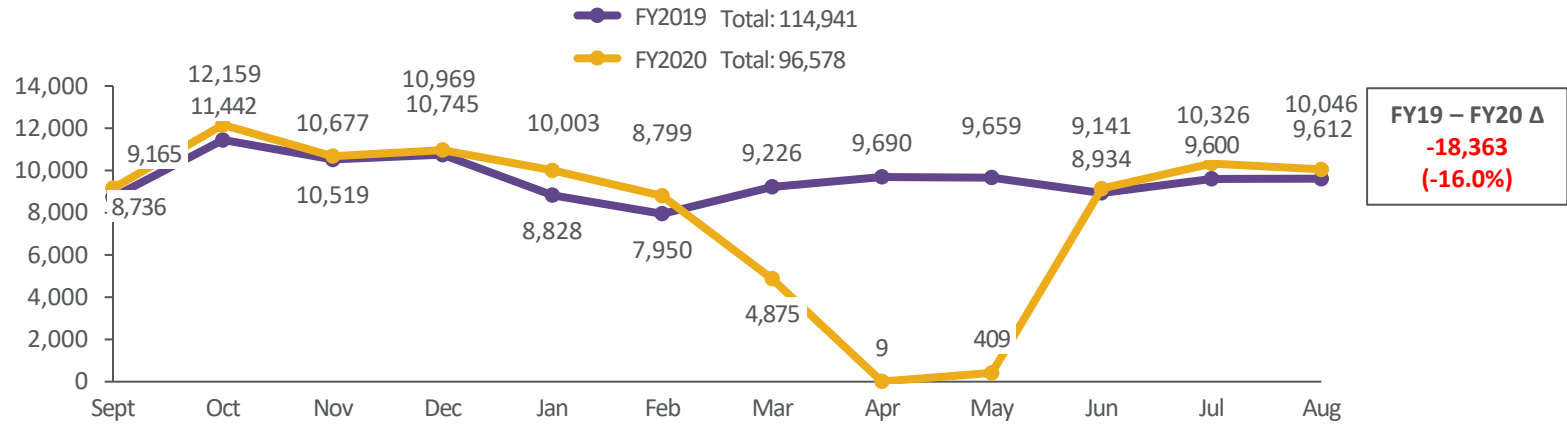


Analyses of 2.7 million patients thru April 2020, 39 health systems, 190 hospitals, 23 states

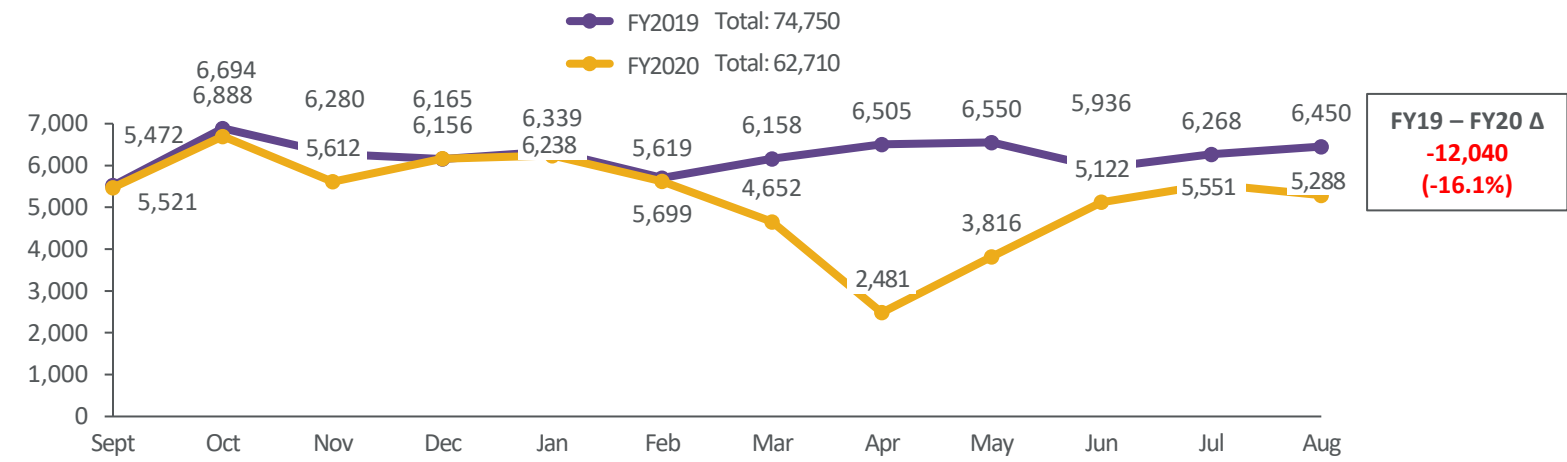


NM/ Demand by Month: Imaging

Screening Mammography



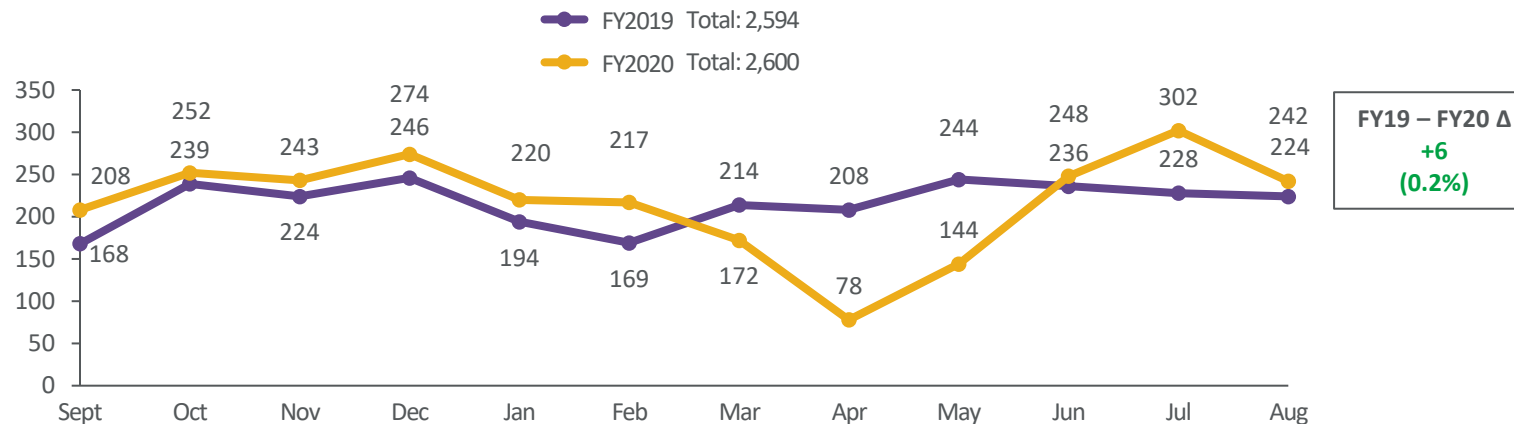
Diagnostic Mammography



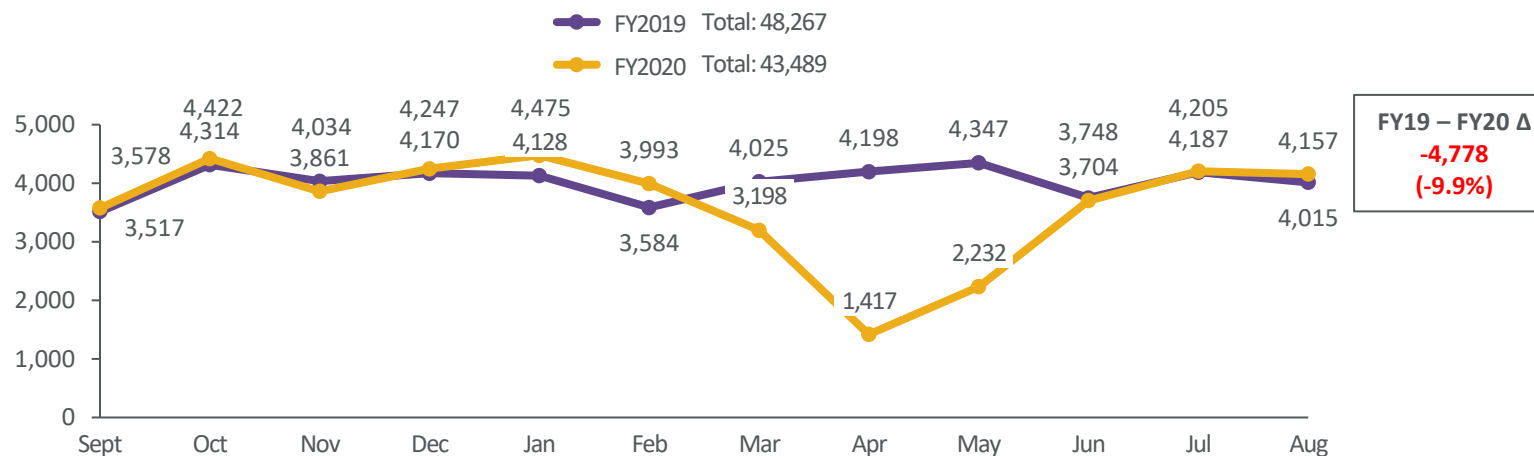


NM/ Demand by Month: Imaging

Breast MRIs



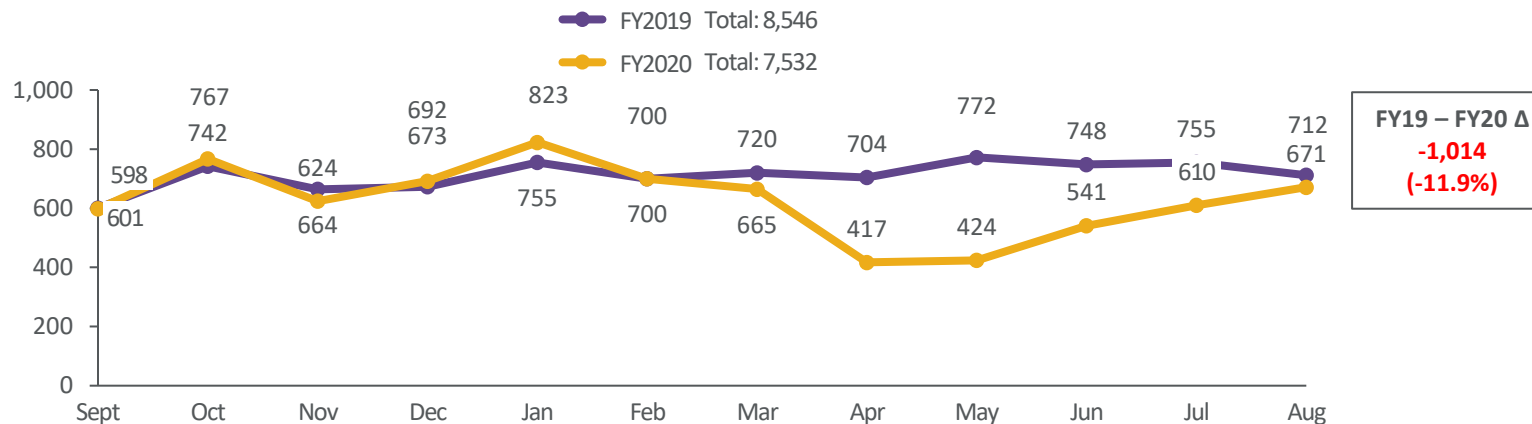
Breast Ultrasounds



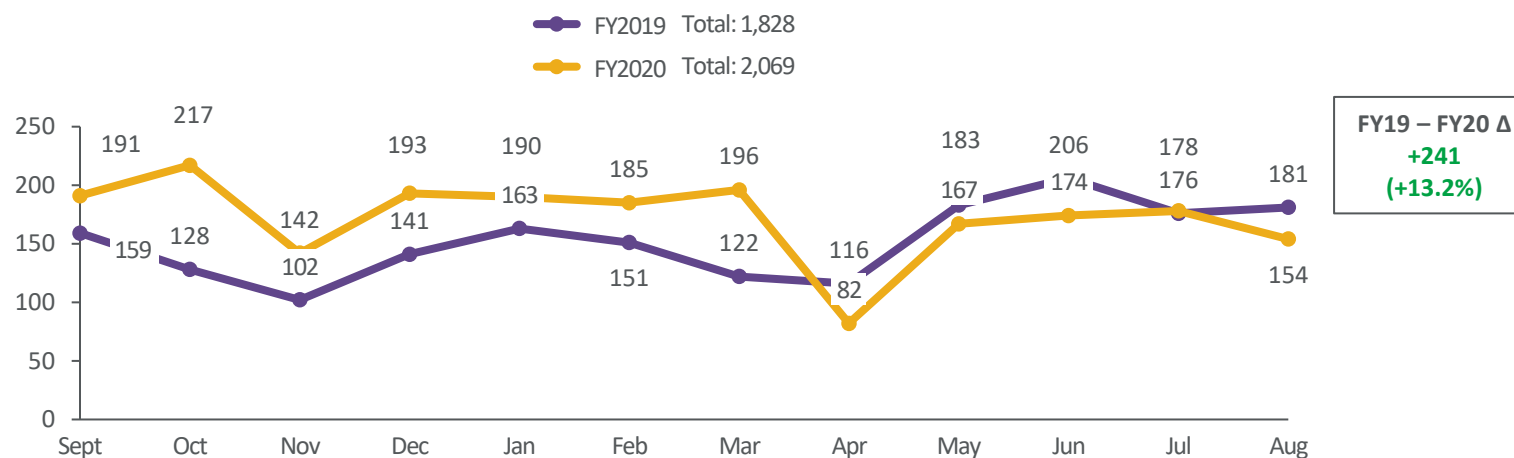


Program Size / Demand by Month: Biopsies

Breast Imaging-Guided Biopsies



*Open, Sentinel, Axillary Lymph Node Biopsies



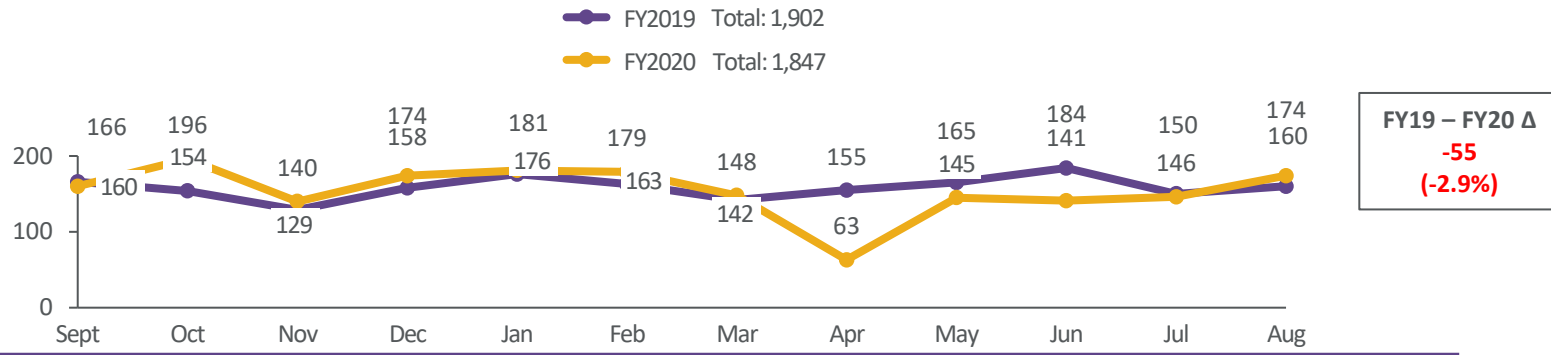
Sources: Stratajazz, accessed September 2020. Breast open biopsies and sentinel and axillary lymph node biopsies for employed breast surgeons: Drs. Ahn, Al-Zubeidy, Bethke, Fredrickson, Hansen, Khan, Kulkarni, Monahan. Biopsies defined by sum of physician-based Billed CPT codes. Axillary lymph node biopsies exclude CPT code 19302 since those volumes are counted within breast surgery category.

Note: *Satellite breast biopsy location volumes included in site totals.

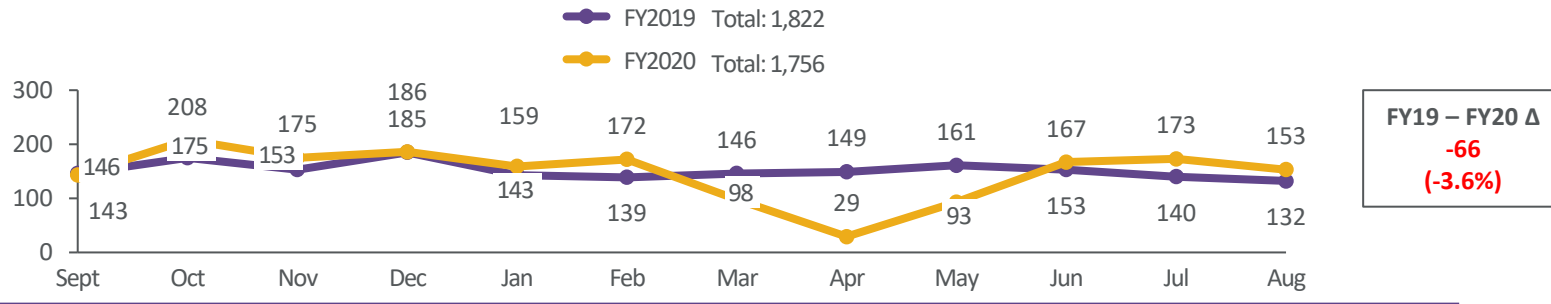


NM/ Demand by Month: Surgeries

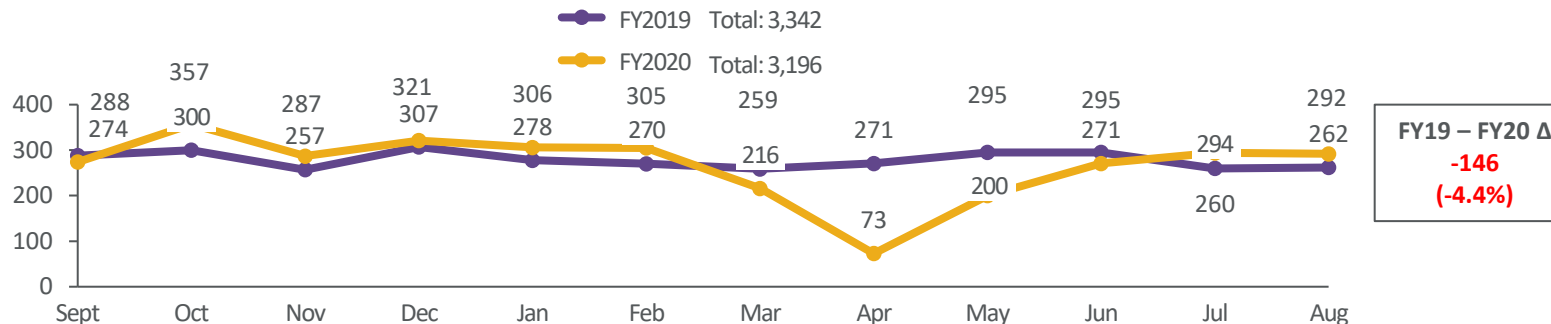
Mastectomy/
Lumpectomy
Breast Surgeries



Reconstructive
Breast Surgeries

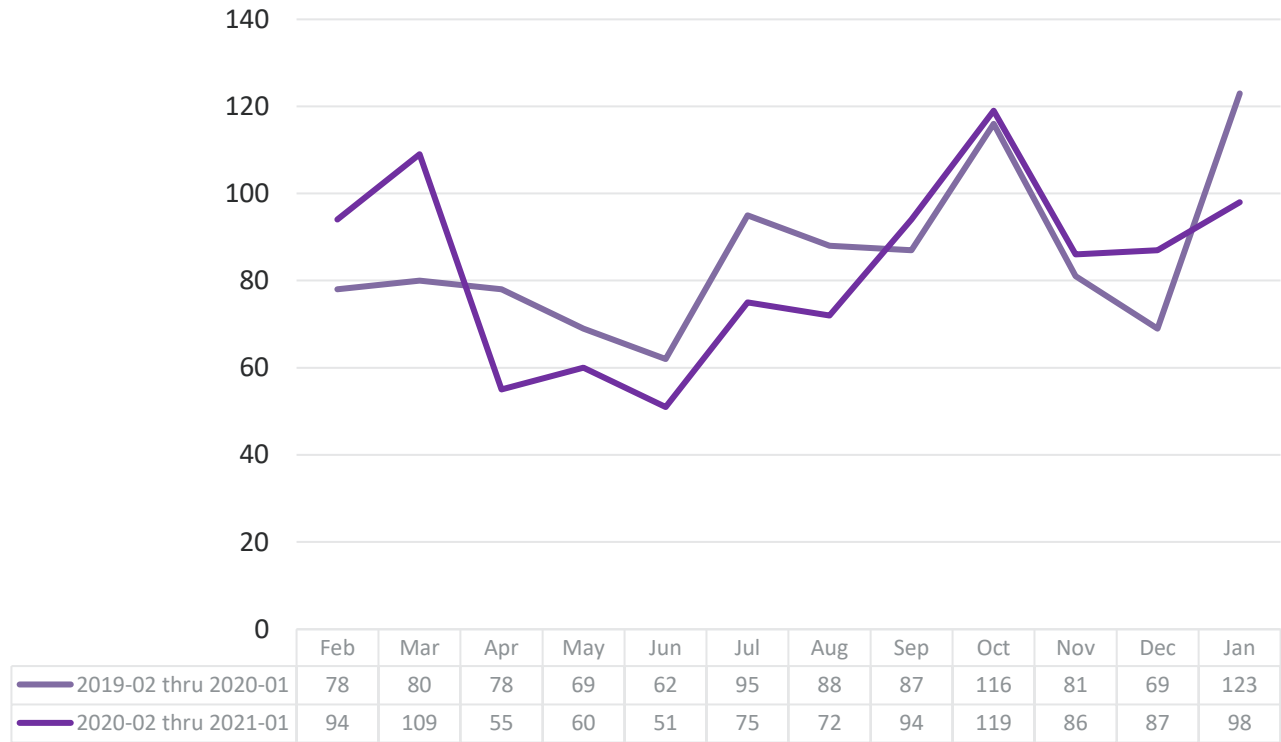


Total Breast
Surgeries



RHLCCC New Encounter Volume

Breast Hematology Oncology MD Only



RISK FOR SARS-COV-2 INFECTION IN PATIENTS WITH BREAST CANCER TREATED WITH CHEMOTHERAPY, BIOLOGIC THERAPY OR ACTIVE SURVEILLANCE: PATIENT OUTCOMES FROM MULTICENTER INSTITUTION IN NEW YORK

Nibash Budhathoki, MBBS

NYU Long Island School of Medicine

Perlmutter Cancer Center

June 4, 2021

COVID-19 INFECTION AND MORTALITY

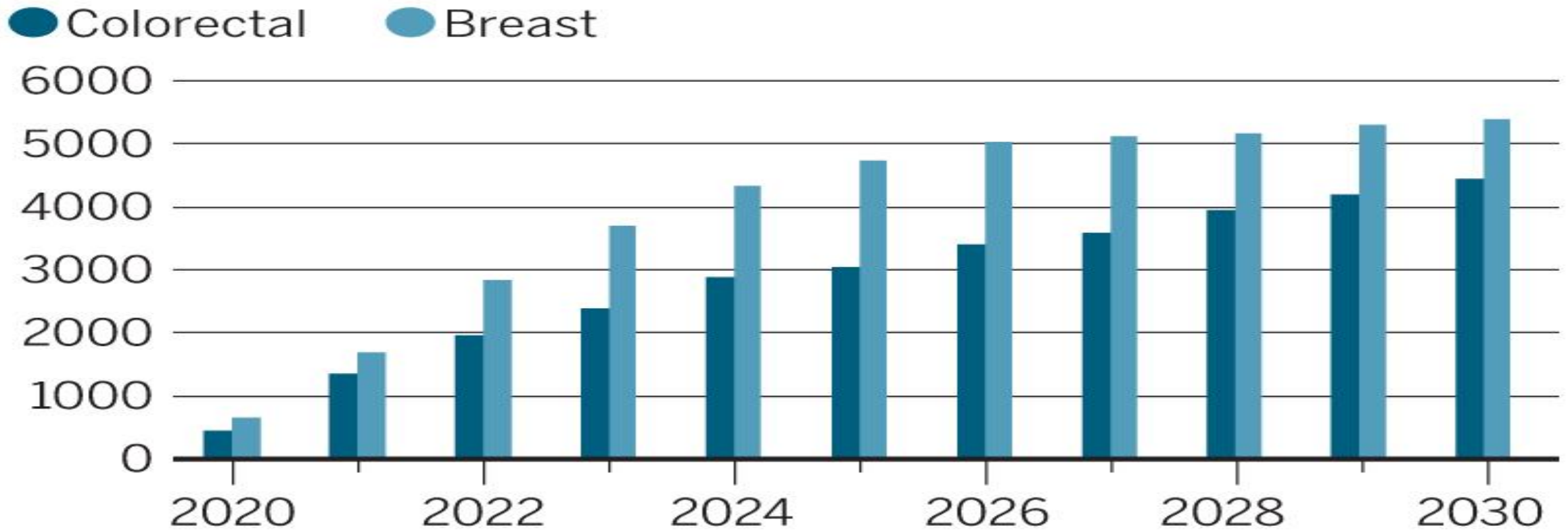
COVID-19 Infection and Mortality by Treatment Groups			
	Rate	Weighted Rate	p value
SARS-CoV-2 Infection			
CT (N=18)	4.7%	3.5%	0.5
E/H (N=43)	1.8%	2.7%	
COVID-19 Specific Mortality			
CT (N=4)	1.1%	0.7%	0.2
E/H (N=2)	0.1%	0.1%	
Overall Survival Outcomes by Demographics			
	Alive	Dead	p value
	N=54/(mean (SD))	N=10/(mean (SD))	
Stage (I-III vs IV)	50 (93%) vs 6 (60%)	4 (7%) vs 4 (40%)	0.02
Age (years)	58.3 (13.6)	73.2 (8.3)	0.001
Body Mass Index (Kg/m²)	29.2 (5.8)	33.5 (8.5)	0.05
Charlson Comorbidity Index	3.4 (3.1)	6.1 (3.1)	0.01

SUMMARY

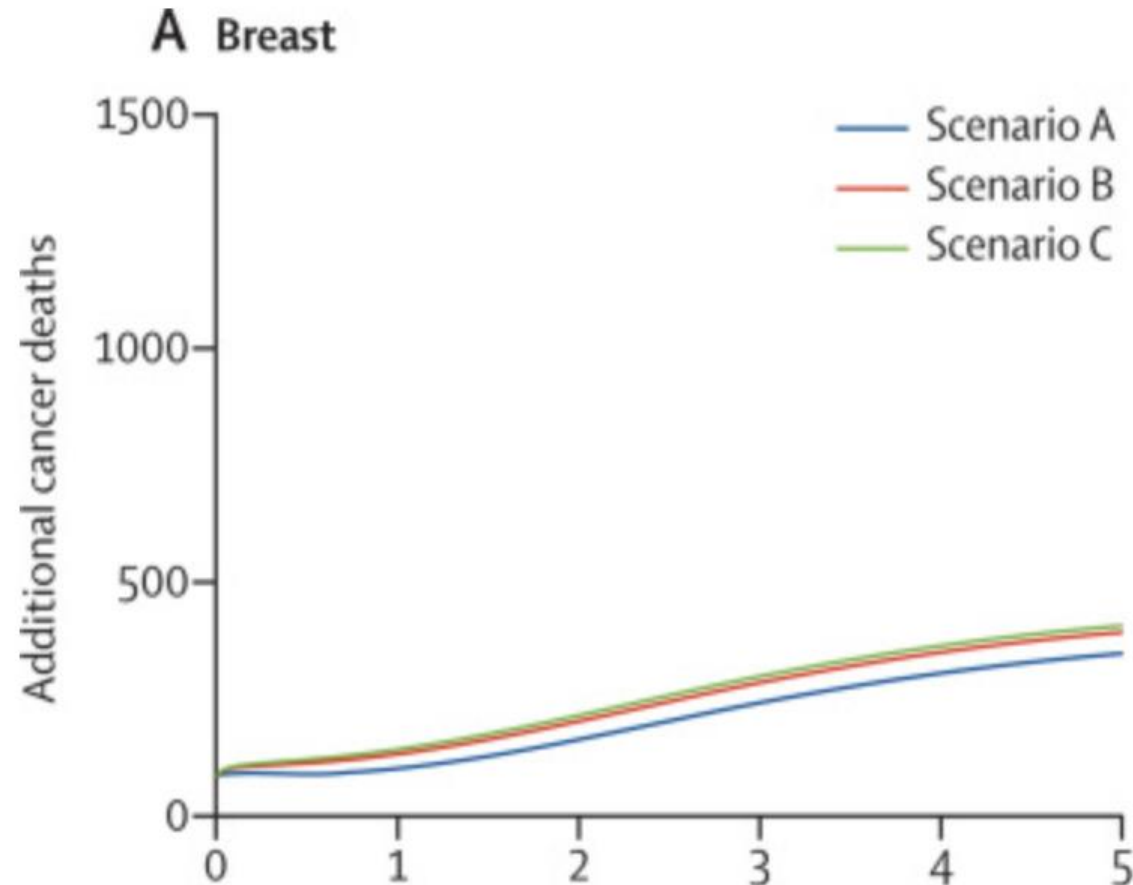
- **Chemotherapy was not associated with increased risk of infection with SARS-CoV-2 or death following infection in this breast cancer population**
- **Breast cancer treatment, including chemotherapy, can be safely administered with enhanced infectious precautions, and in general, should not be withheld, particularly when given with curative intent**

Modeled cumulative excess deaths from colorectal and breast cancers, 2020 to 2030*

Modeled cumulative excess deaths from colorectal and breast cancers, 2020 to 2030*



The impact of the COVID-19 pandemic on cancer deaths due to delays in diagnosis in England, UK: a national, population-based, modelling study



- Collected data on 32,000 pts
- Between 281 and 344 excess deaths
- 7.9-9.6% increase over next 5 years

Background

- The COVID-19 pandemic led to the need for major health services adjustments, reducing other diseases' assistance (1, 2).
- For some cancer patients, delays may importantly impact outcomes.
- We aimed to assess the impact of the COVID-19 pandemic in breast and cervical cancer diagnosis and treatment compared to the same period prior to the pandemic.

Methods

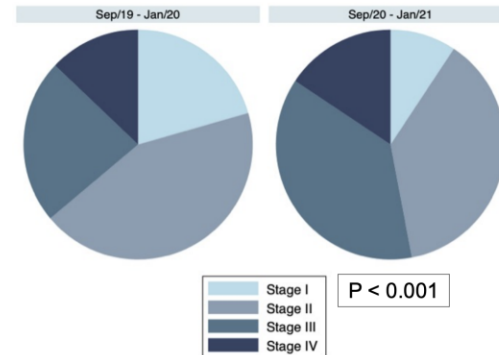
- Single-center retrospective analysis from electronic medical records.
- Data were collected from patients in their first visit to a single academic cancer center from Sep/20-Jan/21 and Sep/19-Jan/20
- The primary endpoint was breast and cervical cancer stages at diagnosis.
- Tumor stages between the two periods were compared using the Chi-squared test.

Results

- 829 patients were evaluated.
- Patients who attended their first visit during the pandemic presented with higher breast cancer ($P < 0.001$) and cervical cancer ($P = 0.328$) stages than those prior to the pandemic, although the difference was not statistically significant for cervical cancer.
- Fewer breast cancer patients (13.7%) were diagnosed by screening mammogram during the pandemic than before it (25.5%) ($P < 0.001$).

Breast cancer stages during and prior to the COVID-19 pandemic

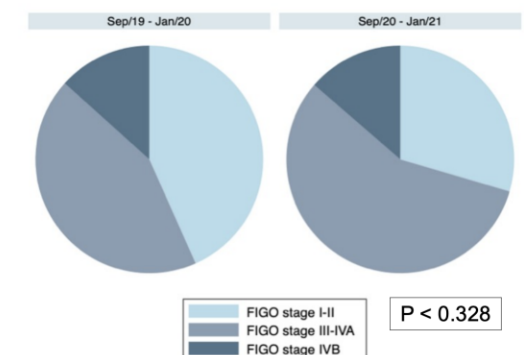
According to the AJCC/UICC 8th edition TNM Anatomic Staging System



Period	Stage I N (%)	Stage II N (%)	Stage III N (%)	Stage IV N (%)
Sep/19-Jan/20 (N=457)	94 (29.6%)	198 (43.3%)	106 (23.2%)	59 (12.9%)
Sep/20-Jan/21 (N=268)	25 (9.3%)	101 (37.7%)	100 (37.3%)	42 (15.7%)

Cervical cancer stages during and prior to the COVID-19 pandemic

According to the 2018 FIGO Staging System



Period	Stage I N (%)	Stage II N (%)	Stage III N (%)	Stage IVA N (%)	Stage IVB N (%)
Sep/19-Jan/20 (N=60)	12 (20.0%)	14 (23.3%)	16 (26.7%)	10 (16.7%)	8 (13.3%)
Sep/20-Jan/21 (N=44)	6 (13.6%)	7 (15.9%)	12 (27.3%)	13 (29.5%)	6 (13/6%)

Conclusions

- Breast and cervical cancer patients had higher disease stages at diagnosis during the COVID-19 pandemic compared to a similar period prior to the pandemic. Rates of breast cancer diagnosis due to screening mammogram also decreased during the pandemic.
- These results confirm the long-term negative impacts of the COVID-19 pandemic for oncologic patients. Hence, efforts should be made not to compromise essential cancer services.

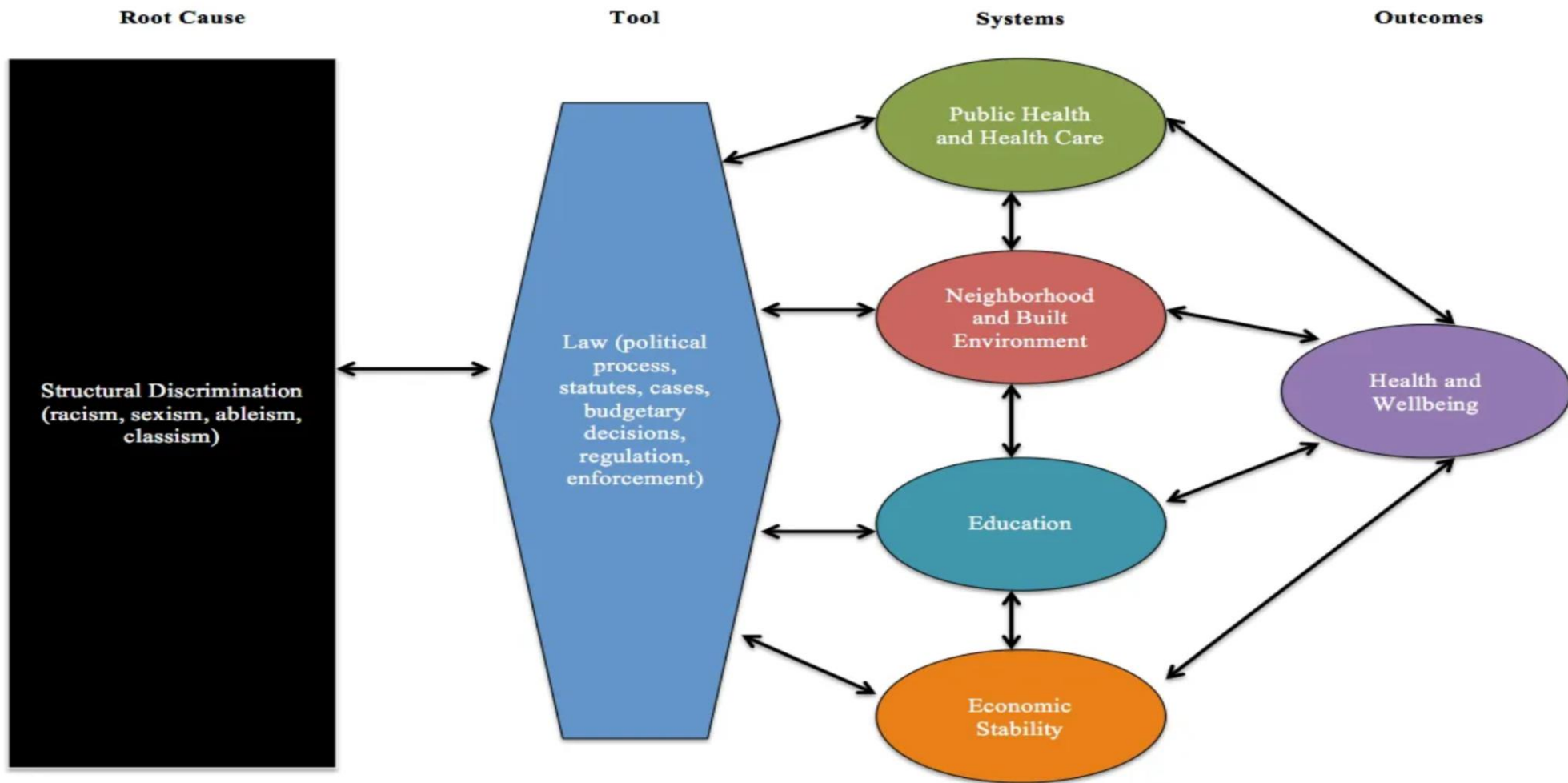
References

- Estevez-Diz M, et al. Ecancermedalscience. 2020;14:1060.
- Bakouny Z, et al. JAMA Oncol. 2021;7(3):458-60.

Disclosures

APM has no disclosure/ conflict of interest to declare.

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Structural Determinants of Health

People of color are:

- at an increased risk for serious illness if they contract COVID-19 due to higher rates of underlying health conditions, such as diabetes, asthma, hypertension, and obesity compared to Whites;
- more likely to be uninsured and to lack a usual source of care which is an impediment to accessing COVID-19 testing and treatment services;
- more likely to work in the service industries such as restaurants, retail, and hospitality that are particularly at risk for loss of income during the pandemic;
- more likely to live in housing situations, such as multigenerational families or low-income and public housing that make it difficult to social distance or self-isolate; and
- often working in jobs that are not amenable to teleworking and use public transportation that puts them at risk for exposure to COVID-19

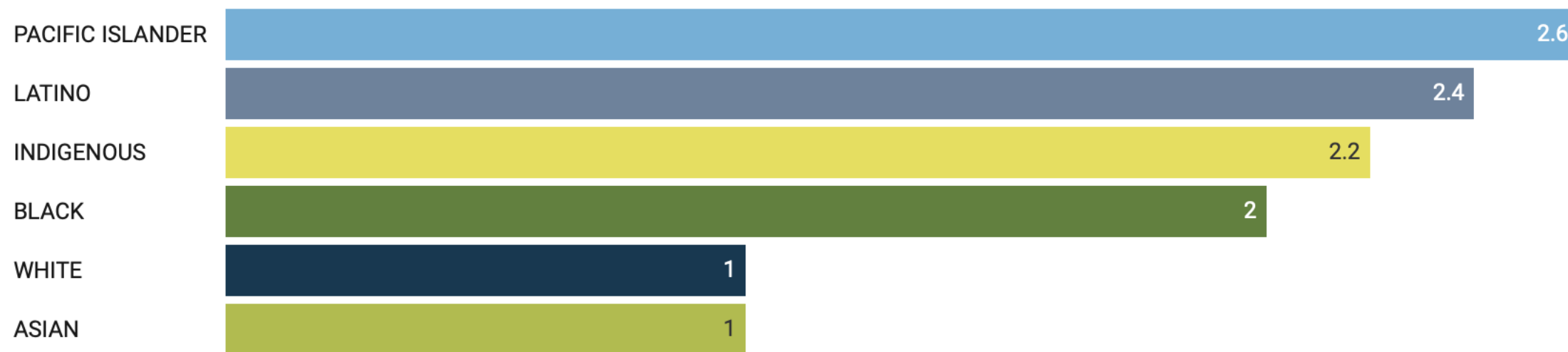
Differences and overlap similarities for the pathogenesis, incidence, and mortality risks between cancer and COVID-19.

<u>CANCER</u>	<u>common to both</u>	<u>COVID-19</u>
<ul style="list-style-type: none">• Series of genetic diseases<ul style="list-style-type: none">• Germline predisposition• Somatic DNA mutations• Local environmental influences<ul style="list-style-type: none">• Inflammation• Microbiome• Onset over months to years• Asymptomatic screening is part of routine health care	<ul style="list-style-type: none">• Socioeconomic disparity<ul style="list-style-type: none">• Level of Income and employment• Housing and location• Level of medical insurance• Level of education• Lifestyle factors and comorbidities<ul style="list-style-type: none">• Tobacco• Alcohol• Diet and obesity• Reduced access to medical care<ul style="list-style-type: none">• Delayed prevention or care• Fear of clinical trial participation• Higher risk of acquiring disease• Higher risk of death from disease• Survivorship medical and socioeconomic issues	<ul style="list-style-type: none">• Single infectious disease• Local environmental influences<ul style="list-style-type: none">• ACE2 receptor• Onset over hours to days• Symptomatic screening<ul style="list-style-type: none">• With widespread testing, can move to asymptomatic screening

Lisa A. Newman et al. Clin Cancer Res 2021;27:24-27

Adjusted for age, other racial groups are this many times more likely to have died of COVID-19 than White Americans

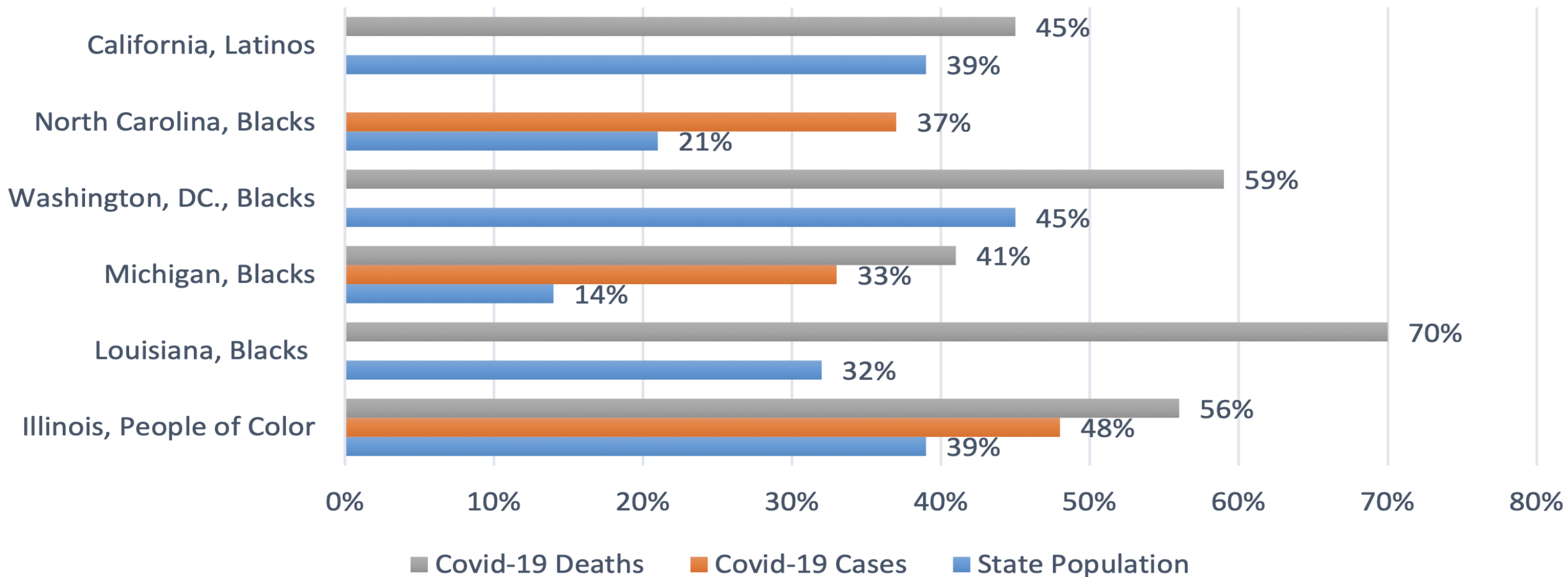
Reflects cumulative mortality rates calculated through March 2, 2021.



Indirect age-adjustment has been used.

Source: [APM Research Lab](#) • [Get the data](#) • Created with [Datawrapper](#)

Percentage of Blacks, Latinos, and People of Color by State Population, COVID-19 Cases, and COVID-19 Deaths (Kaiser Family Foundation, CDC, US Census Bureau)



Diseases with Disproportionate Burden Among African Americans

- Diabetes
- Hypertension
- Asthma
- Obesity
- Cardiovascular/Cerebrovascular Disease
- Venous Thromboembolism
- **COVID-19 Morbidity and Mortality**

Background:

- The SARS-CoV-2 pandemic limited mammography for several months in the United States.
- We hypothesized that this delay in mammography would result in patients presenting with later-stage breast cancer following the initial shutdown period.

Methods:

- Patients diagnosed with invasive breast cancer from 2016-2020 were identified.
- Late-stage disease was defined as initial anatomic stage III-IV disease in the AJCC 8th edition staging system.
- Patients diagnosed from 2016-2019 were the control cohort and those diagnosed in 2020 were the test cohort.
- Chi-squared analysis compared monthly distributions in stage at presentation. Multivariate analysis was performed using a logistic regression model.

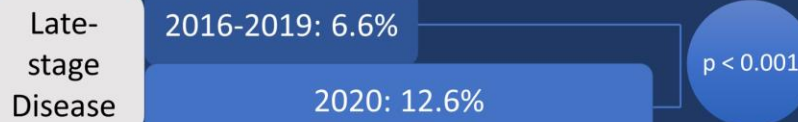
Results:

- 1597 patients were diagnosed between 2016-2019 and 333 patients were diagnosed in 2020.
- Mammography was limited from 3/16/20-6/8/20, with a 90% reduction in volume during this time.
- 92.9% of late-stage diagnoses in 2020 occurred after the shutdown from June–December.

Table: Proportion of Patients with Late Disease by Month

Month	2016-2019	2020	Month	2016-2019	2020
Jan	7% (9/130)	0 (0/24)	Jul	9% (12/142)	7% (1/14)
Feb	5% (6/125)	10% (2/20)	Aug	9% (13/140)	21% (9/42)
Mar	7% (9/132)	3% (1/31)	Sep	5% (6/124)	15% (10/65)
Apr	6% (7/118)	0 (0/9)	Oct	7% (10/135)	19% (10/53)
May	7% (10/141)	0 (0/7)	Nov	7% (10/145)	12% (5/42)
Jun	7% (10/147)	21% (3/14)	Dec	3% (4/118)	8% (1/12)

Patients were more likely to be diagnosed with late-stage breast cancer following the shutdown due to the SARS-CoV-2 pandemic.



Those with lower incomes and medical comorbidities were disproportionately affected.



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Results, continued:

- The proportion of patients diagnosed with late-stage breast cancer in 2020 was 12.6%, compared to 6.6% in 2016-2019 ($p < 0.001$).
- On multivariate analysis, late-stage disease at diagnosis was significantly associated with year of diagnosis, lower income, and increased Charlson Comorbidity Index.

Late-Stage Breast Cancer at Presentation was Associated with:

Year of Diagnosis: 2020 vs. 2016-2019	OR = 1.45 95% CI 1.102-1.883, $p = 0.008$
Lower Income: <200% of Federal Poverty Line	OR = 1.22 95% CI 1.035-1.441, $p = 0.018$
Increased Charlson Comorbidity Index	OR = 1.14 95% CI 1.114-1.167, $p < 0.001$

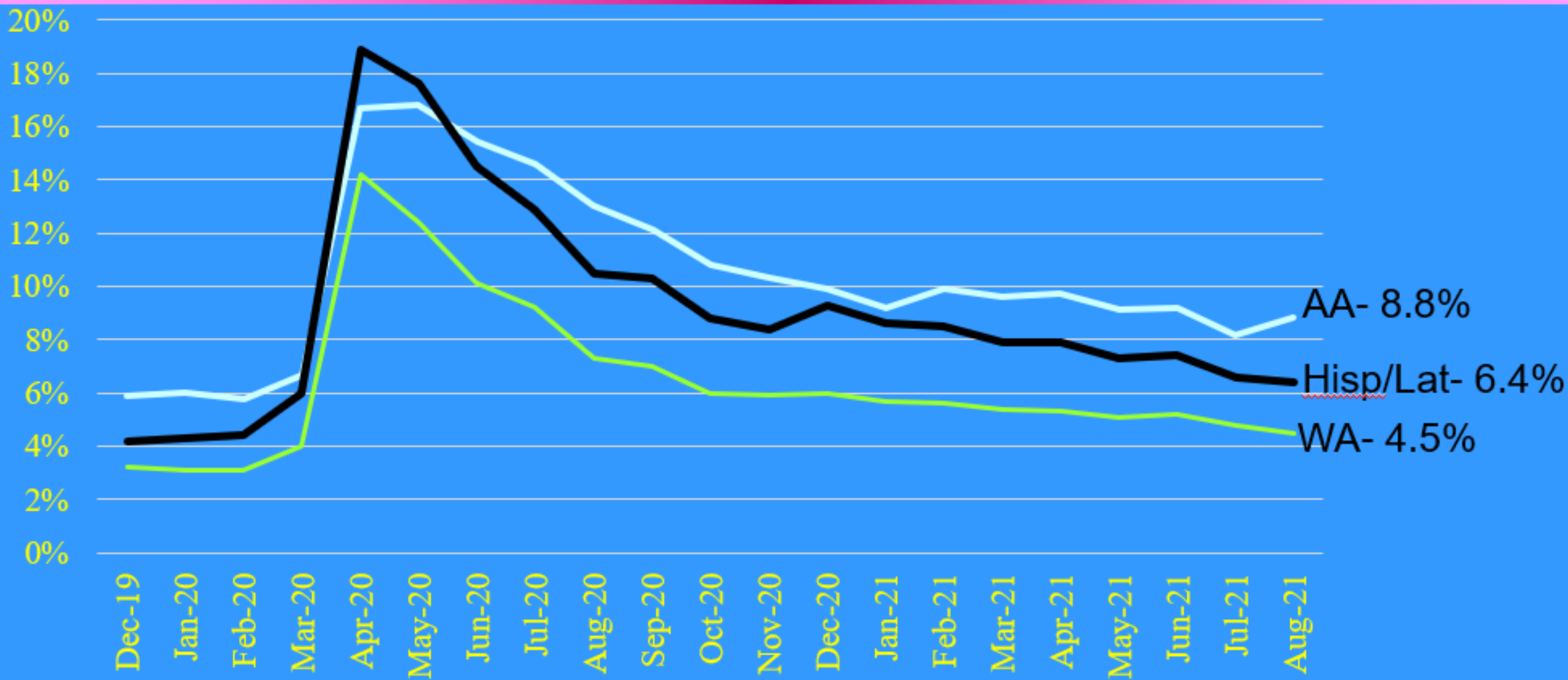
Future Directions for Research:

- These results raise concerns regarding the impact of the SARS-CoV-2 pandemic on long-term cancer outcomes, especially in vulnerable patient populations, and warrant further investigation.
- Analyzing data from other health institutions could help broaden the scope and generalizability of our findings.



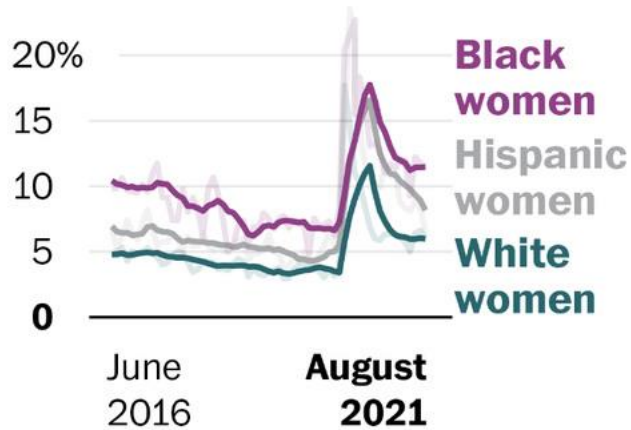
COVID-Era Unemployment Rates: Disparities Persist

U.S. Bureau of Labor Statistics

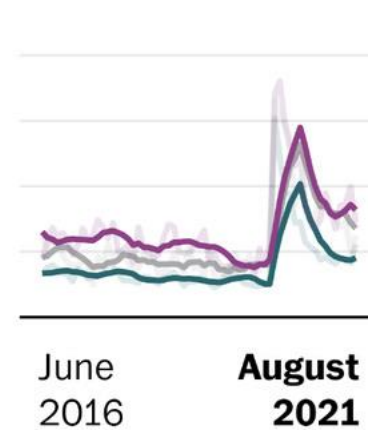


Women

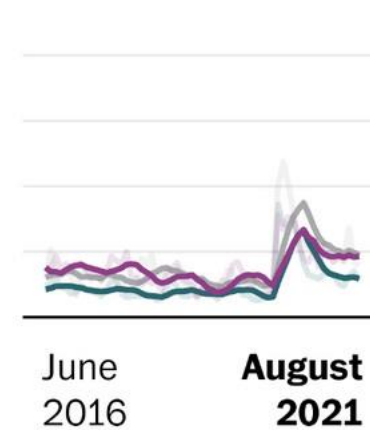
High school diploma or less



Some college or associate's degree



Bachelors degree or higher



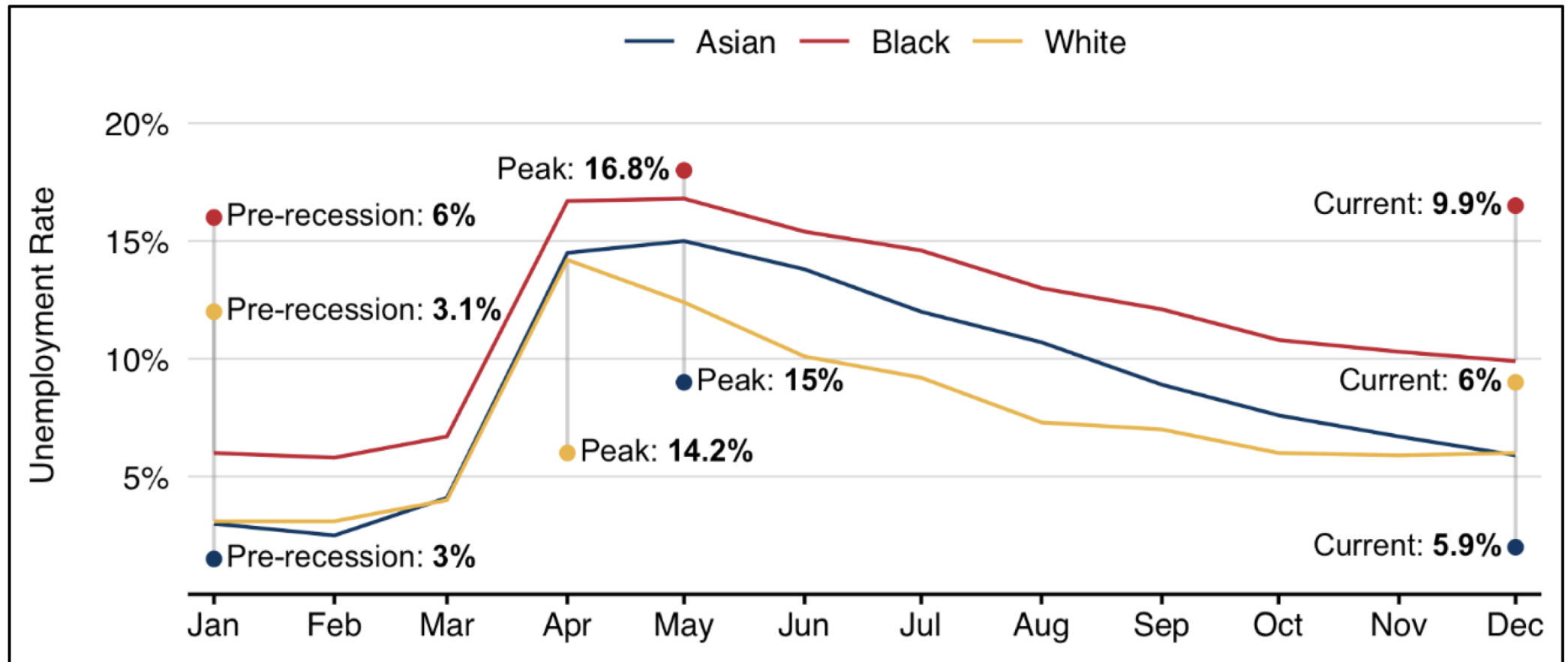
Note: Ages 25 to 64, White and Black racial groupings don't include those of Hispanic ethnicity

Source: Bureau of Labor Statistics via IPUMS

THE WASHINGTON POST

Figure 7. Monthly Unemployment Rates by Racial Group

Seasonally adjusted data, January 2020 to December 2020



Source: Created by CRS using data from the Bureau of Labor Statistics (BLS).

Projected Excess Breast Cancer Mortality in COVID/Post-COVID Era Likely to Disproportionately Impact African Americans

- Disproportionate impact on health care access
- *Covid recession unemployment 30-50% higher for AA compared to WA; loss of employment-based insurance*
- Safety-net hospitals disproportionately devastated by costs of Covid care
 - *AA rely disproportionately on safety-net hospitals for cancer care/screening*
 - *Safety-net hospitals serve as economic hub for many inner-city neighborhoods*
- Impact on advocacy/philanthropic fundraising efforts
 - *Many community outreach programs funded by advocacy organizations*
- Adverse impact of Covid recession on research and hospital budgets
 - *Support for disparities research and navigation services under threat*
- Increased reliance on remote technology/video visits
 - *Digital divide: no broadband/internet access in 36% AA vs 21% WA households*

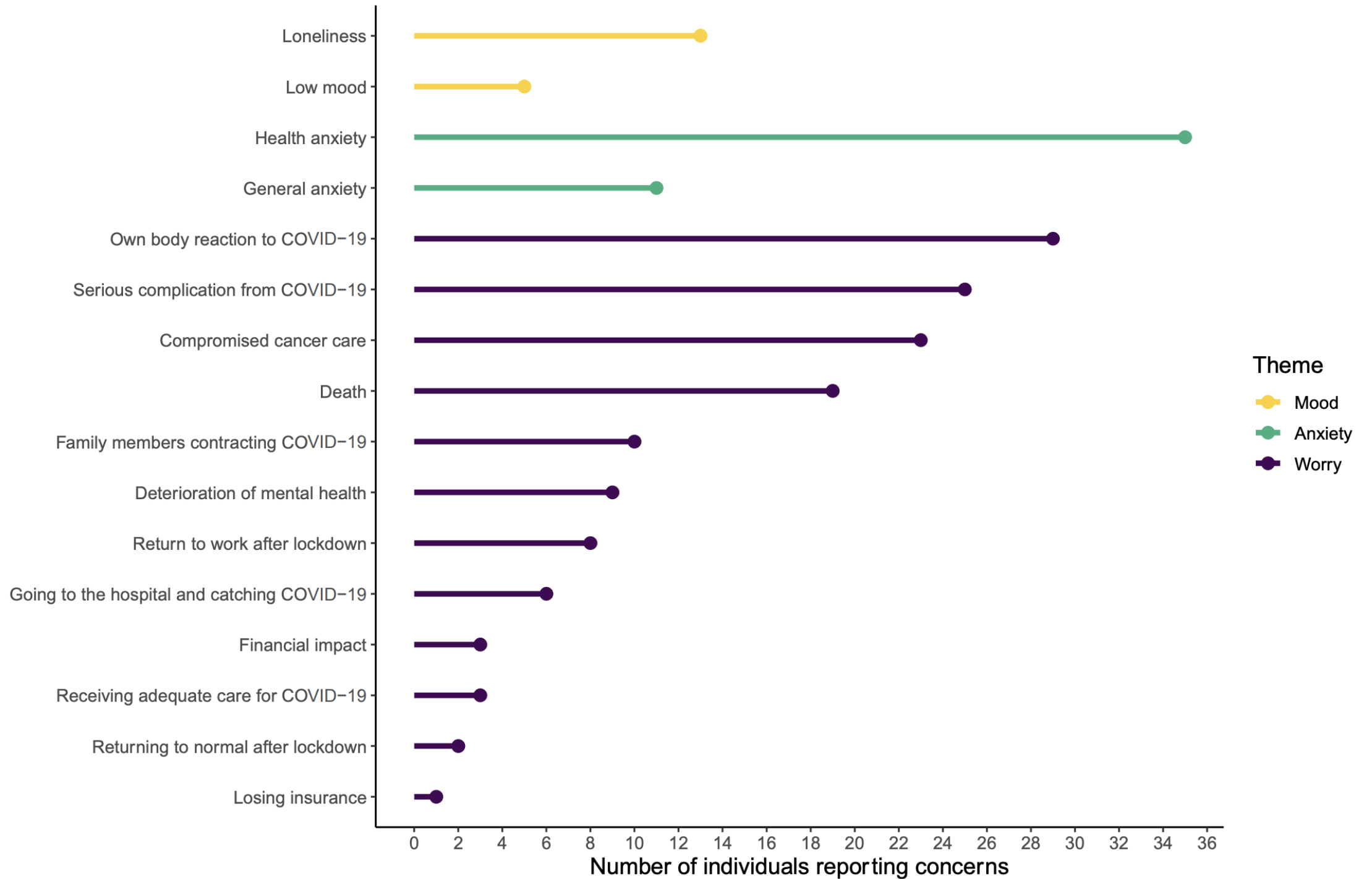
Cancer, COVID, YOUNG PEOPLE

PRE COVID-19 CHALLENGES:

Prolonged route to diagnosis

Loss to follow up

“Every day is just kind of weighing my options.” Perspectives of young adult cancer survivors dealing with the uncertainty of the COVID-19 global pandemic



Impact on mental health (PHQ-4)

- Anxiety > depression/low mood

Psychological distress among AYAs

		Anxiety	Depression	Total
	<i>n</i>	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)
Total sample	177	56 (32%)	34 (19%)	51 (29%)
Undergoing treatment	57	20 (35%)	10 (18%)	17 (30%)
Completed within 6 months	24	12 (50%)	6 (25%)	12 (50%)
Completed more than 6 months ago	96	24 (25%)	18 (19%)	22 (23%)

62% more anxious now
52% more isolated now

BUT

~10% less anxious and
isolated now than before

Connecting with our patients

- See in clinic, cancel/delay, telehealth
- Who is appropriate for in person vs remote?
- Video platforms and billing issues
- Creating fail-safes so patients are not lost if f/u or treatment is delayed

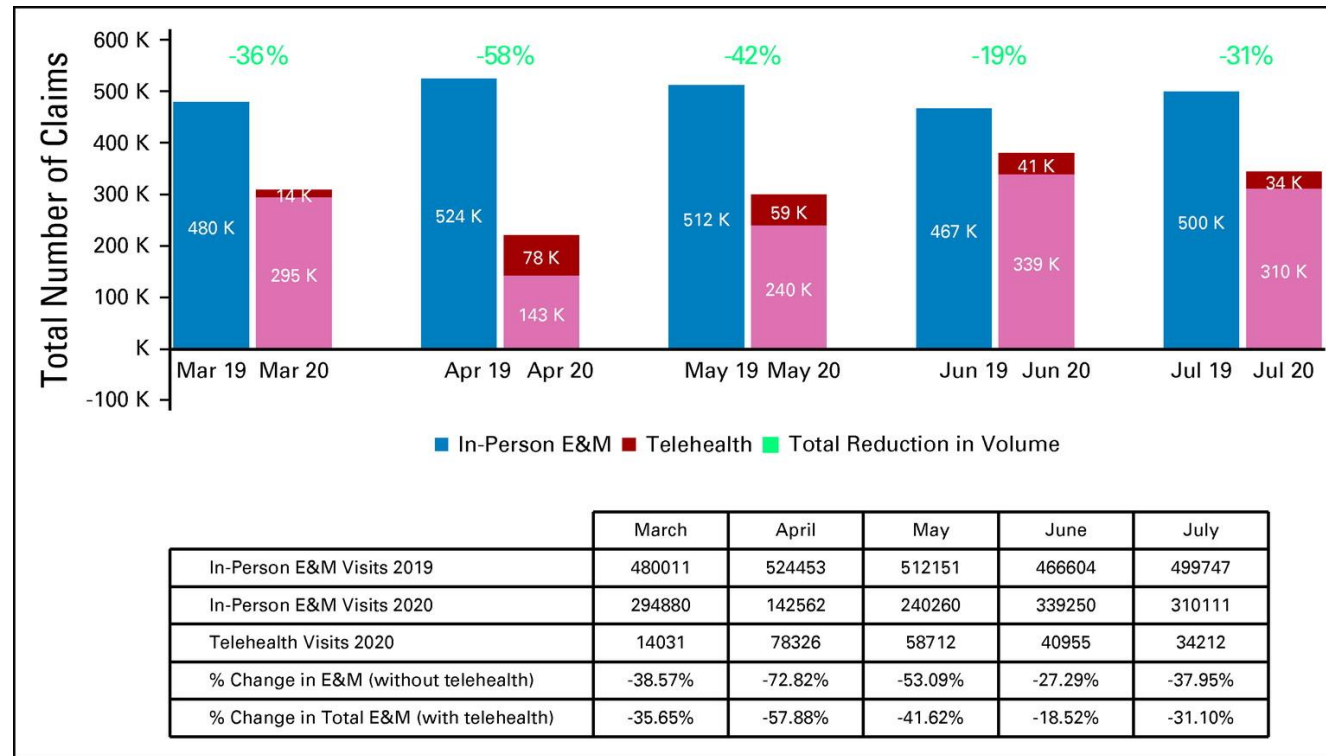


FIG 6. Total number of claims for cancer-related in-office evaluation and management (E&M) v telehealth E&M services and relative change in billing frequencies (March-July 2019/2020). Billing frequencies were determined by the following procedure codes: new patient E&M (99201-99205); established patient E&M (99211-99215); hospital outpatient (G0463).

RHLCCC New eVisit Encounter Volume

Breast Hematology Oncology



Telehealth is here to stay.

We asked oncology providers how they used telehealth and how they want to use it in the future.

200 respondents

Geography

- 42 States
- 5% Rural Practices
- 30% Suburban Practices
- 66% Urban Practices

Practice Size

- 1 - 5 clinicians: 18%
- 6 - 10 clinicians: 15%
- 11 - 15 clinicians: 12%
- 16 - 20 clinicians: 6%
- More than 20: 50%

Respondent Role in Practice

- 72% Medical oncologist
- 6% Nurse/NP/PA/CNS
- 6% Radiation oncologist
- 16% Other

Practice type

- 64% Academic
- 19% Hospital or health system owned
- 12% Private or physician owned
- 5% Government

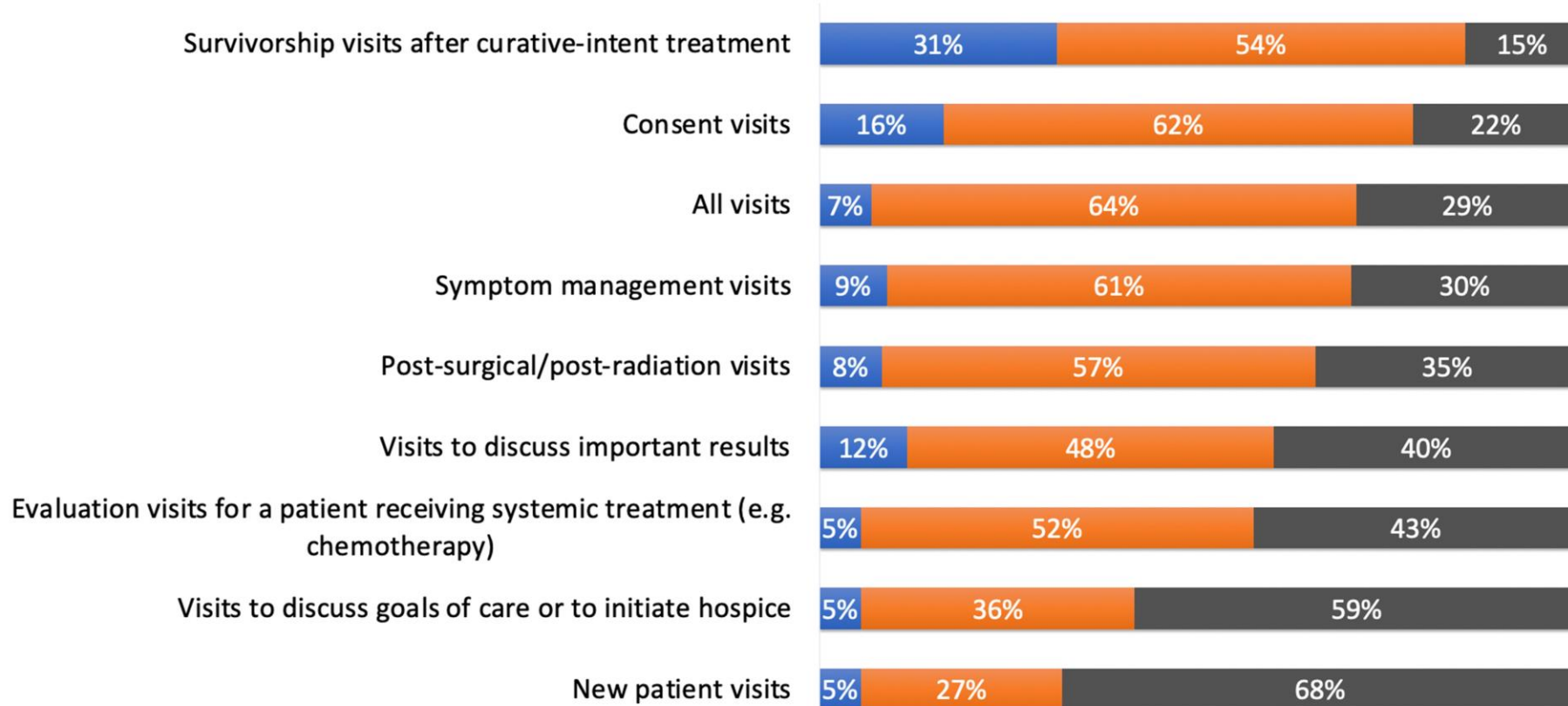
Respondents' use of telehealth by visit type in last 30 days *

% respondents reporting for each visit type	≥ 50% Visits	< 50% Visits	No telehealth visits
Survivorship visits after curative-intent treatment	51%	40%	9%
Symptom management visits	37%	55%	7%
Visits to discuss important test results	36%	54%	10%
Evaluation visits for a patient receiving systemic treatment (<u>e.g.</u> chemotherapy)	24%	53%	23%
New patient visits	22%	50%	28%
Post-surgical/post-radiation visits	21%	44%	35%
Visits to discuss goals of care or to initiate hospice	19%	55%	26%
Consent visits	16%	52%	33%

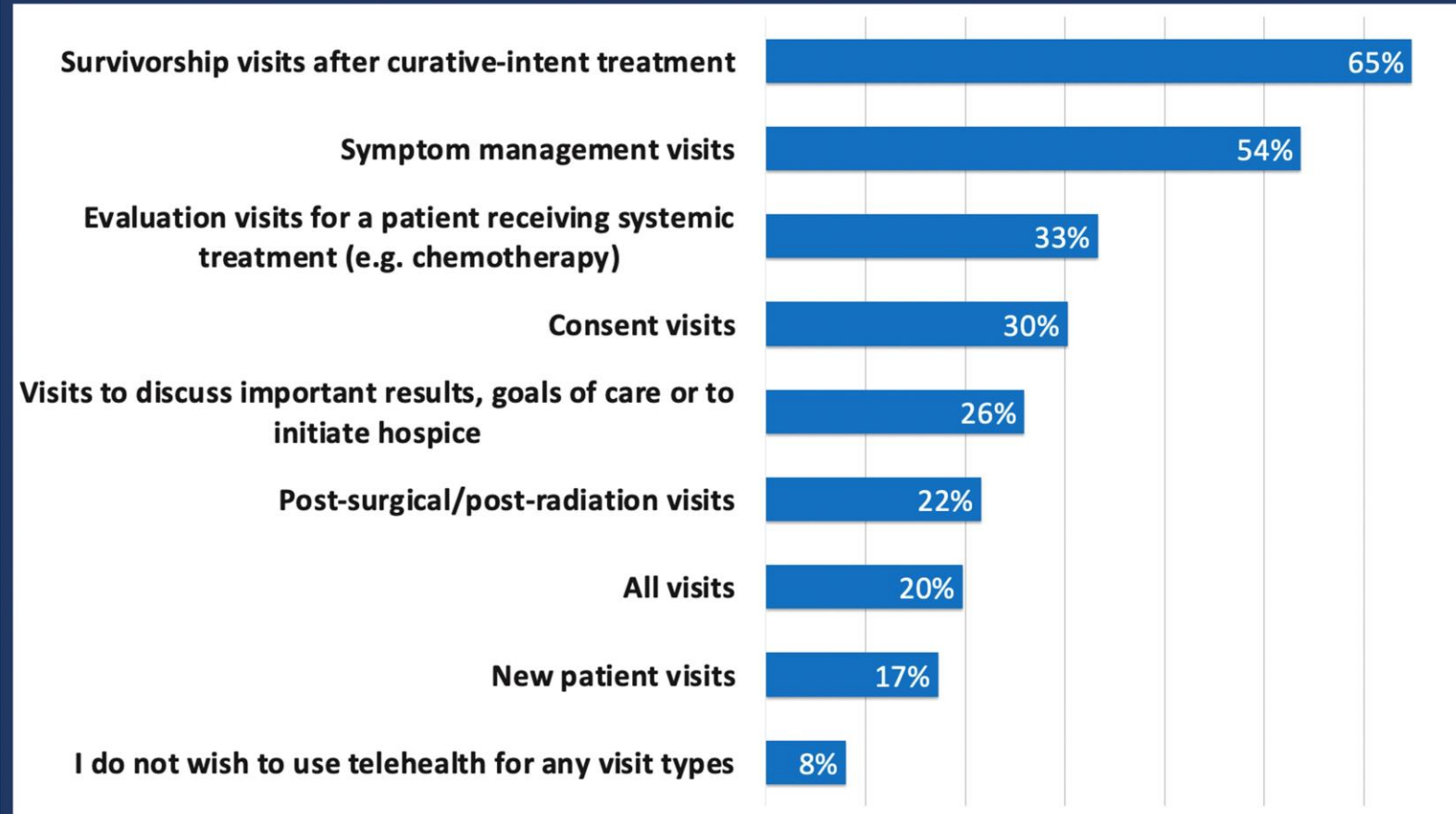
*Each cell is the percent of respondents who reported none, < half, or ≥ half of visits of the visit type in the last 30 days occurred as telehealth. Rows may not sum to 100 due to rounding.

Please indicate the overall quality of care that your patients experience with a telehealth visit compared to an in-person visit:

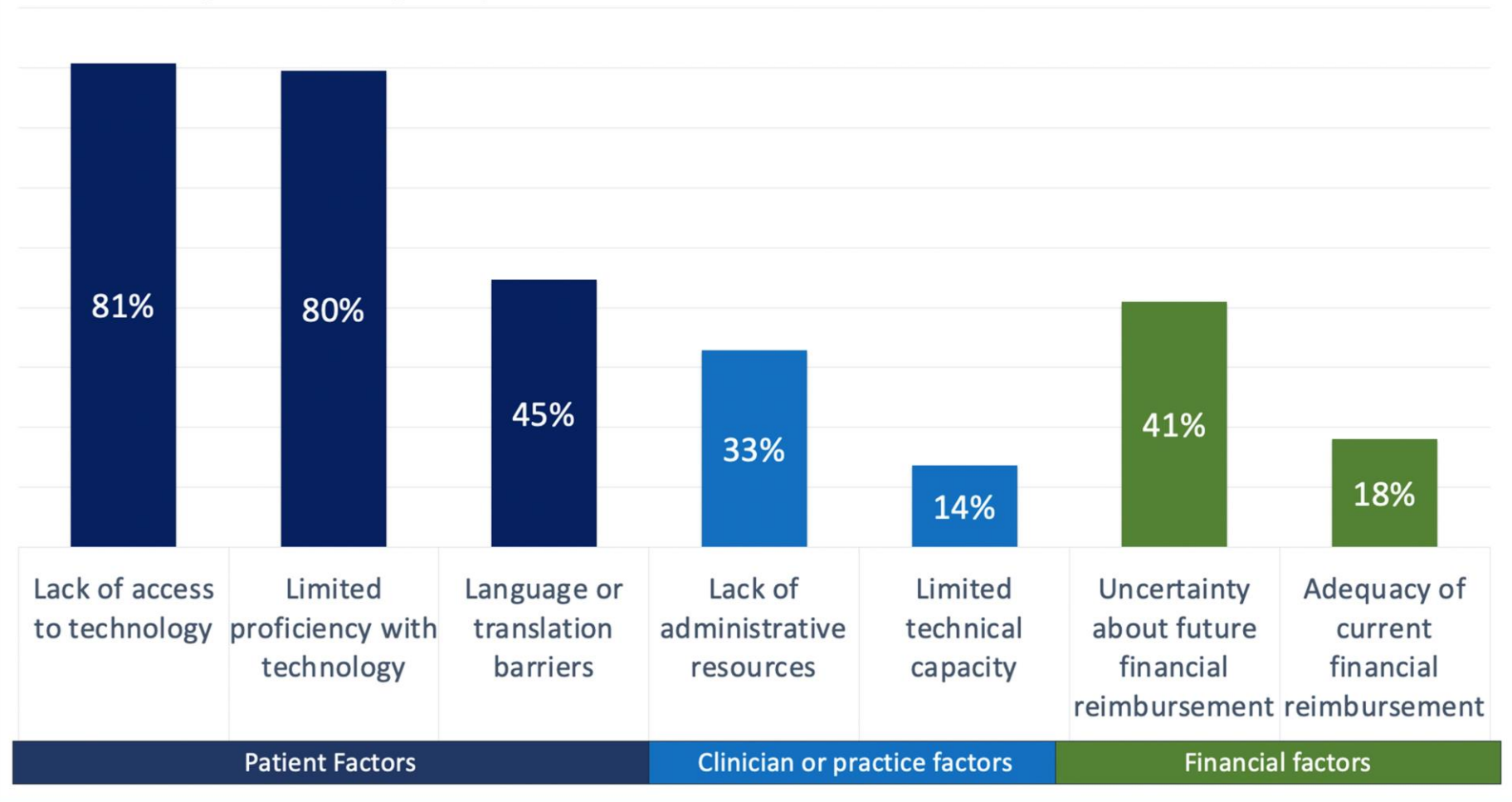
■ Telehealth visit quality is better ■ Telehealth visit quality is similar ■ Telehealth visit quality is worse



After the pandemic has ended and assuming that there are no payment, legal or regulatory barriers to telehealth, for which of the following types of visits would you like to use telehealth?



Please indicate whether the following items are a barrier to providing telehealth services to patients in your practice:



Cancer Care Disparities During the Covid-19 Pandemic

- Significant disruptions to cancer care were observed during the pandemic at tertiary institutions in New York and Boston. A significant decrease in outpatient visits and increase in telehealth visits were noted during the pandemic period. However, **Black and Hispanic patients were less likely to have an increase in telehealth utilization** and were **more likely to develop COVID-19 infection** compared to white patients. Hispanic patients were more likely than White patients to have pandemic-related delays in cancer care. Racial and ethnic barriers to the adoption of telehealth and related socioeconomic factors place members of these vulnerable populations at disproportionate risk for both COVID-19 infection and decreased cancer-related visits, thereby exacerbating existing health disparities.

Schmidt A et al. Cancer Cell 38:2020

Collateral Issues

- Patient Financial Toxicity (loss of health care insurance)
- Institutional Financial Toxicity
 - decrease in high contribution margin activities
 - care for newly uninsured and underinsured
- Labor Force realignment in cancer centers
- Physician Deployment for COVID-19 reassignment (or surge)
- Physician Training (Fellow and resident reassignment)

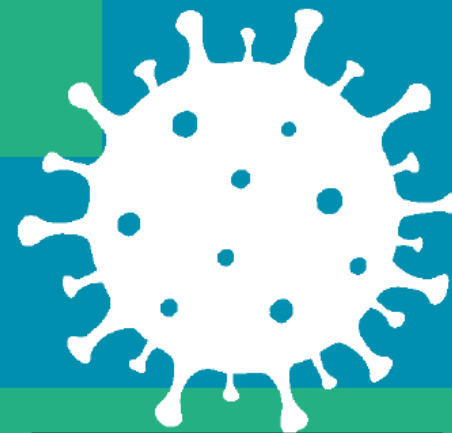
Research during COVID: Classic, and COVID related

- Research in COVID- : continuing current research studies from pre-COVID- IRB, accrual, and other issues
- Cancer specific and other Registries- ASCO, Am College of Surgeons, NCI
- Radiation registries
- Heme/Coag specific

Chicago Cancer Centers continued to meet every Sunday morning to discuss experiences and best practices

CANCER CARE DURING COVID-19

C/5



TUESDAY, MAY 26TH
4:30 – 6:00 PM

- ◆ CONNECTING WITH OUR PATIENTS •
- ◆ DELAYED SURGERIES & SCREENING PROCEDURES •
- ◆ TREATMENT DURING COVID— WHAT IS IDEAL AND WHAT IS POSSIBLE •
- ◆ NEW WORKFLOWS •
- ◆ REGISTRY & OTHER RESEARCH INITIATIVES •
- ◆ DATA & SAFETY •
- ◆ “COLLATERAL” ISSUES •

Speakers and Panelists

- *Bruce Brockstein, MD*
- *Mia A. Levy, MD, PhD*
- *Mary Mulcahy, MD*
- *Jon Richards, MD, PhD*
- *Damiano Rondelli, MD*
- *William Small, MD*
- *Sonali M Smith, MD*
- *Samir Undevia, MD*

Lessons learned (and continuing to learn!)

- Optimizing care during a crisis requires communication between all members of the multi-disciplinary team
- Prioritization of patient issues had to balance impact on disease related outcome, resource utilization during covid for critically ill pts and insuring patients did feel a sense of abandonment or unnecessary fear for certain interactions at the medical ctr
- New knowledge was being acquired in real time...again communication with all stake holders was critical and adjustments were made week to week

Lessons learned (and continuing to learn!)

- Many aspects of care could be maintained with telehealth...here to stay!
- COVID did not effect every population equally in the US! The pandemic highlighted inequities that were present in our society and were being experienced by many for generations.
- The confluence of these events and tragedies will hopefully bring awareness, motivation and commitment to make systemic changes