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The Impact of COVID-19 on Cancer Care and Research

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No one predicted what the impact of COVID-19 upon globe would have been. The impact has been devastating, from a humanistic as well as from healthcare perspective. However, I am constantly reminded that no matter where the final numbers tally out to with respect to the human tragedy, COVID-19 thus far is not even close to the Great Flu Epidemic in 1917 during World War I. What makes the difference now is that we are already familiar with the virus, and in some respects, we have some idea how to treat it, albeit it is mostly symptomatic at this point in time. Some would even contend that control of the spread of the virus has not changed, in that the CDC and WHO are stressing the importance of good hand washing, covering one's face and nose when coughing and sneezing, and staying home when feeling ill. Maybe it is our own sense of immortality that is the main barrier to containment.

Focusing on cancer care, oncology practices were forced to make significant changes to their office workflow in a very short period of time. For the first time, practices were literally forced to ration care in order to modify their level of direct patient interactions based upon recommendations provided by ASCO, NCCN, ESMO, and other organizations. Prioritization is being given to patients based upon tumor type and staging. At a high level, on average, a 20% reduction in patient services were being observed through early April, but services related to aggressive cancers or cancers in advance stages have maintained. Thus, the patients with the greatest need appear to be receiving services. Cancer screening appears to have fallen significantly (by 80-90%) for the routine "screening" testing, while "diagnostic" testing was not down as drastically. In late April, the Cancer Letter provided more detailed information on COVID-19's impact from the community practice perspective. Using data provided by the Flatiron EMR, new patient visits decreased by 40% from February through the end of April. Cancellation and no-shows nearly doubled. Even patient visits involving

treatment infusions were decreased by 17% in the Northeast region of the US (one of the first hotspots of the US), however it is not known if those infusions were administrated at alternative sites e.g. institutional infusion center, home care. In short, fewer patient visits, increased cancellations, and no-shows is a reality [1].

The utilization of Telehealth services has increased, accounting for a significant portion of the remaining patient visits. However, unlike academic centers and primary care practices, telehealth services in oncology community practices is not common. Thanks to today's connectively technology, it appears that community oncology practices were able to get up and running with telehealth services relatively quickly. Luckily the payer community already recognized the cost-effectiveness of Telehealth and were already reimbursing for such services.

From the patient perspective, there is a heightened concern for "Access to Care". Patients, especially the hourly "non-essential" employees working in the service industries appear to be the most impacted due to furloughs and layoffs, resulting in unemployment with subsequent shifting within the various lines of insurance coverage. We have already started to see, and it is anticipated that we will continue to see a shifting from commercial lines of insurance to Medicaid or the uninsured ranks as unemployment continues to rise. The American Cancer Society reports that 38% of patients surveyed reported that reduced work hours had an impact to their ability to afford and access care. Of those reporting a job loss, 43% reported having employer-sponsored health coverage, thus the loss of health insurance coverage is due to a combination of individual coverage and employer sponsored coverage. All too often do we tend to overlook the significance of individual coverage to health care coverage landscape. ACS goes on to report that 25% of their respondents experienced a delay in care or treatment. Most common were delayed access to imaging services (50%), delayed access to supportive services (20%), and delayed access to surgical procedures (8%) [2].

Clinical trials efforts have been hampered. In some specialty areas, clinical trials have come to a halt. The NCI has reported a 44% decline in cooperative group trial accruals as of early April. Patients, as well as the general population, are being repeatedly told to stay home as a step towards containment. However, as previously noted, the fallout of this action are fewer physician visits, as well as fewer diagnostic and testing procedures. What this means to the cancer patient, especially the newly diagnosed where diagnosis maybe be occurring later in the disease process, are less opportunities to hear about and understand their treatment options, as well as to obtain the necessary diagnostic testing and determine eligibility. The Alliance for Clinical Trials in Oncology cited that enrollment in clinical trials are down 40-60% due to the pandemic, in part due to the increase in telehealth visit where it is difficult to identify appropriate patients for any given clinical trial. As well, if the patient is lucky enough to enter a clinical trial, we then have the concerns of the additional visits and testing that is required to fulfill the trial protocol, thereby increase the potential risk of exposure to the COVID-19 infection.

What is unknown at this time, and will probably not know for some time, is what will be the impact to mortality resulting from delayed diagnosis, treatment, and financial toxicities escalated by furloughs, layoffs and consequential loss of health insurance. We also do not know what the long-term impact upon research will be due to the deceased enrollment. What we do know for sure is that we all must be flexible and

adaptable to thinking out of the box and looking for change. The phrase "We Are All in This Together" is a constant message today. I would contend that we should all together work to take what we have learned from this event, see what has worked and what has not, and work towards a new future. We are seeing increased utilization of telehealth services, and while telehealth visits may not be the best method to identify patients for clinical trials, it can be used for simple follow-up visits. We surely have advanced the use of artificial intelligence capabilities enough so that patients may become more readily identified based upon entries into the EMR's. It is incumbent upon us to change the system to be the most responsible from a resource and financial standpoint, while improving our quality of care. Due to COVID-19, we had to take a hard look at what we do, and to quickly implement changes to adapt. Let's not lose this momentum, and work towards a greater future in oncology care. Let's not settle back into our old habits and processes we use to call "normal", mainly because we will probably never get back to a "normal" state [3].

Bibliography

1. The Cancer Letter, COVID-19 vs. Community Oncology: Flatiron's Data Provides First Damage Assessment.

2. American Cancer Society, Survey: COVID-19 Affecting Patient's Access to Cancer Care.

3. The Cancer Letter (2020). With the COVID-19 Pandemic, The Cancer Clinical Trials - They are A-Changing.