While shelter-in-place orders have limited many people across the US from leaving their homes to do more than buy groceries, cancer patients have faced a more daunting challenge—how to continue their treatment, potentially in different ways than they had planned (e.g., telehealth appointments). Others have experienced the initial symptoms of a new cancer (such as a new source of pain or discomfort) but, due to closures and restrictions for healthcare services, have been unable to initiate care.
Preliminary data from Harvard University researchers and Phreesia indicates a precipitous drop in outpatient volumes over a two-week period in mid-March. Oncology providers saw, on average, a 47% decline in outpatient visits during this period. Given the widespread disruption to healthcare services and the US economy, these figures are not surprising. With nearly 150,000 new cancer cases every month,1 there have probably been many new cases where patients were unable to initiate care. Data from Flatiron Health validates this assumption, reflecting an approximate 40% decline in new patient visits from early March to early April. Similar to the outpatient visit data shown above, the rate of new patient visits stabilized in April at a baseline level for the pandemic period.

With service disruptions for cancer programs lasting at least two months (mid-March to mid-May), it can be anticipated that there is a backlog nationally of approximately 120,000 new cancer patients.2 As cancer programs look to restart operations in the new environment, they must also account for how they will work through this backlog.

ECG recently spoke with leaders from National Cancer Institute (NCI)–designated cancer centers across the country to learn how COVID-19 is impacting their programs during the pandemic and how they are preparing for recovery. The interviews we conducted show that every cancer program’s decline in clinical volumes is unique, as is the nature of their recovery. Because the COVID-19 pandemic is a dynamic situation, local trends may change over time and require a more—or less—aggressive response by cancer providers. The surge in patient volume after the pandemic will depend on the magnitude and duration of the disruption to clinical care, as patient volume will be driven by the number of patients who have had to delay care. For some centers, the increase may be considerable, as much as 30% above average, and will potentially last through the end of 2020.

Cancer program leaders should implement the following advice to guide their centers through a successful recovery and ensure the safety of patients and staff while providing essential care to cancer patients.

— Prepare clinical operations to accommodate an increase in patient demand while ensuring patient and staff safety.
— Deploy financial management systems to maximize revenue.
— Develop or maintain strict safety protocols to ensure the safety of patients.
— Prepare the clinical and nonclinical workforce to respond to increases in demand.
— Update the physical environment to meet current social distancing requirements, while at the same time accommodating additional patient volumes.
— Thoughtfully resume clinical research efforts.
— Enhance communication with patients, allaying their fears while also educating them about the risks inherent with delaying treatment.

1 American Cancer Society. Cancer Facts & Figures 2020 reports that more than 1.8 million new cancer cases are expected to be diagnosed in 2020.
2 Assumes two months of service disruption, a 40% decline in new patient visits during the disruption, and 150,000 new cancer patients monthly in the US.
The Cancer Center Response

Planning for a volume surge following the initial outbreak will require a comprehensive approach to all areas that are likely to be affected. We will explore key strategies for each of these areas.
CLINICAL OPERATIONS

Over the last two to three years, many cancer programs began experiencing the combined effects of an aging facility, a growing community, the integration of acquired practices, or the addition of newly recruited providers. While the COVID 19 crisis may provide some temporary relief from the overcrowding experienced just a few months ago, this will last only until the recovery begins. It will be important, in preparation for recovery, for programs to deploy a number of strategies to increase their capacity.

Telehealth: Most programs rapidly implemented or expanded their use of telehealth during the COVID 19 pandemic. Leaders told ECG they saw a 100-fold to 1,000-fold increase in use of the telehealth platform in March. For many programs, the adoption of telehealth services led to a redesign of clinical workflows (e.g., no longer requiring a physician visit before chemotherapy). Telehealth has been embraced by many patients and providers and is a logical tool for managing routine follow-up and survivor visits. Leading centers are planning to maintain telehealth as a core service delivery tool in the program, anticipating that 25% to 50% of office visits will be provided remotely. Telehealth services offer both near- and long-term benefits.

- Increases capacity by allowing the physical center to care for more in-person patients while also offering care remotely
- Improves social distancing by reducing the number of patients in the center
- Creates market differentiation, as early results from both patients and providers indicate positive feedback to virtual visits

Programs should look for opportunities to extend telehealth services, particularly related to survivorship clinics, social work support, and clinical pharmacist follow-up visits for medication management.

Operational Debulking: Centers should carefully evaluate clinical practices across the organization to identify opportunities to further reduce the number of on-site clinical encounters.

- Eliminate unnecessary encounters (e.g., physician consultations before each chemotherapy procedure).
- Transition encounters to alternate care settings (e.g., oral oncology or in-home infusions)
- Reduce the number of encounters required (e.g., hypofractionation for radiation therapy patients).

Surgical Alternatives: Facilitate discussions with medical staff leadership to develop or update clinical protocols regarding the use of radioembolization, radio frequency ablation, and cryoablation as alternatives to surgical procedures.

Addressing Bottlenecks: Identify operational bottlenecks in the system (both in the cancer center and in upstream/diagnostic service areas) and develop solutions to improve capacity (e.g., extended operating hours, increased staffing).

Operating Hours: Of the NCI center leaders ECG interviewed, most are planning to extend operating hours in order to increase their capacity. Centers should develop a clear plan that addresses factors such as when to implement extended hours, how to staff the clinic, etc.

Decanting to Smaller Centers: Many NCI centers are looking to use their community-based network to decant volume out of the main center. Doing so requires a staffing plan, clinical algorithms...
regarding the appropriate care locations, and the potential use of telehealth services to augment the provider services in community clinics. Centers that have begun implementing this strategy report increased patient satisfaction in being able to receive care closer to home.

**Testing:** For the leaders ECG interviewed, a key concern is COVID-19 testing protocols for patients and staff. All the leaders recommended developing a set of policies governing the routine testing of asymptomatic patients and staff. The frequency of testing will evolve, based on the availability and turnaround time for tests; however, the following steps were recommended:

- Test all patients before initiating treatment
- Test patients receiving therapy every two to four weeks
- Develop protocols for staff testing, although there was no consensus regarding the frequency of this testing

**Visitor Policy:** All the NCI centers ECG surveyed had implemented a strict no-visitor policy. While these policies are viewed as being in the patients’ best interests, it was acknowledged that they take an emotional toll and are not very patient friendly. Although these policies are currently necessary, centers must evaluate alternative models to support visitors, such as COVID-19 testing, required use of PPE, or other strategies. The phasing back in of visitors will also need to be gated with the pace of recovery and the incidence rate in the community. Nonetheless, centers should monitor this policy vigilantly to ensure that they provide an optimal healing environment.

**Social Distancing:** Policies have been enacted across each center to increase social distancing. Examples include:

- Not collecting copays to minimize the number of patients at reception.
- Conducting virtual scheduling of new patients (including collecting all necessary financial information).
- Reducing the number of infusion chairs in operation to increase the distance between patients.
FINANCIAL PERFORMANCE

One of the most significant challenges of COVID-19 is the financial strain it places on programs. During the height of the pandemic, programs have likely been operating at reduced revenue levels. This will be followed by periods of volume growth, although the payer mix will likely be less favorable than before. Many patients may transition to governmental plans (Medicare or Medicaid), an exchange product, or have no insurance after losing private insurance that was tied to their jobs.

Programs need to develop a holistic financial improvement plan, complete with scenario modeling and quantification of potential tactics, as soon as possible to understand available tactics, their financial impact, and potential strategic implications. Strategies to include in such a financial improvement playbook can be found below.

Payer Strategy: Begin key conversations with payers early. Our conversations with the NCI center leaders indicate that most have yet to begin these efforts.

- Identify alternative payment constructs that support changes to the care delivery model discussed above (e.g., shorter course therapy, oral chemotherapy).
- Explore potential development of value-based payment models that may generate additional income for the practice.
- Identify potential areas of assistance that payers are offering (e.g., accelerated or advanced payments) and enroll in these programs.
- For contracts that are currently being negotiated, toughen the negotiation stance if possible and take advantage of the fact that payers are likely to be in a favorable financial position.

- Negotiate with payers to extend or expand telehealth coverage models that were implemented during the pandemic. Seek especially to preserve telemedicine rate parity with facility-based services.

Financial Navigation: Recognizing the financial challenges that many patients may be facing, develop or expand your financial navigation program by increasing the number of dedicated FTEs.

Accounts Receivable (A/R): The irregular distribution of patients in CY 2020 will create unique challenges from a cash flow and A/R perspective. In preparation for the recovery surge, add support for A/R functions, either by staffing up in this department or by seeking short-term vendor support. Given the potential competition for limited skilled resources, develop a solution early, before costs increase.

Expense Management: Look for creative ways to reduce costs and eliminate waste, such as the consolidation of regional programs or termination of underperforming programs or services. Given the potential lead time to implement these strategies and the expense management efforts already under way, this is unlikely to be a primary strategy for most programs.

Capital Investments: Operational decanting and debulking strategies should create considerable capacity that will likely endure beyond the period of COVID-19. Centers may find that this virtual capacity enables them to delay potential capital investments that would otherwise have been required to expand physical capacity.
QUALITY AND SAFETY

Now, more than ever, quality and safety issues are of paramount importance. Cancer centers will simultaneously seek to adopt new care models and refine operational practices to improve patient access and ensure patient safety. However, change creates disruption and must be carefully monitored to avoid adverse impacts on patients.

Infection Control: Many programs adopted a variety of infection control policies during the pandemic, such as requiring patients to pass a COVID-19 screening, restricting visitors, limiting vendor access, and mandating use of PPE by patients and employees. Extend these policies for the foreseeable future in order to ensure a safe, healing environment for cancer patients.

Guideline Relaxation: With an eye to the future, establish the criteria and policies that will be used to determine when to relax COVID-19 infection control measures.

Triage Criteria: Anticipating periods during the recovery surge when the program is overwhelmed by patient demand, develop (or adopt) a set of triage protocols that govern access to services. The triage protocols published by ASCO and ACoS to guide patient management through the pandemic may provide a baseline from which to begin.

WORKFORCE

The post-outbreak period will present a number of workforce challenges. Programs will need to balance staffing to meet patient demands with efforts to prevent burnout among the workforce; specific challenges will likely vary by employee category.

Increase Capacity: Develop plans to scale up staffing, as appropriate, to meet increased patient demands. Given the physical limitations of each facility, many could find this involves moving to extended hours of operation, as most of the center leaders we interviewed are planning to do. Begin by surveying staff to understand their preferences and/or flexibility for alternative work schedules. With limited day care options, younger parents may favor work schedules that allow them to balance child care with their significant other. At the same time, evaluate your compensation policies to ensure that staff are fairly paid and incentivized to provide much-needed services.

Provider Staffing: Evaluate your provider (physician and APP) staffing model soon. Stress-test the model to determine how much additional capacity it can absorb, and then begin looking for additional resources to fill any gaps. Also, consider potential changes in the provider mix and roles (e.g., more APPs working at the top of their license to manage follow-up and survivorship visits). Programs with a clinical affiliation partner may be able to tap into additional resources, either to provide in-person care or to support telemedicine visits.

Provider Compensation: During the pandemic, many programs offered guarantees or subsidies to providers on production-based compensation plans. It is important to address how these guarantees will be treated going forward. Many programs are extending the compensation plan’s reconciliation period to look at the full year of 2020, rather than doing a midyear reconciliation. If providers can meet the demands of the recovery surge, they should be able to make up the guarantees that were extended during the pandemic period. However, it is important to have clear communication with providers about what to expect for 2020 from a compensation perspective.
PREPARING FOR THE RETURN OF CANCER CASES

ECG MANAGEMENT CONSULTANTS

FACILITIES

Preparing cancer care facilities for the post-outbreak volume recovery involves readiness for an increase in patient volume while also ensuring patients’ health and safety.

Maintain Distancing Measures: Until a vaccine is widely distributed, plan on continuing key safety measures that were implemented during the pandemic, such as physical barriers for reception, decreased seating capacity in waiting areas, screening stations at entrances, and similar measures. Distinct egress and circulation for patients and staff should be defined to minimize risk within the building if possible. Doing so will help to prevent the spread of COVID-19 through the center and reassure patients that their health and safety is of paramount importance.

Adjust the Air Pressure Environment: An updated air pressure environment will help supplement the distancing measures already in place. Establish a positive air environment to better protect patients from COVID-19 entering their room (or zone). For patients who have tested positive for COVID-19, a negative pressure environment should be established, or measures put in place, to filter air in exiting rooms or zones housing those patients. These spaces should be developed by first assessing current conditions, installing room pressure monitors, and then updating operations of the centralized HVAC system. In general, establishing positive pressure zones is a low-cost measure that can be accomplished with most existing HVAC systems. Establishing negative pressurization usually requires more costly modifications or adjustments to existing systems.

Off-Site Operations: Consider relocating nonclinical and nonessential staff and operations off site from the cancer center. Doing so will reduce the density of people in the building and support efforts to create spatial distancing. This will free up additional office space for clinicians or provide an area for positive pressure zone(s).

Additional Space: The combined effect of social distancing and patient volume increases may mean that additional office space must be found for consultations. Begin identifying nearby options now, potentially in the offices of other specialists or clinics that are not projected to experience a surge in volume. In identifying additional clinical space, it is important to ensure that spatial and/or temporal distancing from the non-oncology patients can be achieved and that the spaces will be cleaned and maintained in a manner that is similar to the primary oncology spaces.

Telehealth Space: Given the increase in digital and telehealth care in the industry, additional space for telemedicine clinicians should be made available. Using existing clinical offices on site, and with support of the main oncology staff, could prove valuable.

Alternative Waiting Spaces: Evaluate alternative options for check-in and patient waiting to avoid large groups of patients in waiting areas. For example, consider a pager system that allows patients to wait in their car until the provider is ready. Another alternative is to install temporary structures (e.g., modular trailers) outside, adjacent to the main building egress point.

Parking: The surge of patient volume may be more than the site’s parking was originally planned to accommodate. Give top priority to patients needing access close to the building’s egress point(s). Short-term solutions that could be implemented quickly include implementing or expanding shuttle service, leasing additional space, and/or rezoning staff or physician spaces near the center.
As of early May, approximately 10% of clinical research sites remain open to enrollment, as most research programs have halted screening and enrolling participants. For ongoing trials, research teams have struggled with protocol adherence due to fewer patients and research staff. The good news is that a significant backlog of trials is planned. Cancer centers will be able to continue to serve their patients with novel treatments; this will be balanced against the need to conduct research in a new, post-outbreak environment. It is vital that research efforts be coordinated with previously discussed processes, especially around PPE distribution, infection control, and facilities management.

**Federal Guidelines:** Cancer centers must continue to follow announcements from the Food and Drug Administration (FDA), NCI, NIH, and other federal agencies related to the management of covered clinical studies. Clinical research leadership should monitor the respective websites for updates and provide this information to investigators and study teams as new guidance is released or organizational protocols shift.

**Virtual Studies:** Research participants are hesitant to travel to their health systems for care. This has forced research teams to implement and expand telehealth, mobile nursing, and other remote monitoring tools throughout the pandemic. While there are few clinical oncology studies that can be fully managed in a virtual format, investigators and research teams should continue to embrace remote consent, telehealth, remote patient care, and mobile nursing visits with research participants.

**Sponsor Management:** Our clients report continued challenges with protocol modifications due to the pandemic that are starting to lighten up as the entire industry adapts to the need for flexibility in contracting, site visits, and drug distribution. Clinical research administration must document, by sponsor, their respective protocol modifications and make this information available to study teams.

**Study Management:** Protocol deviations will continue to be a concern, as research participants may be reluctant to fully comply with their scheduled visits. Research teams must continue to fully document whether these constitute minor or major protocol deviations, with any major deviations being reported per organizational protocol to the appropriate IRBs.

**Research Staff:** Cancer centers need to continually monitor the workload of the respective study teams. Some may consider centralizing their clinical research staff to better manage study deployment, while others may create dedicated backup teams to manage any staff shortages.

**Blood and Tissue Samples:** Many organizations stopped collecting biospecimens for all patients in the early stages of the pandemic. Coordinate with infection control to document handling precautions for COVID-19–infected and noninfected patients. There are typically no additional handling precautions for noninfected samples; however, biospecimens from COVID-19 patients should have clearly documented procedures around collection, processing, and disposal.
Communication with patients is vitally important, now more than ever. For months, patients have seen images on television of overwhelmed hospitals, and many are avoiding healthcare services for fear of being at an increased risk of exposure to COVID-19. However, for cancer patients, these fears may place them in greater danger for an unfavorable outcome from their disease. Now is the time for cancer programs to proactively begin a dialogue with their patients.

**Education:** Providers should educate patients about local developments in the community and how these impact their treatment.

**Safety:** Patients need to understand that providers are taking their safety seriously. Communication to patients should highlight the various safeguards put in place to protect them, such as those highlighted above.

**Risks:** Providers also need to make certain that patients fully understand the risks inherent with delays in treatment. For cancer patients, this is a key concern—delays in treatment may result in a more advanced disease and/or may affect the type of therapy they receive.

**Compassion:** Cancer is a scary and emotional journey for patients. Providers should seek to engage with patients to understand their fears and concerns as a treatment plan is being formulated. In certain cases, the care team may consider alternative treatment pathways, such as the use of neoadjuvant therapy, to navigate these challenges. By empowering patients to have a role in establishing their treatment plan, providers can better address patients’ psychological needs while treating their physical needs, thereby keeping them engaged with their therapy.
Interviews with NCI cancer center leaders also highlighted the need to develop a plan to care for COVID 19–positive cancer patients. The prevalence of this patient population will trend with the COVID 19 incidence, but it is possible that any community may encounter these patients. NCI center leaders indicated the importance of physical distancing this patient population from other patients. For instance, one center asks COVID 19–positive cancer patients to use a separate entrance to the facility and manages these patients in an area that is isolated from the rest of the patient population. Many of the facility planning issues discussed above may be applied to improve segregation of this patient population (e.g., physical barriers, airflow), and many operational precautions will also apply. In addition, other operational practices centers may choose to have dedicated staff supporting these patients either full time or on a rotational basis. Doing so reduces the use of PPE by staff moving in and out of the “hot zone.”

Now is the time, regardless of your program or your community’s current circumstances, to begin planning or refining strategies to support the recovery of the cancer program. A recovery plan will ensure that the necessary resources are in place to maintain support for the expected surge in cancer patients who need care. The recovery plan needs to be comprehensive—encompassing the care delivery model, operational requirements, financial implications, and the near- and long-term strategic considerations. When such a plan is carefully developed and vetted with program and health system leadership, it will be ready for implementation when it is needed.
ABOUT ECG

With knowledge and expertise built over the course of nearly 50 years, ECG is a national consulting firm that is leading healthcare forward. ECG offers a broad range of strategic, financial, operational, and technology-related consulting services to providers, building multidisciplinary teams to meet each client’s unique needs—from discrete operational issues to enterprise-wide strategic and financial challenges. ECG is an industry leader, offering specialized expertise to hospitals, health systems, medical groups, academic medical centers, children’s hospitals, ambulatory surgery centers, and healthcare payers. Part of Siemens Healthineers’ global enterprise services practice, ECG’s subject matter experts deliver smart counsel and pragmatic solutions.

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