ASSOCIATION OF CANCER EXECUTIVES UPDATE

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association of cancer executives
Connecting All Oncology Leaders

WHAT'S INSIDE

Members on the Move

Ollieta Nicholas
Senior Director, Strategy and Operations for Internal Medicine
University of Texas Dell Medical School

Wendy Austin
Senior Vice President of Operations
City of Hope Orange County

The 2020 ACE Webinar Schedule

DELIVERING CANCER CARE IN THE COVID-19 ERA – SESSION 4: HOW COVID-19 IS IMPACTING ONCOLOGY ADMINISTRATION AND HOW TO BUILD A MORE SUSTAINABLE PRACTICE FOR THE FUTURE
STAY TUNED FOR DATE AND TIME

Presenters:
Srulik Dvorsky, CEO, TailorMed

Mike Trapani, Director of Patient Financial Services, Memorial Sloan Kettering

For complete ACE webinar information and to register, please visit us here.

Oncology Operational Excellence During COVID-19: Takeaways from an Expert Panel Discussion

For many in healthcare, it feels like a lifetime since COVID-19 turned the world upside down. The pandemic, since March, has changed the industry in countless ways—how patients are seen, how practices are run, how care delivery is managed, and how to keep up with news and developments. Providers in some cases have been pushed to the breaking point as they've struggled to adapt in this rapidly shifting landscape, and executives have struggled to implement consistent policies across many locations. While the focus in oncology is always on patient care and safety, it can be hard not to worry about the future.

With that in mind, RxVantage gathered a panel of oncology experts from around the country who have exhibited impressive leadership amid the pandemic. These executives met via video conference to share experiences, discuss strategies that have worked (and those that have not), and their plans for moving forward.

We heard from Candice Hulse, Regional Director of New York Cancer & Blood Specialists, which has offices in New York City and across Long Island, about their efforts to continue providing care in an area that's become the pandemic's epicenter. From the Southern Cancer Center, which has five locations in and around Mobile, Alabama, we talked with Executive Director Lauren Pettis about how COVID screening might lead to more lung cancer diagnoses. We also spoke with Kathy Oubre, Chief Operations Officer at Pontchartrain Cancer Center, about everything from staff resilience to the impact of COVID on value-based care. And

finally, we heard from Lance Ortega, who as Director of Nursing at Texas Oncology oversees a practice network that includes more than 200 sites.

Ortega, for his part, summarized the challenge that all of the panelists face as they look to technologies like telehealth to continue seeing patients who might not otherwise come in. "Cancer doesn't stop," he said. "Cancer doesn't abide by the pandemic rule [requiring that people] shelter in place."

Telehealth, in fact, was front and center in the discussion, as those on the call shared what it's been like to go from providing nearly no telehealth services at all to actively promoting it to their patient populations. Also on the agenda was pharma-rep education, and how each of the practices were managing rep visits at a time when on-site lunches and presentations remain out of the question. And then the panelists talked about re-opening: how they might handle a surge of patient visits, and whether the measures they've put in place for the pandemic will continue to be necessary in the months and years ahead.

Each of the panelists had their own predictions, and each expressed some trepidation about what the post-coronavirus world will eventually look like. In the end, however, across the board, Pettis, Hulse, Ortega, and Oubre all agreed there was a path to success. "It's been overwhelming at times," Pettis admitted when she was asked for her closing thoughts. But then, she added, "it takes a village—it takes a team to make this work."

Noona: A Vital Solution for Tennessee Oncology During COVID-19 Emergency

Remote Symptom Monitoring and Patient Communication Features Unburden Care Team

When Tennessee Oncology implemented Noona to connect with patients across its 32-clinic network, administrators could never have foreseen the potential for this useful solution to serve on the frontlines of protecting cancer patients from the potentially deadly COVID-19 virus. As new cases began to rise, Tennessee Oncology clinicians encountered difficulty getting access to protective health equipment and found that early infection rate projections had been underestimated.

"To protect vulnerable patients and our staff, we limited visitors, delayed appointments for non-acute patients, and further embraced telemedicine to help keep patients at home," explains Dr. Jeff Patton, former CEO of Tennessee Oncology and current CEO of its parent organization, OneOncology. "Communication with patients during a crisis can be a challenge, but Noona has given us an opportunity to communicate updates, follow-up instructions, and other key information quickly, and give our patients the timely reassurance they need at this stressful time."

Tennessee Oncology treats about 25,000 new cancer cases each year. With the onset of the pandemic, they initiated an outreach program to encourage even broader patient adoption of Noona. In the last several months, they've added about 1,000 new patient users each month to the platform. Today, almost 10,000 patients in the network have adopted the Noona patient application and care teams are using it to manage more than 31,000 patients with its telephone triage feature.

"With Noona, we've been able to be more proactive and quickly respond to the need for increased patient communication in a way that is more efficient for our personnel," Dr. Patton says. "It took some of the burden off our triage nurses who were answering calls from patients and had started to feel a little overwhelmed. Noona has helped us manage the massive increase in calls."

Noona comprises a number of key features designed to help ensure resource efficiency, improve communication and connectivity with patients, and reduce patient visits to the clinic, thereby reducing patients' exposure to the virus. Through the web-based app, patients can report symptoms in real time, and access important information through secure messaging, general announcements, and educational materials provided by their care teams. Patients can respond to questionnaires electronically and Noona will automatically prioritize and flag patients for evaluation based on their responses. Tennessee Oncology is also leveraging Noona to share telehealth visit information and scheduled

appointments with patients, which has been critical to remotely alleviating patient concerns and reducing clinic visits.

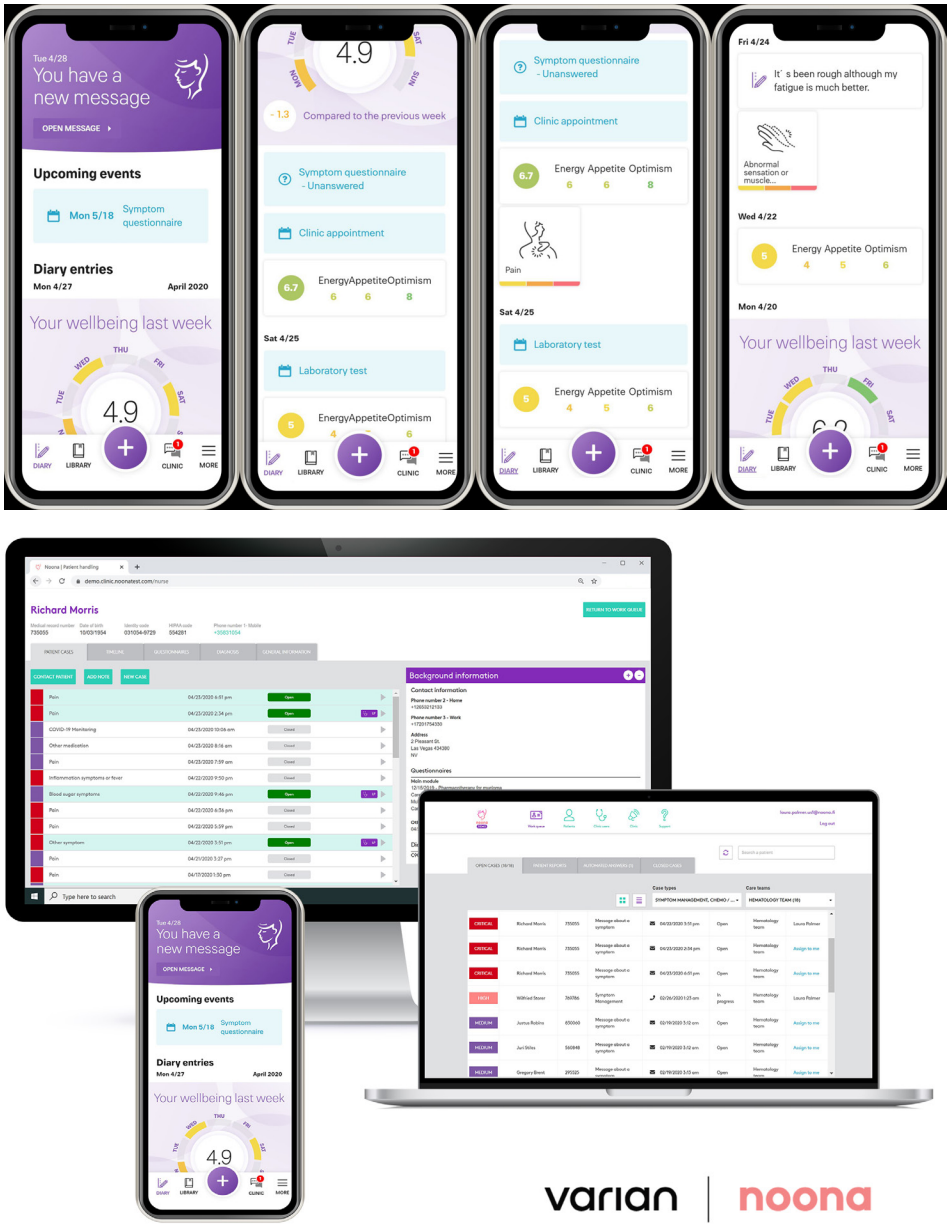
"With a cancer diagnosis, patients are often afraid of the outcome and are dealing with a plethora of disease and treatment-related symptoms," says Jani Ahonala, co-founder of Noona and current vice president of global patient outcomes at Varian. "We originally developed Noona to help oncology patients feel more connected to their care teams. This pandemic truly highlights the critical need for this solution, enabling a connection with care teams even when patients are isolated at home and more at-risk than the general population."

"With Noona, we are more prepared to deal with the current crisis and any other similar crises that happen in the future," said Dr. Patton. "This experience has confirmed, reaffirmed, and emphasized how important it is to have digital patient communication tools and that we have the right strategy in place."

"Telemedicine and digital communication are here to stay, so do it now and do it forever," Dr. Patton advises. "Noona has helped us reduce the risk of exposure for patients and staff, while keeping our healthcare communities fully informed. Since the COVID-19 outbreak first hit, we've found our 'new abnormal' and at the moment it's stable so we can function in a steady state."

In his new role as CEO of OneOncology, the parent organization of Tennessee Oncology, Dr. Patton and his staff are looking to implement a similar approach to remote patient monitoring and patient outcome management across the entire OneOncology network.

"Our patients love it, so now it's time for us to look at what has worked well and spread that across our network," Dr. Patton says. "For example, we have a bone marrow transplant program that required some patients to travel two hours or more every six months for checkups. Now, they can enjoy the convenience and safety of having their blood work done locally with follow-up communication done digitally instead of in-person."



A version of this article previously appeared on the Centerline website, Varian's online magazine for the clinical oncology community. For more information about Noona.

COVID-19 and Its Impact on Caseloads, Diagnosis, Treatment and Follow Up

BY KAREN SCHMIDT, CTR, VICE PRESIDENT OF CHAMPS ONCOLOGY

Since the beginning of the COVID-19 pandemic, cancer patients and physicians have been forced to make difficult decisions regarding cancer treatments. Some cancer patients have had treatment delayed or treatment plans altered because of the pandemic, as patients with cancer are among those at high risk of infection with COVID-19. For cancer registrars, they are beginning to see the impact COVID-19 is having on cancer patients and how they are treated. It's critical to understand how the pandemic will affect caseloads, diagnosis, treatment and follow up.

"This is an unprecedented time in our nation as we all come together to address the COVID-19 crisis. We need to understand the impact of COVID-19 and cancer decisions to delay cancer patients' treatment which could affect survival in the future."

Because many of us have been confined to our homes because of the pandemic, there has been a decrease in cancer diagnosis as well as cancer treatments -- which means decreases in caseloads. There also will be fewer pathology reports and fewer cases in suspense in the coming months. Registrars are already starting to see delays in workups and treatments because of the pandemic restrictions.

Registrars are likely to see a decrease in colonoscopies, mammograms, PSA testing and lung CT scanning. Additionally, cancer programs may be canceling their screening and prevention activities. Some of our staff have already seen documentation about delays in treatment or treatment modifications when they are in the EMR abstracting cases.

At the onset of this pandemic, hospitals needed to conserve critical resources, such as hospital and ICU beds, ventilators, as well as personal protective equipment critical for protecting patients, care providers and staff. It was generally advised that hospitals discontinue elective surgeries, particularly with patients that have a high likelihood of the need to utilize the ICU postoperatively or patients who may require respiratory equipment. This resulted in canceled or postponed surgical procedures.

CHANGES IN CASELOAD

- Anticipate decrease in pathology reports / suspense cases
- Decrease in physician office visits for diagnostics
- Screening procedures on hold / delays in treatment
  - Colonoscopy
  - Mammogram
  - Lung CT Screenings
  - Cancer Program Screenings
- Canceled elective surgical procedures (diagnostic biopsies)

There have been non-surgical changes in care since the beginning of the pandemic. Hospitals reduced patient time to avoid infection in immunocompromised patients, managed staffing shortages and aided patients with transportation issues. Cancer patients opted out of visiting the hospital in fear of being exposed, and some had to stay at home or self-quarantine due to a spouse or family member testing positive for COVID-19. All of these factors have contributed to changes in the delivery of systemic care and physicians are modifying treatment plans. This can mean that IV chemotherapy may be changed to oral chemotherapy or immunotherapy. Hormone therapy may be started before surgery. We are also seeing major delays in radiation therapy.

What is the impact on data collection? Registrars may see an increase in the incidence of neoadjuvant therapy or an increase in active surveillance or patients with no treatment, which may affect the assignment of Class of Case. CTRs will need to utilize "Reason No" codes for "Reason No Surgery" and "Reason No Radiation." Although the "Reason No Chemotherapy" and "Reason No Hormone Therapy" fields are no longer required,

we always recommend completing those fields, particularly during this pandemic.

The cancer registry should lead the way in capturing data on these treatment delays, treatment modifications and COVID-19 positivity and impacts on cancer care. Ask your cancer registrar to create additional fields to capture this information. At a minimum, everyone should collect COVID-19 positivity (yes or no) and Treatment Delayed due to COVID -19 (yes or no). This information will help inform hospitals and physicians on the true impact of COVID-19 on cancer.

To find out more about how the pandemic may affect cancer program activities as well as updates from *The Annals of Internal Medicine*, the American College of Surgeons and the Commission on Cancer, please visit CHAMPSOncology.com/resources to view our "2020 Pandemic and the Cancer Registry" webinar.

NCCN Updates for Hereditary Breast and Ovarian Cancer Genetic Testing: Implications for Patients, Providers, and Health Plans

Changes highlight the growing need for pre- and post-test genetic counseling

The most recent National Comprehensive Cancer Network (NCCN) changes to hereditary breast and/or ovarian cancer (HBOC) genetic testing guidelines were significant. These guidelines, which inform decisions on the appropriate testing of BRCA1 and BRCA2, as well as other hereditary cancer susceptibility genes, also provide medical management recommendations for positive individuals. The updates recognize significant changes to testing practices, especially higher utilization of genetic testing panels that include additional genes with clinical utility. The NCCN continues to recommend pre-test genetic counseling by a provider with expertise in cancer genetics, such as a board-certified genetic counselor. Some of the more significant changes noted by InformedDNA® genetic counselors include the following:

- The updated NCCN guidelines for HBOC have a new name: Genetic/Familial High-Risk Assessment: Breast, Ovarian, and Pancreatic, representing an expansion of the guidelines to address the clinical overlap with these three cancers and the potential genetic cause.
- For the first time, there are screening recommendations for those at high risk for pancreatic cancer, and it is recommended that ALL patients with exocrine pancreatic cancer receive genetic counseling and be offered genetic testing.
- The testing criteria that were previously specific to BRCA1 and BRCA2, now include moderate-penetrant genes beyond these two.
- Patients of Ashkenazi Jewish ancestry who meet testing criteria no longer need to start with founder mutation testing, per the new testing algorithm.
- Criteria were added to allow for testing when prior probability models like Tyrer-Cuzick or BRCAPro indicate a greater than 5% risk for a BRCA1 or BRCA2 mutation in an individual.
- The guidelines outline which scenarios should prompt an evaluation by a genetic counselor and more clearly defines the cancers that are included in HBOC. The testing criteria for those with breast cancer, including invasive and DCIS, but not LCIS, remain unchanged. However, the guidelines now specify all epithelial ovarian cancer, all exocrine pancreatic cancer, and aggressive prostate cancer types should raise a suspicion for HBOC. Many patients do not know the details of their family history of cancer, and so it is unclear how providers and health plans will approach these specific definitions. This emphasizes the benefit of additional genetics expertise and focus in the pre-test evaluation.
- The new NCCN guidelines provide a stratification of risk categories to assist providers in determining which patients are at highest risk for a mutation in one of the genes and which patients are unlikely to benefit from testing. These categories include:
  - 'Clinically indicated'
  - 'May be considered' (for this category, criteria should be met and pre- AND post-test genetic counseling should be provided)
  - 'Low probability of having clinical utility' (e.g., testing is not clinically indicated)
- The guidelines also include a list of genes without clinical utility because a positive result would not impact medical management (i.e., there is no clinical reason to order testing for these genes for hereditary breast/ovarian cancer).
- Guidelines for hereditary pancreatic cancer testing are outlined, as well as

medical management recommendations for the associated genes.

IMPACT TO PATIENTS

- Stronger support for pre-test genetic counseling by experts
- More genes considered clinically indicated
- Specific cancer types mean that patients should advocate for detailed reports from providers and relatives

IMPACT TO HEALTHCARE PROVIDERS

- More genes = more complexity = greater need for genetic expertise support and genetic counseling
- Genes classified as having low clinical utility
- Greater emphasis on detail and family history
- Review of previously referred patients for additional genetic counseling when previous genetic testing was negative as well as patients who did not previously meet criteria for testing.

IMPACT TO HEALTH PLANS

- Greater evidence for clinical utility in more genes, leading to increase in recommendations for appropriate multi-gene panels
- Careful evaluation of medical policies to incorporate appropriate panels and effects of testing genes with no indication
- Pre-test genetic counseling may be increasingly useful navigating changes and the multitude of tests now offered

InformedDNA is the authority on the appropriate use of genetic testing. It leverages the expertise of the largest, most experienced, lab-independent staff of board-certified genetic specialists in the U.S. to help ensure that health systems, hospitals, clinicians and patients all have access to the highest quality genetic services. Reach us by email or phone: healthsystems@informeddna.com or 844-846-3763.