association of cancer executives

A special monthly webinar series for ACE Members:

Delivering Cancer Care in the Covid-19 Era

Session 2: A Return to Operations NOT as Usual — Practical Strategies for Cancer Programs

Wednesday, June10th | 2:00PM EDT

Nancy Bookbinder
Webinar Moderator

Jessica Turgon
Principal
ECG Management Consultants

Matt Sturm
Principal
ECG Management Consultants

association of cancer executives
Connecting All Oncology Leaders

About ACE

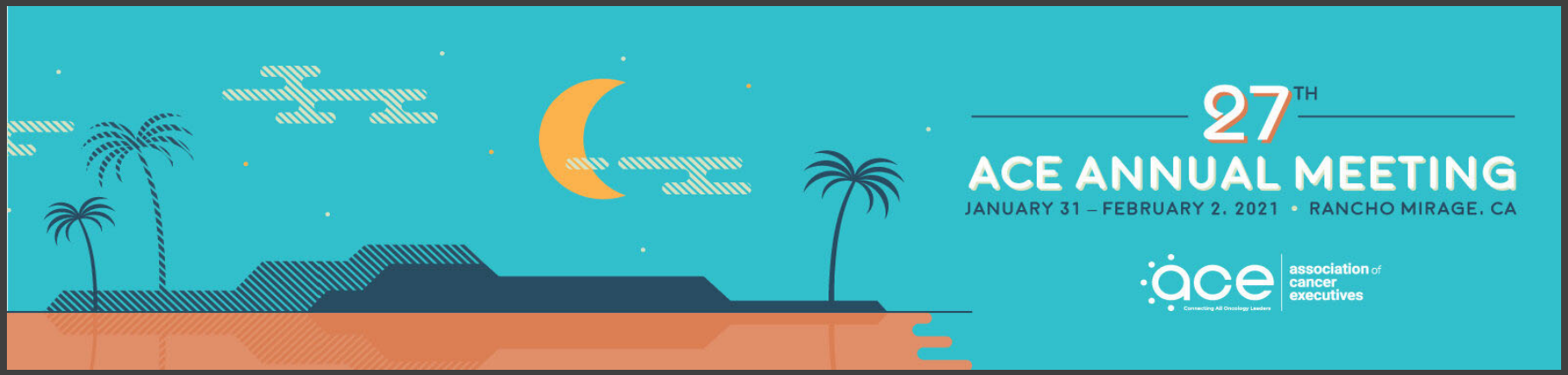
Association of Cancer Executives (ACE) is a national organization committed to the leadership development of oncology executives through continuing education and professional networking designed to promote improvement in patient care delivery.

ACE Membership

Become a part of the premier association for oncology administration. ACE members represent a wide range of leading oncology institutions nationwide.

Join ACE for only $275 per year!

Please visit www.cancerexecutives.org for more information.



We look forward to welcoming you to Rancho Mirage, CA January 31 – February 2, 2021!

Sponsorship and exhibitor opportunities are now available!

Attendee registration will open later this year.

Please visit www.cancerexecutivesmeeting.com for more information.

Webinar Faculty

» **Nancy Bookbinder**
Webinar Moderator

» **Jessica Turgon**
Principal
ECG Management Consultants

» **Matt Sturm**
Principal
ECG Management Consultants

Audience Polling Question One

How many analytic cases does your cancer program see each year?

COVID-19: Cancer Care Disruption

The delivery of cancer care to patients was disrupted by COVID-19.

Existing Cancer Patients

- Treatment was interrupted or postponed by either the treatment facility or patient.
- Quarantine and social distancing guidelines affected patient scheduling and prevented patients from receiving timely treatments.
- Caregivers were unable to provide the necessary support, limiting treatment adherence.

New Cancer Patients

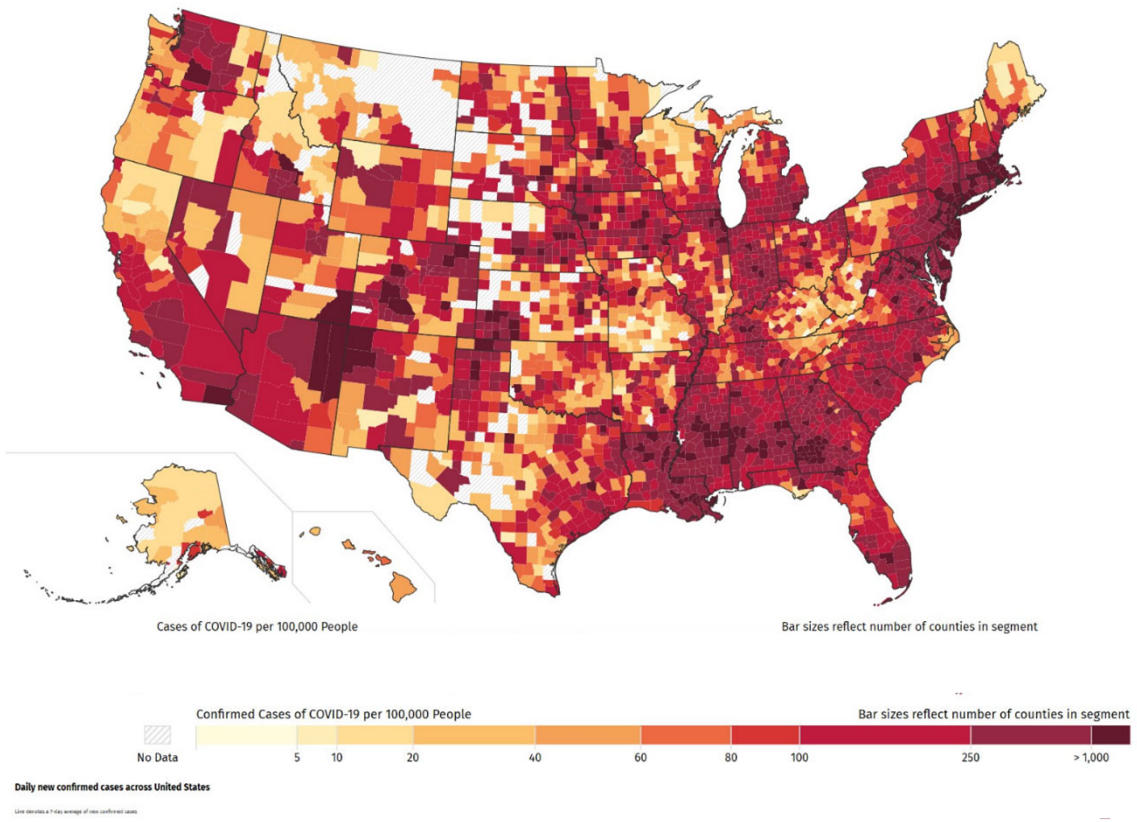
- Patient care-seeking patterns were interrupted due to shelter-in-place orders.
- Physician offices and treatment centers were closed or backlogged, which in turn led to delays in detection and diagnosis.

Oncology providers saw, on average, a 47% decline in outpatients during a two-week period in mid March. The estimated backlog of patients nationally is 120,000 new cancer patients.[1]

[1] Assumes two months of service disruption, a 40% decline in new patient visits during the service disruption, and 150,000 new cancer patients monthly in the US.

The Need for Community-Specific Plans

Based on information from cancer centers nationwide, it appears the impact of COVID-19 on clinical volumes and services varies from facility to facility.



- As of early June, there is considerable variability in COVID-19 incidence rates across the country.[1]
- Every program and community is likely to have a unique story regarding the impact of COVID-19.
- Certain centers with significant COVID-19 community outbreaks have maintained treatment volumes, while others in less-impacted areas did not.
- Accordingly, recovery strategies will need to be uniquely tailored to the specific circumstances and needs of each community.

[1] COVID-19 Case Mapper is created and maintained by Pitch Interactive and Big Local News, with support from Google News Initiative. https://covid19.biglocalnews.org/county-maps/index.html.

Audience Polling Question Two

How much of a decline in ambulatory volume did your program experience in March and April?

Program Recovery from COVID-19

Cancer program leaders are implementing protocols to guide their centers through a successful recovery.

- Prepare clinical operations to accommodate an increase in patient demand while ensuring patient and staff safety.
- Update the facility's physical environment to adhere to current social distancing requirements while also accommodating additional patient volumes.
- Enhance communication with patients and families, reassuring their fears and educating them regarding the risks inherent with delaying treatment.
- Prepare the clinical and nonclinical workforce to respond to increases in demand.
- Deploy financial management systems to maximize revenue.

[1] *The Cancer Letter*, May 22, 2020.

UCSF Helen Diller Family Comprehensive Cancer Center has seen a "dramatic uptick" in consultations since reopening.[1]

Clinical Operations: Telehealth

Most programs rapidly implemented or expanded telehealth offerings during the COVID-19 pandemic.

- Program leaders told ECG they saw a 100% to 1,000% increase in the use of telehealth platforms in March.
- Telehealth has been embraced by many patients and providers for select services. Programs should look to expand telehealth services, particularly in the areas of survivorship clinic offerings, social work support, and clinical pharmacist follow-up visits for medication management.
- Some organizations are using remote patient monitoring devices, which include sensors that can measure heart rate, blood pressure, temperature, and weight, to avoid unnecessary trips to the doctor's office.
- Leading centers are anticipating that 25% to 50% of office visits will continue to be provided remotely.
- Telehealth increases facility capacity, supports social distancing, and enhances patient satisfaction by removing the need to travel to appointments.

COVID-19 Front Line: Midwest Cancer Center

In early May, ECG interviewed representatives from a Midwest cancer center that is located within an academic medical center.

Telehealth

- Patient appointments were postponed as far as possible without compromising care, then utilized telehealth.
- APPs embraced telehealth.
- Telehealth allows patients to see providers' entire facial expressions, unlike when staff are wearing masks.
- Introduction video clips were developed for physicians, which allowed patients to "meet" the provider prior to a visit and see them without a mask.
- Scripts were developed for staff to improve the efficiency of telehealth visits.
- The center virtually "rooms" the patient before the physician arrives.
- CNTs don't have their own Zoom licenses but are invited to appointments as guests.
- Integrating Zoom into Epic decreased inefficiencies.

Staff

- Separate strategy meetings are held with nursing staff and physicians, respectively, each day.
- When a staff member or patient tests positive, all staff are tested.

Testing

- The center tested 500 asymptomatic cancer patients; all were negative.

Overall Effect

- The center's typical hospital census is 840 to 850 patients.
- The center experienced a 50% drop in its census, though it is slowly recovering.

Telehealth for Medicare Beneficiaries

In March, the COVID-19 relief bill reduced restrictions related to the originating site of care and provided the ability to receive a telehealth screening via smartphone.

1135 Waiver: Previously, for a Medicare beneficiary to receive telehealth services, they were required to have an established relationship with the provider. Under CMS's 1135 Waiver, *audits will not be conducted to ensure that a prior relationship existed.* Therefore, telehealth services may be provided by a new provider and paid by Medicare.

Expanded Services: Medicare beneficiaries can now also receive an expanded list of services via telehealth, including office and hospital E&M visits. *All telehealth visits will be reimbursed at the same rate as in-person visits.*

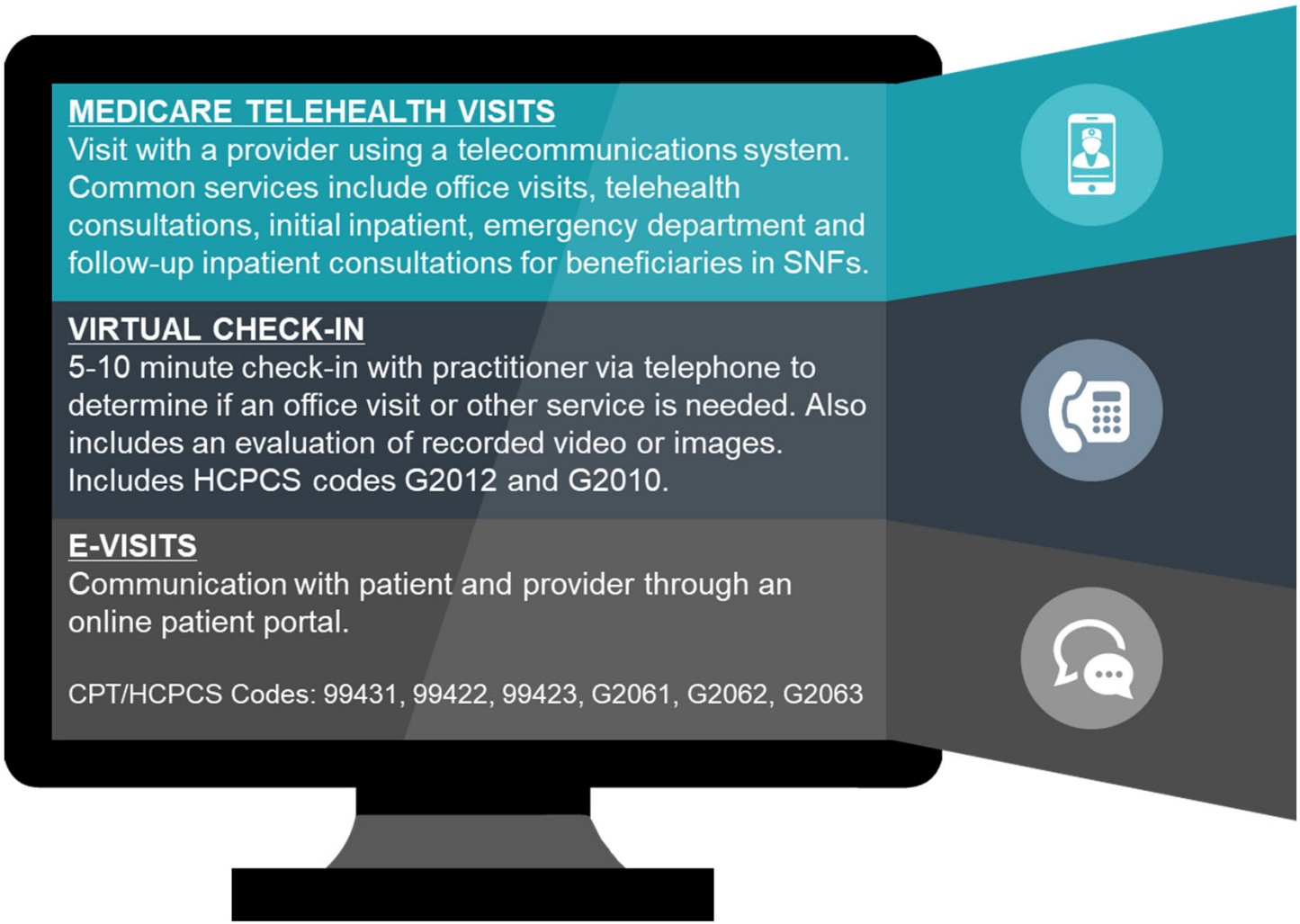
HIPAA: HHS has agreed to "exercise discretion and waive penalties" for any HIPAA violations committed by healthcare providers who "serve patients in good faith through everyday communication technologies such as FaceTime or Skype" during the recognized national public health emergency time period.

Medicare Advantage (MA): MA plans follow published Medicare guidelines, including telehealth policies and expanded telehealth access. However, payers do have discretion, and providers should consult the coverage of MA plans to confirm that they will follow new CMS guidelines.

Please note: The new federal guidelines can greatly expand providers' ability to appropriately screen and treat patients through telehealth; however, ***state-specific regulations are still active*** and providers should verify state policies.

Telehealth for Medicare Beneficiaries

(continued)



Clinical Operations

In preparing for a successful recovery, it will be important for programs to deploy a number of operational strategies to support increases in clinical capacity.

Capacity Management

- Reduce the number of on-site clinical encounters by embracing telehealth and virtual care strategies.
- Transition to alternate care settings (e.g., local lab services, virtual medication management).
- Eliminate in-person prechemotherapy visits or conduct them via telehealth.
- Increase use of hypofractionation for radiation therapy to reduce the number of treatments in a course.

Social Distancing

- Virtually schedule patients and collect financial information, including copays.
- Reduce the number of infusion chairs in use to increase space between patients.
- Reduce (or eliminate) capacity in waiting areas; adopt alternative patient queuing procedures.

Addressing Bottlenecks

- Extend operating hours.
- Implement time blocks between patient visits and treatments.

Clinical Operations *(continued)*

Utilization of Smaller Centers

» Decant patients out of the main center to community-based networks or home health.
» Develop staffing plans, clinical algorithms, and telehealth services for alternate care locations.

Surgical Alternatives

Develop or update clinical protocols regarding the use of radioembolization, radio frequency ablation, and cryoablation as alternatives to surgical procedures.

Testing

» Implement COVID-19 testing guidelines for asymptomatic patients and staff.
» Recommend testing all patients before initial treatment and every two to four weeks thereafter.

Visitor Policy

» Limit and gate visitors in accordance with local COVID-19 recovery and incidence rates.
» Implement visitor testing and the use of PPE.
» Augment visitor and family support structures; increase e-chart messaging with family members and align clinical teams to more proactively communicate with families.

Audience Polling Question Three

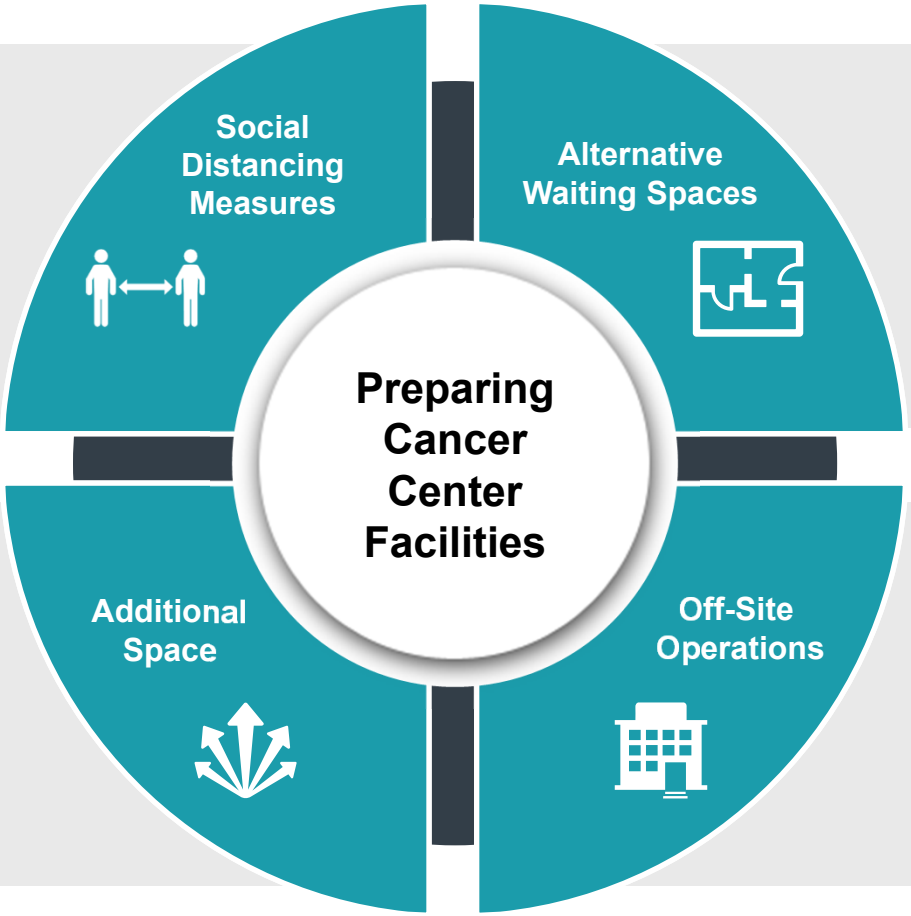
What strategies have you implemented or do you plan to implement to increase the capacity of your center? (Select all that apply.)

Audience Polling Question Four

Of the operational changes you have implemented related to COVID-19, which do you believe will be adopted long term? (Select all that apply.)

Facility and Operational Updates

Social distancing guidelines require an increase in facility capacity and, possibly, the use of alternate locations.



- Erect physical barriers for reception, lab, treatment areas, etc.
- Decrease seating capacity in waiting areas.
- Establish screening stations at entrances.
- Implement directional egress and circulation.

- Decrease the number of patients in waiting areas.
- Utilize a pager or mobile text system as patients wait in cars or alternate space.
- Construct temporary space for waiting areas.

- Identify alternate office space for consultations.
- Maintain distancing from nononcology patients in all spaces used by oncology patients.
- Clean all spaces in a manner similar to primary oncology space.

- Relocate nonclinical and nonessential staff and operations.
- Reduce the density of people in the building.
- Repurpose office space for clinicians or positive pressure zones.

Facility and Operational Updates *(continued)*

Preparing cancer care facilities for the postoutbreak recovery involves readiness to absorb an increase in patient volume while simultaneously ensuring patients' health and safety.

- Establish a positive air environment.
- Create a negative air pressure environment for COVID-19-positive patients.
- Install room pressure monitors.

- Designate telehealth space and/or clinics (both inside and outside the facility).
- Increase use of virtual care services, including nurse calls, coordination, and medication management.
- Determine any care model changes necessary to facilitate the increase in telehealth.

- Prioritize parking for patients needing to be in close proximity to the building.
- Implement a shuttle service.
- Lease additional parking space.
- Repurpose physician parking.

Audience Polling Question Five

What policies do you anticipate continuing or adopting to protect patients and staff in your center? (Select all that apply.)

COVID Front Line: Large Northeast Cancer Center

The Northeast cancer center discussed below is located in an area with a high volume of COVID-19 cases. Cancer center administration and staff worked quickly to transition their facility to provide safe and efficient COVID-19 care.

Repurposed Facility Space	» Converted two cancer inpatient units into general COVID-19 units » Converted one inpatient unit into a general care unit and, subsequently, a COVID-19 ICU unit » Shifted selected care from main campus to satellites and home care » Treated COVID-19 patients in the BMT unit » Placed research on hold and repurposed research unit as the infusion unit
Distancing and Disinfecting	» COVID-19 patients use separate entrances and elevators. » Clinicians clean their own exam rooms after each visit. » Dedicated cleaning staff shadow COVID-19 patients at all times.
Separate Space for COVID-19-Positive Cases	» Separate COVID-19 ambulatory cancer infusion and clinic space was established for COVID-19 patients (both positive and presumed positive). » Nurse sits in glass-enclosed cube to see patients; this allows the center to save 30% on PPE, as the nurse does not need to change PPE with each patient. » The separate COVID-19 space will be decommissioned as the number of cases decline.

Communication to Patients and Families

Patient communication is more important than ever to calm fears related to the COVID-19 pandemic and get patients back on the path to prioritized cancer care, timely treatment, and successful outcomes.

- **Education**

  Educate patients about local community developments and associated treatment impacts.

  Examples: Telehealth availability and advantages, shuttle services and additional treatment locations, promotion of leadership messages through various marketing mediums.

- **Safety**

  Communicate the importance of patient safety and quality care.

  Examples: COVID-19 screening for patients and staff, visitor restrictions, limited vendor access, and PPE use by patients and employees.

- **Risks**

  Stress the risks of delays in treatment.

  Example: Delays may result in more advanced disease and impact the type of therapy received.

- **Compassion**

  Given the challenges with visitor policies, navigating family-friendly policies is a must. Additional transport staff may be needed throughout the day, and care managers will likely see an increase in calls and e-messages for follow-up care instructions.

Workforce Stability

While much of the focus is on patient survival during the COVID-19 pandemic, healthcare organizations must also protect their workforce. Programs need to balance staffing to meet patient demand with efforts to prevent burnout.

Increased Staffing Capacity

- Scale staffing to meet patient demand.
- Survey staff to understand availability to support extended operating hours.
- Evaluate compensation and benefits policies to ensure adherence to fair payment and governmental leave guidelines.

Provider Productivity and Compensation

- Evaluate provider staffing model to determine readiness to handle additional capacity.
- Consider increasing role of APPs.
- Address production-based compensation plans and adjust if necessary.

Clear Communication

- Provide clear and frequent communication regarding policies and procedural changes, staff benefits, and other pertinent information.
- Consider using social media and daily texting for updates.

Emotional and Mental Support

- Be cognizant of employees' outside lives by considering:
  - Child care arrangements/ homeschooling.
  - Staff limitations due to extra physical or mental strain.
- Offer access to counseling or encourage counseling if needed.

Current Events: TJC Announcement

In its *Quick Safety* newsletter released on June 4, TJC addressed the psychosocial well-being of healthcare staff.[1]

Strategies for Individuals

- Practice self-care and engage in healthy coping strategies.
- Take microbreaks from patient care.
- Practice good sleeping habits.
- Partner with colleagues to cross-monitor each other's well-being.
- Stay connected with friends and family.
- Check in with yourself.
- Strive for resilience in post-crisis recovery.

Strategies for Managers and Leaders

- Communicate regularly.
- Model behaviors that promote self-monitoring.
- Encourage sharing of concerns to build transparency and mutual trust.
- Demonstrate the value of staff.
- Orient staff to psychosocial resources and offer the basics on psychosocial first aid.
- Proactively monitor mental well-being and provide active outreach.
- Encourage peer support.
- Share positive feedback.
- Adapt staffing, such as rotating staff between higher- and lower-stress functions, where possible.
- Strive for resilience in post-crisis recovery.

[1] https://www.jointcommission.org/resources/news-and-multimedia/news/2020/06/the-joint-commission-releases-quick-safety-on-promoting-psychosocial-well-being/?ref=TJCAL20.

Financial Challenges

One of the most significant challenges of COVID-19 is the financial strain it has placed on programs.

Financial Effects of COVID-19

- Reduced revenue levels during quarantine
- Volume growth expected during recovery, meaning:
  - Less-favorable payer mix
  - Patient transition to governmental plans
  - Insurance exchange products
  - Patients whose private insurance was tied to employment are now uninsured

Solutions for Financial Recovery

- Develop a financial improvement plan, including scenario modeling, financial impact, and recovery tactics.
- Assess potential strategic implications.
- Set reasonable goals and develop strategies for achievement.
- Accelerate 340B expansion efforts.

Payer Strategies

Programs must be proactive with financial recovery by having key conversations early.

Payer Strategy

- Identify alternative (short term) payment constructs (e.g., shorter course therapy, oral chemotherapy).
- Discuss value-based payment models.
- Enroll in payer assistance programs. (e.g., accelerated or advanced payments).
- Ask payers to extend or expand telehealth coverage.
- Try to preserve telemedicine rate parity with facility-based services.

Current Events: 340B Flexibility

In March, the Health Resources & Services Administration Office of Pharmacy Affairs (HRSA OPA) made changes to some of the requirements for 340B-qualified entities to help meet increased patient demand.[1]

- Patient record-keeping requirements were relaxed for covered 340B entities.
- Volunteer healthcare providers supplying care on behalf of the 340B-qualified entity are considered eligible providers for purposes of the 340B program.
- Case-by-case exceptions will be made for covered entities to expand services to new sites, outside of the normal approval process.
- Telehealth encounters are eligible for 340B program purposes. Auditable records must be maintained for each patient who is prescribed a 340B drug.
- 340B audits may be conducted virtually during the covered public health emergency period while HSRA OPA assesses the impact to the 340B program.
- Participating 340B entities should closely monitor changes that are made to 340B requirements in the next few months as the pandemic period progresses.

[1] https://www.hrsa.gov/opa/COVID-19-resources.

Current Events: CMS Adjustments to Oncology Care Model (OCM)

On June 3, CMS announced changes to the OCM in response to the COVID-19 public health emergency. [1]

Payment Methodology	» Allow OCM practices to elect to forgo upside and downside risk for performance periods affected by COVID-19. » For OCM practices that decide to remain in one- or two-sided risk for the affected performance periods, remove COVID-19 episodes from reconciliation for those performance periods.
Quality Reporting	» Make the following optional for the affected performance periods: › Aggregate-level reporting of quality measures › Beneficiary-level reporting of clinical and staging data » Remove the requirement for cost and resource utilization reporting and practice transformation plan reporting in July and August 2020.
Timeline	» Extend model for one year (i.e., through June 2022).

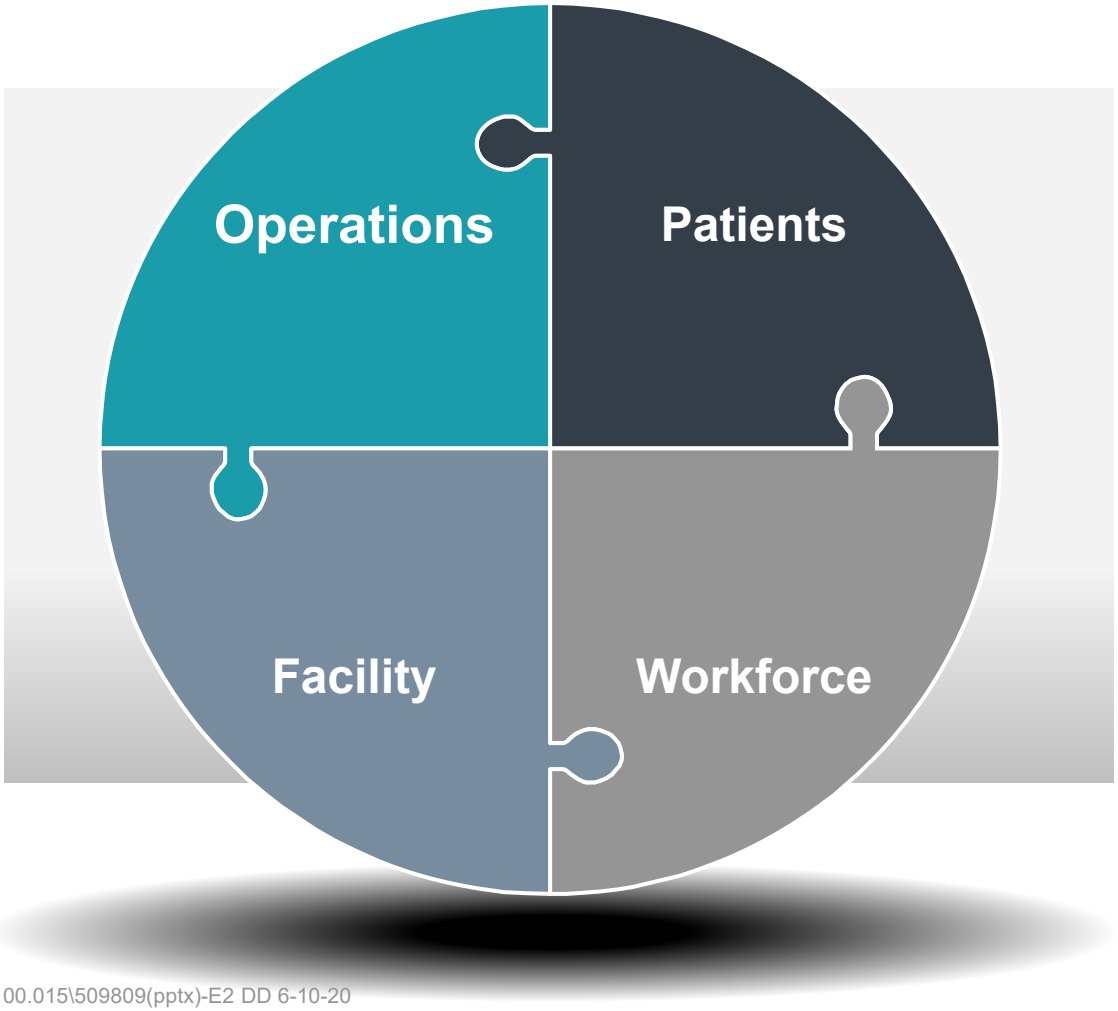
[1] https://www.aha.org/special-bulletin/2020-06-03-cmmi-issues-summary-covid-19-related-adjustments-alternative-payment.

Audience Polling Question Six

Which financial strategies are your center considering in response to the COVID-19 public health emergency? (Select all that apply.)

Recovery: It's What You Make It

Every cancer program's experience with COVID-19 will be different. Leaders should implement initiatives that work best for their specific patient population and facility design.



- Cancer centers should start now in creating strategies to support their cancer program recovery. A plan should be developed *before* it is needed and include the flexibility to be tailored to local COVID-19 recovery efforts and incidence rates.
- The recovery plan needs to be comprehensive, encompassing the care delivery model, operational requirements, financial implications, and strategic considerations.
- When a plan is carefully developed and vetted with program and health system leadership, resources will be ready for implementation when needed to address the expected surge in cancer patients.

Source: *The Cancer Letter*, May 8, 2020.

Questions & Discussion

Matt Sturm
MSturm@ecgmc.com
206-689-2243

Jessica Turgon
jturgon@ecgmc.com
571-257-1017