**Introduction**.

COVID-19 (the "Virus") significantly disrupted the "Cancer Care Continuum" (or the "Continuum"). Access to care among patients who have cancer and those who are suspected of having cancer has been profoundly impacted. There is widespread agreement among cancer care experts that the Virus itself and disruptions to the Cancer Care Continuum caused by the Virus may lead to excess cancer deaths.[1]

Cancer and the treatments deployed to combat cancer often weaken the immune system, placing individuals at high risk for experiencing serious illness from COVID-19. After treatment ends, the immune system may return to normal, but each patient is different. Strict adherence to up-to-date recommendations is paramount to protect individuals under active treatment for cancer, as well as those who have recently completed treatment or those who suffer chronically from the disease.

Louisiana's cancer death rate (2013 – 2017) ranks 46$^{th}$ in the U.S. at 180 deaths per 100,000 citizens vs. a rate of 158.2 nationally.[2] A new diagnosis of cancer (2012 – 2016) occurred for 480.8 Louisianans per 100,000 population, also ranking 46$^{th}$.[2] In the whole of the U.S., cancer incidence for the same period was 448.5.[2] Prior to the onset of the Virus, Louisiana expected 26,480 new cancer cases and 9,300 deaths.[2]

In the absence of coordinated actions, Louisiana citizens will likely bear a disproportionate share of excess cancer death in the U.S. due to the Virus. The guidelines below are intended as countermeasures to lessen excess death from cancer in Louisiana during the pandemic. Taking Aim at Cancer in Louisiana, Inc. will be essential in promoting and helping to disseminate the aforementioned guidelines.

We must do everything possible to improve preventative screening, early detection, adherence to treatment protocols and survivorship to lessen the burden of cancer.

**The Cancer Care Continuum**.

Cancer care outcomes are impacted by the interventions listed below. Together these interventions and the many associated areas of specialization within each area form the Cancer Care Continuum. Advancements in basic science and clinical research hover over the Continuum, stimulating progress and improved outcomes. In normal times, service delivery across the Continuum is extremely challenging. Comprehensive cancer care programs with experts leading each aspect of the Continuum are essential to advancing cancer outcomes in Louisiana.

Appropriate measures must be considered by cancer care providers and individuals across the Continuum.

+ Education
+ Prevention
+ Screening
+ Diagnosis
+ Treatment
+ Survivorship
+ End-of-Life

* SARS-Cov-2 should be used when referring to the virus and COVID-19 when referring to the syndrome according to CDC.

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## Immediate Countermeasures

Immediate attention must be two-fold: 1. Remain focused on individuals with a confirmed cancer diagnosis. These individuals face the risk of being exposed to the Virus when accessing care in person, which could result in their outcome being negatively impacted because of disruptions to the interventions required to manage their cancer care needs; and 2. Focus on screening, particularly mammography and FIT. These are low-risk procedures for both the patient and staff.

While focus on existing patients is important to continue their treatment and protect them from the effects Covid-19 could have on them while immunosuppressed, it's equally as imperative that we continue to find patients who have cancer but don't yet know it. It will take time for people to feel comfortable in a healthcare setting and the sooner we start, the sooner they can be diagnosed.

Colonoscopy, while potentially more prone to disease transmission can be less so if asymptomatic patients are able to be screened prior to the procedure. We should recommend a timeframe within which the procedure is done after negative Covid test. Other approved modalities like FIT testing (which is covered by most health plans, including medicaid ), can help reduce the colonoscopy backlog due to the additional time it takes to negative pressurize procedure rooms for colonoscopies.

Cancer patients experience an array of clinic visits across multiple specialists, infusion therapy, invasive procedures and surgeries, radiation therapy appointments, hospital admissions, laboratory blood draws, and imaging studies while under active treatment. Each of these steps is essential to an accurate diagnosis, treatment, and surveillance of outcomes the patient experiences during their journey. Determining when and how to carry out these lifesaving services must remain the immediate focus across the entire cancer care industry.

To aid cancer care professionals on the front lines, all of the major cancer-related medical societies formed task forces to inform caregivers and patients about methods to navigate through these difficult decisions. The major societies and their COVID-19 resources centers are listed below.

+ American Society of Clinical Oncology
  https://www.asco.org/asco-coronavirus-information
+ American Society of Hematology
  https://www.hematology.org/covid-19
+ Society of Surgical Oncology
  https://www.surgonc.org/resources/covid-19-resources/
+ American Society of Therapeutic Radiation Oncology
  https://www.astro.org/daily-practice/covid-19-recommendations-and-information
+ National Comprehensive Cancer Network
  https://www.nccn.org/covid-19/default.aspx
+ American Cancer Society
  https://www.acs.org/content/acs/en/covid-19.html

Guidelines addressed in the clinical societies' resource centers are based on best-level evidence, considered on a consensus basis and committee member recommendations.[3]

Cancer care providers in Louisiana and across the U.S. have been responsive to these recommendations by updating operational practices and clinical guidelines based on CDC and oncology society specific

recommendations as the pandemic evolves. Generally, these interventions fall into the following categories:

+ Healthcare Facility Safety Measures
+ Remote Care (Telehealth)
+ Guideline-based Avoidance, Deferral, and/or Reduction of In-Person Medical Interventions
+ Evidence-based testing and symptom-based screening of cancer patients undergoing therapy

The following links, which were updated to focus on the management of prostate cancer as stay at home orders were initiated across the globe, is a representative example of the information that is readily available to cancer care professionals.

https://www.nccn.org/covid-19/pdf/NCCN_PCa_COVID_guidelines.pdf
https://www.nccn.org/covid-19/pdf/Prostate_Early_Detection.pdf

The following provides a reference point in coordination with reopening Louisiana.

**Current Status (Phase I)**

+ Cancer care facilities protect patients and staff by following Phase I CDC guidelines and applicable recommendations from cancer care societies.

+ Cancer care facilities must implement active entry screening practices that limit access to essential personnel and patients who require person-to-person intervention as ordered by the patient's physician. A significant proportion of cancer care is provided on an outpatient basis. The MGMA's *COVID-19 Medical Practice Reopening Checklist* represents an appropriate standard for most physician offices caring for patients with cancer. An additional resource specific to oncology practices can be found at https://www.asco.org/asco-coronavirus-information/provider-practice-preparedness-covid-19
Additional provisions and precautions must be considered for outpatient infusion centers, imaging centers, and specialty practices that see patients with certain types of cancer, e.g., head and neck cancer.

+ Physicians and other cancer care professionals (nurse practitioners, physician assistants, social workers, navigators, etc.) provide person-to-person interventions with their patients *via telehealth* when possible.

+ Physicians and other cancer care professions who are making medical decisions or coordination of care decisions with their patients should consider options to avoid, defer, and shorten/reduce staging, and treatment when possible based on each patient's situation and disease specific recommendations provided by oncology societies.

    + When resources and testing capability permit, consideration can be given to COVID testing of asymptomatic patients prior to aerosol generating procedures such as intubation and certain surgical procedures and immune suppressive therapies, given the risk of worse outcomes for cancer patients who develop concurrent COVID19 infection.

+ Limit *new* accrual to clinical research trials unless a clinical trial offers the most appropriate medical option to the patient.

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+ Consider pre-visit Covid-19 testing of symptomatic patients, patients in high risk groups (nursing homes, retirement communities, prisons, patients undergoing immune compromising procedures) or those undergoing aerosolizing procedures. For patients who test positive, defer care (if at all possible) until CDC conditions for ending home isolation of immunocompromised persons are met.

+ Defer work-up of recently diagnosed cancer patients at healthcare facilities until they are considered safe and harbor a low risk for COVID-19 infection.

+ Negative pressure rooms in combination with appropriate personal protective measures must be in place to accommodate aerosolizing procedures.*

+ Cancer care providers follow *Phase One* Opening Up America Again guidelines applicable to employers to limit person-to-person contact within the cancer care delivery continuum.

+ Below are recommendations to ensure established patients remain engaged and that non-emergent care is resumed when the pandemic slows? [4]

- Establish clinic-by-clinic lists of (a) which patients have been re-scheduled from face-to-face visits to e-visits and (b) which patients have had visits delayed entirely. Use these lists to prevent "loss-to-follow up" via periodic review.
- Categorize patients by urgency of return. Track any cancer screening or follow up that is missed.
- Assemble routine patient call lists for nurses, APPs or other providers (even those working from home or on quarantine). Providers can review symptoms, update patients on safety strategies, review questions about medications or triage patients for more urgent, in-person visits.
- Engage with patient advocacy groups. These larger organizations can then, via Social Media or online engagement, remind cohorts of individuals, en masse, not to let their cancer and blood disease care slip.
- Develop strategies now for extending hours and days (weekend) for clinics, radiology, labs, infusion centers etc., to help handle post-pandemic care needs.

**Phase II**

+ Cancer care facilities protect patients and staff by following Phase II CDC guidelines and applicable recommendations from cancer care societies.

+ Cancer care facilities continue active entry screening practices that limit access to essential personnel and patients who require person-to-person intervention as ordered by the patient's physician. During Phase II, cancer care facilities with space to cohort *visitors* in public areas in compliance with social distancing requirements may elect to relax entry guidelines by allowing one visitor to accompany patients. However, visitors will be restricted to cohort in public areas that are geographically and physically disconnected from patient care areas and set-up to strictly promote social distancing.

**Negative pressure rooms are not required for AGPs (there is no data on this, only opinion). PPE and appropriate room cleaning are required for AGPs on COVID+ patients and those who are under investigation for COVID19. With adequate pre-procedure testing, the need for negative pressure rooms is eliminated, as long as PPE is worn.*

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+ Physicians and other cancer care professionals continue to provide person-to-person interventions with their patients *via telehealth* when possible.

+ Physicians and other cancer care professions who are making medical decisions or coordination of care decisions with their patients should consider options to avoid, defer, and shorten/reduce staging, and treatment *for patients who are at an elevated risk for COVID-19 complications.* Physicians should continue to consider recommendations provided by oncology societies by disease type.

+ Any *new* accrual to a clinical research trial should be considered in light of the physician's assessment of the patient's clinical presentation and care needs, and in balance with factors that might give rise to options to avoid, defer, and shorten/reduce care. Accrual to clinical research trials should continue to be avoided for the most vulnerable of patients unless the trial is best medical option under the circumstances.

+ Screening asymptomatic patients, mammography, colonoscopies, etc. can commence under strict adherence to *facility* access screening protocols, social distancing, and adherence to universal precautions (Note the correlation to the second bullet above in Phase II). Patients who present with a positive finding upon screening would still be subject to management based on guidelines that require consideration of measures to avoid, defer, shorten/reduce further workup.

+ Consider pre-visit Covid-19 testing of symptomatic patients, patients in high risk groups (nursing homes, retirement communities, prisons) or those undergoing aerosolizing procedures. For patients who test positive, defer care (if at all possible) until CDC conditions for ending home isolation of immunocompromised persons are met.

+ Negative pressure rooms in combination with appropriate personal protective measures should remain in place to accommodate aerosolizing procedures.*

+ Cancer care providers follow *Phase Two* Opening Up America Again guidelines applicable to employers to limit person-to-person contact within the cancer care delivery continuum.

**Phase III**

+ Cancer care facilities protect patients and staff by following Phase III CDC guidelines and applicable recommendations from cancer care societies.

+ Cancer care facilities may relax screening practices, but should assess those measures in consideration of the vulnerable nature of their patients. Consideration should be given to continuing to restrict access to worksite personnel, patients, and limiting the number of guests who may accompany patients during their visits. Consideration should be given to restrict access to vulnerable individuals accompanying a patient. To accommodate vulnerable visitors during Phase III, cancer care facilities that implemented public cohort areas during Phase II should continue to direct at risk guests to wait in these designated areas.

**Negative pressure rooms are not required for AGPs (there is no data on this, only opinion). PPE and appropriate room cleaning are required for AGPs on COVID+ patients and those who are under investigation for COVID19. With adequate pre-procedure testing, the need for negative pressure rooms is eliminated, as long as PPE is worn.*

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+ Physicians and other cancer care professionals continue to provide person-to-person interventions with their patients *via telehealth* when possible.

+ Physicians who elect to offer enrollment into a clinical research trial should consider the process as a routine part of medical decision making and shared decision making with their patients, with the exception of the most vulnerable of patients who should be considered for clinical research pursuant to Phase I measures.

+ Physicians and other cancer care professions who are making medical decisions or coordination of care decisions with their patients should consider options to avoid, defer, and shorten/reduce staging, and treatment *only for their most vulnerable patients who are at an elevated risk for COVID-19 complications.* For these patients, physicians should continue to consider guidelines and recommendations provided by appropriate oncology societies.

+ Screening asymptomatic patients, mammography, colonoscopies, etc. is provided in adherence to *facility* access guidelines, social distancing, and universal precautions as may be applicable at the time.

+ Negative pressure rooms in combination with appropriate personal protective measures should remain in place to accommodate aerosolizing procedures for the most vulnerable patients.

+ Cancer care providers follow *Phase Three* Opening Up America Again guidelines applicable to employers to limit person-to-person contact within the cancer care delivery continuum.

References:

[1] Medscape, Excess Cancer Deaths Predicted as Care Disrupted by COVID-19
[2] American Cancer Society, Cancer Facts Statistics Center; www.cancerstatisticcenter.cancer.org
[3] Managing Cancer Care During the COVID-19; ScienceDirect; https://www.sciencedirect.com/science/article/pii/S2405803320301357
[4] American Society of Hematology, COVID-19 and Resuming Clinical Visits; https://www.hematology.org/covid-19/covid-19-and-resuming-clinical-visits

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**Taking Aim at Cancer in Louisiana (TACL)** is a state-wide cancer initiative that brings together leaders across sectors in healthcare, payers, business, government, community, advocacy, philanthropy and other sectors to work toward the common goal of improving cancer outcomes in Louisiana.

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TACL is Louisiana's united force to reduce cancer mortality by eliminating racial disparities and health inequities.

Collectively our efforts are taking shape with partners across the state to better align policies, programs and practices among all who diagnose and treat cancer.

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