Cancer Australia consensus statement on COVID-19 and cancer care: embedding high value changes in practice

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Abstract

Introduction: Driven by the need to reduce risk of SARS-CoV-2 infection and optimise use of health system resources, while maximising patient outcomes, the COVID-19 pandemic has prompted unprecedented changes in cancer care. Some new or modified health care practices adopted during the pandemic will be of long term value in improving the quality and resilience of cancer care in Australia and internationally. The Cancer Australia consensus statement is intended to guide and enhance the delivery of cancer care during the pandemic and in a post-pandemic environment. This article summarises the full statement, which is available at https://www.canceraustralia.gov.au/covid-19/covid-19-recovery-implications-cancer-care.

Main recommendations: The statement is informed by a desktop literature review and input from cancer experts and consumers at a virtual roundtable, held in July 2020, on key elements of cancer care that changed during the pandemic. It describes targeted strategies (at system, service, practitioner and patient levels) to retain, enhance and embed high value changes in practice. Principal strategies include:

- implementing innovative models of care that are digitally enabled and underpinned by clear governance, policies and procedures to guide best practice cancer care;
- enabling health professionals to deliver evidence-based best practice and coordinated, person-centred cancer care; and
- empowering patients to improve health literacy and enhancing their ability to engage in informed, shared decision making.

Changes in management as a result of this statement: Widespread adoption of high value health care practices across all levels of the cancer control sector will be of considerable benefit to the delivery of optimal cancer care into the future.

The coronavirus disease 2019 (COVID-19) pandemic has prompted unprecedented changes in cancer care. Approaches to cancer care during the pandemic have required balancing the risk of exposure to, and harm from, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection against the benefits of treatment and the optimal use of health system resources, while maximising patient outcomes.[1] Some new or modified health care practices will be of long term value in improving the quality and resilience of cancer care.

The Cancer Australia consensus statement on COVID-19 and cancer care, summarised here, is intended to guide and enhance national and jurisdictional efforts to improve cancer care during, and in the wake of, the COVID-19 pandemic.[2]

Methods

Cancer Australia undertook a review of national and international peer-reviewed and grey literature published during the COVID-19 pandemic up to July 2020, including research and data articles, clinical guidelines and health professional guidance, to identify elements of cancer care that had changed during the pandemic. A virtual roundtable was held in July 2020, comprising 30 leading Australian cancer experts, and consumer representatives. Input was sought and consensus gained on the following questions:

- What elements of cancer care changed during the COVID-19 pandemic?
- What is the impact of this change?
- What targeted strategies could be identified to retain, enhance and embed high value changes in practice?

Roundtable attendees continued to provide feedback and emerging evidence over the following 6 months, to support consensus on elements of care and strategies. Owing to the emerging nature of the evidence and limited data, the consensus statement is primarily based on observational data, shared experiences, and expert input.

The full version of the statement is available at https://www.canceraustralia.gov.au/covid-19/covid-19-recovery-implications-cancer-care.

Recommendations

This article explores 12 elements of cancer care that changed during the COVID-19 pandemic (Box 1), and provides recommended strategies to enhance and embed the identified high value elements of cancer care and research across the care continuum.

Further information on detailed strategies for each element — at the health system, service (including specialist and primary care, in both public and private sectors), health practitioner and patient levels — are provided in the full version of the statement available at https://www.canceraustralia.gov.au/covid-19/covid-19-recovery-implications-cancer-care.

Expanded use of telehealth

The pandemic led to an unprecedented uptake in telehealth within Australia. Telehealth offers benefits regarding choice, convenience and safety for both patients and clinicians,[3] and potentially reduces rural–urban disparity in cancer care.[4] However, uptake of telehealth was impacted by administrative and coordination challenges, and software and network issues. Additionally, patients and health professionals expressed concerns relating to protecting patient privacy, and difficulty in communicating sensitive or distressing information. Telehealth, and in particular videoconferencing, may also present unique challenges for certain population groups, such as people with diverse needs and people with disabilities (including vision or hearing impairment).[5]

Strategies to enhance the use of telehealth include:

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1 Twelve elements of cancer care that changed during the COVID-19 pandemic

- Expanded use of telehealth
- Changes to prevention and early detection
- Virtual multidisciplinary team meetings
- Modifications to treatment schedules
- Hypofractionated radiotherapy
- Oncology hospital in the home
- Responsive patient support
- Innovative care and hospital infrastructure models
- Shared follow-up and survivorship care
- Supportive and palliative care
- Cancer research and clinical trials
- Collaboration in the oncology sector and data sharing

- Developing clear governance, policies and procedures to guide safety and quality in telehealth consultations.[6]
- Clarifying the ethical, clinical and legal responsibilities of clinicians, technology providers and health care organisations.[6]
- Evaluating the relative safety, effectiveness and cost-effectiveness of telehealth consultations compared with face-to-face consultations, to inform better quality and value-based cancer care.
- Strategically investing in sustainable information technology infrastructure, and technical and administrative personnel,[7] to support safe and efficient cancer care via telehealth (preferably by videoconferencing), including prioritising data security and patient privacy.[8]
- Improving health professional capabilities in providing culturally safe telehealth consultations for Aboriginal and Torres Strait Islander peoples, and people from culturally and linguistically diverse backgrounds.
- Improving access to telehealth by providing telehealth coordinators, enhanced technologies and wearable devices; providing technical support for people with diverse needs, disabilities and low computer literacy; and facilitating consultations in safe and accessible locations.

Changes to prevention and early detection

Early in the pandemic, BreastScreen Australia services were temporarily suspended.[9] While the temporary pause of BreastScreen helped limit exposure to SARS-CoV-2 infection for patients and staff, the disruptions resulted in a backlog of missed appointments.[9] Moreover, some jurisdictions reported reductions in cancer referrals, fewer people attending health consultations, and a reduction cancer-related diagnostic and treatment services.[10-12] Potential diagnostic delays may result in patients presenting with more advanced disease, requiring more complex treatments including systemic therapies, with poorer outcomes.[11] Compounding the impact of potential delayed diagnosis was a reported increase in risky behaviours such as alcohol consumption,[13] although mixed findings from several self-reported surveys of alcohol consumption during COVID-19 were reported in Australia.[14]

Strategies to promote high value approaches in population cancer screening and early detection include:

- Promoting and facilitating patient access to population screening programs and implementing catch-up plans for patients who have missed screening and follow-up appointments; and prioritising available services for population subgroups most likely to benefit, such as through risk stratification on resuming screening services.
- Promoting the importance of early detection by disseminating awareness messaging and encouraging patients to see their doctor about red flag symptoms suggestive of cancer (eg, Cancer Australia's Cancer Won't Wait [https://www.canceraustralia.gov.au/cancer-wont-wait] campaign).
- Prioritising available services for investigation of symptoms and signs suggestive of cancer and follow-up of positive results, according to evidence-based clinical practice guidelines.

Virtual multidisciplinary team meetings

Cancer multidisciplinary team (MDT) meetings transformed rapidly from in-person to virtual meetings in response to the pandemic.[15] This helped to minimise potential spread of SARS-CoV-2 infection among clinicians, improved ease of clinician attendance,[15] and enabled engagement of the MDT with primary care for improved care planning. There is an opportunity for virtual MDTs to become a standard component of future clinical workflows.[16]

Strategies to embed high value changes to MDT meetings include:

- Strategically investing in information technology infrastructure, and technical and administrative personnel, to support the workflows of virtual MDTs, including prioritising data security and patient privacy when using digital platforms.[8]
- Establishing communication linkages, including technical capabilities to allow rapid data transfer, to enable team preparation and participation, integrate decision making, and implement comprehensive care.[17]
- Evaluating the extent to which virtual MDTs affect patient outcomes and improve guideline adherence compared with traditional face-to-face MDTs, and evaluating the effectiveness and cost-effectiveness of virtual MDTs in urban settings, to supplement established evidence in rural settings.[4]

Modifications to treatment schedules

Refinements were considered for individual treatment plans to minimise patients' risk of exposure to, and harm from, SARS-CoV-2 infection, while ensuring the best possible patient outcomes.[18,19] Some evidence-based modifications to cancer management include transitioning from intravenous to oral chemotherapy if there are alternatives, and considering alternative and less resource-intensive treatment regimens where appropriate, on a case-by-case basis with both patient and multidisciplinary input.[20] Despite aiming to improve quality of life and patient experience, patients may experience anxiety or distress resulting from changes to usual treatment. Furthermore, it may be difficult for clinicians to calculate the risk–benefit equation of modifications to treatment plans.[21]

Strategies to embed high value modifications to treatment schedules include:

- Developing and disseminating evidence- and consensus-based guidance for health professionals, and standardised, validated risk stratification protocols to identify patients who are eligible for modifications to treatment. Best practice recommendations should be shared through formalised, electronic means that are accessible for all health practitioners.[22]
- Ensuring goals of patient care are clearly documented and easily accessible, in order to minimise undertreatment of patients with good prognosis and overtreatment of those with poor prognosis either from cancer or COVID-19.[19]

- Educating and supporting consumers to increase their health literacy, confidence, and ability to engage in informed, shared decision-making processes regarding their treatment schedule.

Hypofractionated radiotherapy

For selected cancers, the use of hypofractionated or short-course schedules increased in Australia and overseas during the pandemic, with various national and international cancer organisations recommending hypofractionated regimens where appropriate.[23,24]

Strategies to embed high value changes in delivery of radiotherapy include:

- Developing and distributing tumour-specific, evidence-based, validated guidance for the use of hypofractionated radiotherapy, including information on patient eligibility, standardised dose and fractionation schedules, and safety and toxicity concerns.[25]
- Educating and training health professionals on the appropriate use of hypofractionated radiotherapy, to minimise unwarranted variations in practice.
- Increasing the use of patient-reported outcome measures, to evaluate the use of hypofractionated radiotherapy in terms of quality of life, with a focus on safety and toxicity.[26]

Oncology hospital in the home

The pandemic has prompted rapid uptake of in-home care, including home-based intravenous chemotherapy administration. In-home oncology models may help protect the wellbeing of immunocompromised patients while better managing acute care resources;[27] however, there are inherent concerns around safety of home infusions of chemotherapy drugs[28] and potential medicolegal risks in staff providing treatment outside the clinical setting.

Strategies to enhance oncology hospital in the home include:

- Developing and implementing policy and guidance for safe and efficient administration of intravenous chemotherapy in the home, to ensure minimum standards for chemotherapy delivery are maintained.[29]
- Implementing electronic prescribing and improving linkages between clinical information systems, to improve safety and efficiency in medication management and reduce medication errors.[29,30]
- Establishing detailed escalation plans for managing treatment complications.[29]
- Training health professionals, including cancer nurses, physicians and pharmacists, to meet standards for adopting in-home cancer care models.[30-32]

Responsive patient support

Cancer organisations rapidly and proactively increased information support for cancer patients during the pandemic, providing timely information about cancer care and treatment, and advice about infection control.

Strategies to enhance patient support include:

- Conducting patient experience surveys, to support rapid identification of emerging needs of cancer patients.
- Encouraging timely communication and collaboration among the cancer community, to share learnings and address the needs of cancer patients.
- Disseminating and promoting consistent, coordinated and coherent evidence-based patient information, including via digital health technologies such as mobile applications, to support the physical and psychological wellbeing of cancer patients and carers.

2 Innovative care and hospital infrastructure models adopted during the COVID-19 pandemic

- Establishment of temporary spaces for cancer treatment[33]
- Implementation of hub-and-spoke models for cancer centres[34]
- Adoption of segregated team models in the workforce[35]
- Synergising of public and private institutions[34]
- Uptake of innovative models of care for review of symptoms and treatment-related toxicities, including novel triage protocols facilitated by telehealth and nurse-led models[19,36,37]
- Changes to hospital design to accommodate readily convertible spaces such as for additional intensive care units[33] and separation into COVID-19-positive and COVID-19-clear spaces.[38]

Innovative care and hospital infrastructure models

The pandemic has highlighted the importance of health system organisation and hospital design. Some innovative care and hospital infrastructure models adopted to minimise overloading of acute care facilities and reduce community transmission of disease are shown in Box 2.

Strategies to enhance innovative models include:

- Adopting models of care that incorporate patient-reported outcomes, underpinned by ethical principles of equity, proportionality and transparency in resource allocation decisions.[39]
- Developing and promoting education and training programs and guidance for health professionals, to increase acceptance of, and skills in delivering, new models of care, including outpatient and home-based oncological care utilising telehealth, e-prescribing and e-ordering of investigations, and nurse-led care.[37]
- Promoting deliberation in hospital design to include readily convertible spaces that consider flexible patient and staff flows through the hospital, to be responsive to current and future pandemics.

Shared follow-up and survivorship care

During the pandemic, some patients who were unable or reluctant to visit their cancer service for follow-up appointments reported having their follow-up care appointments shared between their cancer specialist and general practitioner,[40] with many consultations conducted using telehealth. Shared care supports continuity of follow-up care, helps minimise unnecessary presentations to acute care facilities, increases the capacity of specialists and hospitals to focus on patients requiring urgent care,[31] and enables engagement between patients and health professionals in diverse locations.[32]

Strategies to embed shared follow-up and survivorship care include:

- Implementing national evidence-based and collaborative models of shared follow-up and survivorship care.

- Establishing and embedding processes and templates, to support shared follow-up care plans between multidisciplinary health professionals, and facilitation of rapid access to tertiary care settings for clinical issues requiring specialist consultation or advice.[40]
- Empowering clinicians, care coordinators and allied health professionals, including Aboriginal and Torres Strait Islander health workers, to use telehealth to provide quality, digitally enabled follow-up and survivorship care.[31,32]

Supportive and palliative care

The pandemic has impacted the mental wellbeing of people affected by cancer and their carers, with psychosocial impacts amplified by factors including increased vulnerability to infection, changes to planned cancer treatment, and strict hospital visiting policies.[41] Home-based and virtual palliative care services were initiated or rapidly expanded.[32] Virtual supportive and palliative care aims to maintain continuity of care and may have future applications for cancer management throughout the care pathway. Additionally, advance care planning promotes proactive care coordination and autonomy for patients and their families,[31] and can help prevent unnecessary emergency presentations and hospitalisations.[31] Nonetheless, socially distanced care limits can lead to a feeling of impersonality.[31] In addition, inappropriate, inconsistent or suboptimal delivery of virtual supportive and palliative care during the pandemic may have further affected psychosocial wellbeing.[31]

Strategies to embed high value changes in supportive and palliative care include:

- Improving access, and equity of access, to supportive and palliative care services through innovative models of care, enabling services to continue care for patients outside of the hospital.[31]
- Providing psychosocial support for patients and their carers, including normalising anxiety and adopting mindfulness-, compassion- and value-based approaches.[41]
- Providing psychosocial support for staff, to avoid compassion fatigue in the workforce.[42]

Cancer research and clinical trials

During the pandemic, some researchers were unable to work from home effectively because many clinical trial assessments require face-to-face encounters;[43] laboratory research and grant programs were disrupted or suspended; ethics committees prioritised research for COVID-19;[37,44] a marked reduction in philanthropic funding was reported;[45] and use of some immunosuppressive cancer medicines in clinical trials was avoided, to ensure patient safety.[46] The pandemic also prompted rapid deployment of teletrials worldwide,[46] which facilitated access to trials[47] and prevented postponement or termination of some cancer clinical trials. Guidance and frameworks have addressed issues of safety, trial integrity,[43,48] and operational burden of implementing clinical trials during the pandemic.

Strategies to embed high value changes in cancer research include:

- Facilitating access to clinical trials by streamlining cancer trial methodology and documentation, harmonising responses of individual human research ethics committees to new national standards,[37] reducing unnecessary red tape, and reducing the number of mandatory hospital visits.[47]
- Encouraging, facilitating and evaluating digital approaches to working, such as virtual peer review panels[45] and using telehealth for remote review of patient symptoms and adverse events.
- Incorporating contingency plans and digital adaptation approaches into trial designs, including enabling home delivery of trial drugs and remote laboratory collections, conducting remote site visits by trial sponsors, and allowing e-signatures for study documentation.[47]

Collaboration in the oncology sector and data sharing

During the pandemic there has been strengthened collaboration among national and international academic and clinical bodies within the oncology sector, including sharing of data and information, and timely publication. These collaborative efforts have informed clinical practice in real-time and helped improve outcomes for cancer patients[49] by enabling the rapid accumulation of knowledge and dissemination of information and guidance for people affected by cancer. The sharing of experiences has increased the consistency and timeliness of evidence-based care recommendations.[37]

Strategies to enhance collaboration in the oncology sector include:

- Supporting continued and improved sustainability of national and international collaborations for sharing of data and information, including collaboration between state and territory cancer registries, and government agencies, to enable timely access to cancer data for clinicians and researchers.
- Identifying opportunities to further leverage collaboration in the oncology sector, such as incorporating mathematical oncology and bioengineering expertise into clinical trial design, health services research, and developing decision-making tools to more effectively diagnose and manage cancer.[50]
- Encouraging health practitioner and patient engagement in collaboration across the oncology sector.

Conclusion

The COVID-19 pandemic has accelerated revision and reform of health care practices and implementation of value-based care. Health systems and health care professionals have demonstrated a remarkable ability to rapidly adapt or modify care practices to deliver optimal cancer care, while minimising risk of SARS-CoV-2 infection and optimising health system resources. A range of strategies has been identified to enhance and embed these high value changes in cancer care during the pandemic and in a post-pandemic environment.[2] These strategies allow flexibility for jurisdictions, organisations and individuals to address these priorities in ways that suit their local context and workforce capacity. Regular and ongoing review of health care practices, underpinned by clear documentation of changes in practice and learnings, will be critical to maintaining optimal and sustainable value-based cancer care into the future.

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