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AMERICAN SOCIETY OF CLINICAL ONCOLOGY

ASCO SPECIAL REPORT:
A GUIDE TO CANCER CARE DELIVERY DURING THE COVID-19 PANDEMIC

MAY 19, 2020

Introduction

As states and municipalities implement phased easing of pandemic-related restrictions, the American Society of Clinical Oncology (ASCO) has received requests from its members for guidance on preparations that should be in place to safely continue cancer center operations and resume elective procedures. The *ASCO Special Report: A Guide to Cancer Care Delivery During the COVID-19 Pandemic* describes immediate and short-term steps oncology practices can take to protect the safety of patients and healthcare staff as the pandemic response continues. Practices should consider internal cancer center and practice policies as well as state, medical board, and municipality regulations or guidance regarding practice operations, as circumstances vary widely across the United States.

ASCO clinical experts have reviewed a wide range of policies and practices adopted and/or planned by cancer facilities, as well as guidance provided by government agencies and other medical societies. With this information, we hope cancer practices have more confidence in determining when and how to resume their usual practice operations during this phase of the pandemic. This document is not a systematic review of evidence and does not provide clinical guidance for individual patient care. This document should supplement and not supersede applicable institutional, local, regional, or national plans or guidance and is not intended as clinical, legal, or medical advice.

This report represents a narrative review of available agency guidance, published information and clinical examples from ASCO members, government agencies, and professional organizations. ASCO developed this report in the following fashion:

o ASCO staff received guidance and examples of local policies and procedures from members of its Clinical Practice Committee, COVID-19 Clinical Questions Advisory Group, and speakers in the ASCO-ONS Webinar Series: Caring for People with Cancer During the COVID-19 Pandemic.

o For each subject area, ASCO staff used the information received to create a summary of available information for use by individual practices in developing their own policies and procedures.

o The entire report was reviewed by the ASCO Clinical Practice Committee and approved by ASCO's Chief Medical Officer and Executive Vice President.

For questions regarding this document, please contact ASCO's Clinical Affairs Department at clinicalaffairs@asco.org.

Disclaimer

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A GUIDE TO CANCER CARE DELIVERY DURING THE COVID-19 PANDEMIC

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Triage/Screening

Before Patient Arrival

- o When scheduling appointments, inform patients that appointments will need to be rescheduled if the patient develops symptoms of a respiratory infection (e.g., cough, shortness of breath, fever, chills, myalgias, sore throat, new loss of taste or smell, or other flu-like symptoms) on the day they are scheduled to be seen. Instruct patients to call the office prior to departing for appointment (or sooner).
- o Advise patients that they are required to put on a face mask or other face covering, regardless of symptoms, before entering the facility.
- o Contact the patient 48 to 72 hours prior to the appointment to screen for symptoms of cough, shortness of breath, fever, chills, myalgias, sore throat, new loss of taste or smell, or other flu-like symptoms. If symptoms are present, triage protocols should be utilized to determine if an appointment is necessary or if the patient can be managed from home.
- o If the patient can be managed from home, the patient should be instructed to contact their primary care physician if symptoms worsen or do not resolve within 14 days. The patient appointment should be rescheduled when he or she is determined to be no longer infectious.
- o An in-person or telemedicine provider visit may be necessary to assess symptoms related to cancer treatment or COVID-19-positive/potential COVID-19-positive to avoid an emergency department visit (e.g., assessing for COVID-19 and/or neutropenic fever).
- o Residents in long-term care facilities or other congregate living settings, including prisons and shelters, should be considered high risk, particularly if the patient lives within a documented COVID-19-positive facility or area.

Upon Patient Arrival

- o Limit access to the facility through one point of entry, if possible. If there are multiple points of entry, screening must occur at all entrances. No visitors should be permitted, unless a patient requires accompaniment due to specific patient needs, such as intellectual and/or developmental disabilities or other cognitive or physical impairments. No one under 18 years of age should be permitted as a visitor. Facility access should exclude non-essential vendors and allow only essential ancillary services. Practices should consider remote or virtual communication with business partners and support services.
- o Establish triage stations outside the facility, with social/physical distancing of six feet apart to screen patients and visitors for COVID-19 symptoms and fever before they enter. All patients should wear masks on arrival and follow a strict handwashing protocol.
- o Implement face masks for everyone entering the facility, regardless of symptoms to help prevent transmission from infected individuals who may not have symptoms of COVID-19.
- o Symptoms of coronavirus appear 2 to 14 days following exposure. Symptoms include:
    - • Cough, shortness of breath, fever, chills, myalgias, sore throat, new loss of taste or smell, or other flu-like symptoms.
- o Include signage with COVID-19 screening questions and visualization of symptoms for all patient/visitors, as well as patient education materials and illustrations of proper hygiene for infection prevention and symptoms to report. Provide signage and patient education materials in language(s) appropriate for your patient population.
- o Patient screening status and COVID-positive status should be documented prior to the patient entering the facility (e.g., EMR, patient identification wrist band with date of screening).

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Additional resources:

Centers for Disease Control and Prevention (CDC) COVID-19 Prevention Poster
https://www.cdc.gov/coronavirus/2019-ncov/communication/graphics.html

CDC COVID-19 Symptoms Poster
https://www.cdc.gov/coronavirus/2019-ncov/downloads/COVID19-symptoms.pdf

Healthcare Facilities: Preparing for Community Transmission
https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-hcf.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhealthcare-facilities%2Fguidance-hcf.html

Symptoms of Coronavirus
https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html

Screening illustration workflow and checklist:

Screening workflow
https://practice.asco.org/sites/default/files/drupalfiles/2020-05/COVID-19%20diagram%20updated.pdf

Screening checklist example
https://practice.asco.org/sites/default/files/drupalfiles/2020-05/COVID%20-%2019%20Checklist_v3.pdf

COVID-19 Patients Under Investigation/Positive

Patient under investigation (PUI)
- In the event a patient screens positive as a PUI, staff should activate facility protocol for immediate management, including notification of appropriate infection control and state/local health department.
- Patients designated as PUI after arriving at the clinic should wear a mask and be escorted to a designated isolation room/area. The oncologist provider should review and determine appropriate action for delivery of care/services.
- Patients with fever as the only symptoms should be evaluated to determine whether a COVID-19 test is appropriate. Patients should be evaluated on an individual basis for other potential infections or possible "tumor fever".
- If a viral test is ordered, cancer treatment should be delayed until the result is available. In the event of a positive result, the patient's oncologist, in consultation with the patient, should determine next steps.

COVID-positive criteria for infusion services
- In-office care for COVID-19-positive patients should be delayed for a minimum of 14 days from symptom onset.
- The patient should be symptom-free (including fever-free without the use of any fever-reducing medications) and improving for a minimum of 72 hours before receiving an infusion.

o   After the delay of in-office care and when the patient is symptom-free, there should be two successive negative COVID-19 tests a minimum of 24 hours apart. If testing is not available, treatment should be at the discretion of the oncologist provider and healthcare facility/practice infection control policies.

Additional resources:

Discontinuation of Isolation for Persons with COVID-19 Not in Healthcare Settings
https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-patients.html

Information for Health Departments on Reporting Cases of COVID-19
https://www.cdc.gov/coronavirus/2019-ncov/php/reporting-pui.html

COVID-19 Diagnostic Testing

Current testing available for COVID-19 include:
o   Nucleic acid amplification tests for viral RNA (polymerase chain reaction), in order to measure current infection with SARS-CoV-2.
o   Antigen tests for rapid detection of SARS-CoV-2.
o   Antibody (serology) tests to detect presence of antibodies to SARS-CoV-2.

The following testing strategies should be implemented using RNA tests. If the facility chooses to use rapid antigen testing for symptomatic patients, such patients with negative results should be retested with an RNA test.

Operational testing policies for patients will be dependent upon available testing resources and laboratory capacity. Recommended priorities are below:

o   Priority 1:
- Hospitalized patients with symptoms.
- Symptomatic residents of long-term care facilities or other congregate living settings, including prisons and shelters.
o   Priority 2:
- Persons with COVID-19 symptoms, including cough, shortness of breath, fever, chills, myalgias, sore throat, new loss of taste or smell, or other flu-like symptoms.
o   Priority 3:
- Asymptomatic patients prior to receipt of immunosuppressive therapy (e.g., cytotoxic chemotherapy, stem cell transplantation, biologic therapy, cellular immunotherapy, or high-dose corticosteroids).
- Asymptomatic individuals prioritized by health departments or clinicians, for any reason, including but not limited to: public health monitoring, sentinel surveillance, or screening according to state and local plans.

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Processes for pre-screening of asymptomatic patients with cancer (dependent upon availability of testing supplies and laboratory capacity)
- New patients to receive cytotoxic chemotherapy, stem cell transplantation, long acting biologic therapy, cellular immunotherapy, or high-dose corticosteroids should be tested 48 to 72 hours before initiation of therapy.
- During treatment, all patients should be screened 48 to 72 hours prior to each new cycle of therapy. Screening should include administration of a standardized questionnaire about symptoms and potential exposure.
- Based on screening results, oncology practices should test any patient identified as having a potential risk of exposure, respiratory symptoms, and/or two other symptoms (cough, shortness of breath, fever, chills, myalgias, sore throat, new loss of taste or smell, or other flu-like symptoms).
- If possible, testing should occur at a site other than the cancer care facility. Testing at the cancer care facility should be limited to patients identified as symptomatic or at risk after arrival at the clinic.
- As above, all patients should be screened upon arrival to the facility, to determine whether there has been a change in status and/or the need for testing or retesting.

Testing policies for healthcare personnel (HCP)
- Priority 1
  - Healthcare facility workers, workers in congregate living settings, and first responders with symptoms.
- Priority 2
  - Persons with symptoms of potential COVID-19 infection, including cough, shortness of breath, fever, chills, myalgias, sore throat, new loss of taste or smell, or other flu-like symptoms.
  - Persons without symptoms who are prioritized by health departments or clinicians, for any reason, including but not limited to: public health monitoring, sentinel surveillance, or screening of other asymptomatic individuals according to state and local plans.
- Priority 3:
  - Asymptomatic individuals who are either known or suspected to have been exposed to COVID-19 while not wearing appropriate personal protective equipment (PPE). Known exposure is defined as direct contact with a laboratory confirmed case of COVID-19. Suspected exposure is defined as working or residing in a congregate setting.

- Testing Policies and Protocols
  - Testing should be considered if there has been exposure to a patient or person with suspected COVID-19, with or without laboratory confirmation.
  - HCPs in the high- or medium-risk category should undergo active monitoring, including restriction from work in any healthcare setting until 14 days after their last exposure.
  - If an HCP develops a fever (measured temperature of at least 100.4°F) OR presents with COVID-19 symptoms (e.g., cough, shortness of breath, fever, chills, myalgias, sore throat, new loss of taste or smell, or other flu-like symptoms), they should immediately self-isolate and notify their local or state public health authority and

their healthcare facility management and obtain referral to a healthcare provider for further evaluation.

- HCPs in the low-risk category should perform self-monitoring with delegated supervision until 14 days after the last potential exposure.
  - Low-risk HCP who report potential exposure and are asymptomatic are not restricted from work. They should check their temperature twice daily and remain alert for symptoms consistent with COVID-19 (e.g., cough, shortness of breath, fever, chills, myalgias, sore throat, new loss of taste or smell, or other flu-like symptoms).
  - Such individuals should ensure they are afebrile and asymptomatic before leaving home and reporting for work. If they do not have fever or symptoms consistent with COVID-19 they may report to work. If they develop fever (measured temperature of at least 100.4°F or subjective fever) OR symptoms consistent with COVID-19, they should immediately self-isolate and notify their local or state public health authority or healthcare facility management so that they can coordinate consultation and referral to a healthcare provider for further evaluation.
- Healthcare facilities should consider measuring temperature and assessing symptoms for all HCP prior to starting every work shift.
- Facilities should consider COVID-19 testing for all HCP at the beginning of a cycle of consecutive workdays.
- Commercially manufactured antibody tests check for SARS-CoV-2 antibodies in individuals and are available through healthcare providers and commercial laboratories. CDC is evaluating the performance of these tests. Antibody test results should not be used to diagnose someone with an active SARS-CoV-2 infection. It typically takes 1 to 3 weeks after someone becomes infected with SARS-CoV-2 for their body to make antibodies; some people may take longer to develop antibodies.

Additional resources:

Evaluating and Testing Persons for Coronavirus Disease 2019 (COVID-19)
https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html

Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 (COVID-19)
https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

Processes for testing and questionnaires for asymptomatic cancer treatment patients was developed from recommendations from the Infectious Diseases Society of America Guidelines on the Diagnosis of COVID-19. https://www.idsociety.org/practice-guideline/covid-19-guideline-diagnostics

Serology Testing for COVID-19
https://www.cdc.gov/coronavirus/2019-ncov/lab/serology-testing.html

Patient and HCP testing; HCP return to work illustration workflows:

COVID-19 Patient Testing
https://practice.asco.org/sites/default/files/drupalfiles/2020-05/COVID_Patient_Testing.pdf

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COVID-19 HCP Testing
https://practice.asco.org/sites/default/files/drupalfiles/2020-05/COVID-19%20%20HCP%20testing.pdf

COVID-19 Return to Work
https://practice.asco.org/sites/default/files/drupalfiles/2020-05/COVID-19%20%20HCP%20return%20to%20work.pdf

Infection Prevention Controls

Personal Protective Equipment (PPE)
- o HCP should always wear a facemask while they are in the healthcare facility. When available, medical grade facemasks are preferred over cloth face coverings for HCP.
- o All staff entering the room of a patient with known or suspected COVID-19 should adhere to recommended CDC Standard Precautions and use an N95 respirator or medical grade facemask, gown, gloves, and eye protection. Cloth face coverings are not proven effective PPE and should not be worn for the care of patients with known or suspected COVID-19.
- o All physical contact between staff should be minimized and 6-foot distancing maintained whenever possible.
- o The facility should have a clear policy on optimizing the supply of PPE and planning for healthcare professional inventory needs.
- o Healthcare facilities should consider decontamination and reuse of filtering facepiece respirators as one means of optimizing scarce resources.

Additional resources:

Decontaminating and Reuse of Filtering Facepiece Respirators
https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/decontamination-reuse-respirators.html

Oncology Nursing Society (ONS) Interim Guidelines During the COVID-19 Pandemic
https://www.ons.org/covid-19-interim-guidelines

Standard Precautions for All Patient Care
https://www.cdc.gov/infectioncontrol/basics/standard-precautions.html

Strategies to Optimize the Supply of PPE and Equipment
https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/

Workforce

Workforce
- o Screen all HCP at the beginning of their shift for fever and symptoms consistent with COVID-19. CDC considers a person to have a fever when he or she has a measured temperature of at least 100.4 °F [38 °C].

- o As part of routine practice, HCP should be asked to regularly monitor themselves for fever and symptoms of COVID-19.
  - HCP should be reminded to stay home when they are ill. Criteria for return to work should be based on employer requirements. If an HCP is COVID-19-positive, they should follow the criteria for return to work with confirmed or suspected COVID-19.
  - If HCP develops a fever (of at least 100.4°F) or symptoms consistent with COVID-19 while at work, they should keep their facemask on, inform their supervisor, and leave the workplace.
- o Facilities should consider COVID-19 testing for HCP at the beginning of a cycle of consecutive workdays.
- o Facilities should use CDC Standard Precautions and other infection prevention and control strategies to limit exposure.
- o Healthcare facilities should follow interim CDC guidance on recommended criteria for return to work for healthcare personnel with confirmed or suspected COVID-19. Return to work criteria include:
  - Symptom-based strategy. Exclude from work until:
    - At least 3 days (72 hours) have passed since recovery [defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath)]; and
    - At least 10 days have passed since symptoms first appeared.
  - Test-based strategy. Exclude from work until:
    - Resolution of fever without the use of fever-reducing medications and
    - Improvement in respiratory symptoms (e.g., cough, shortness of breath), and negative results of a Food and Drug Administration Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens).
- o Reduce the number of staff in the clinic by allowing work-from-home for scheduling, billing, and other phone-based staff.
- o Healthcare facilities should impose social/physical distancing of 6-foot distance in workspaces.
- o Move cancer conferences and other meetings to a virtual format.
- o Identify number of staff essential for facility operations and patient care and treatment.
- o Identify separate, designated staff for COVID-19-positive patient care.
- o Modify duties and make other accommodations for HCP with additional risk factors.
- o Workforce/Staff Education
  - Provide training for infection control, proper selection and use/disposal of PPE, and use of respiratory equipment.
  - Provide training on proper use/cleaning of equipment and isolation rooms.
  - Provide training for proper disposal of potentially infectious waste.
  - Conduct routine cleaning of rooms and exam equipment.
- o Practices should require all staff to get an annual influenza vaccine.
- o Personal travel should be based on an abundance of caution to help lower the probability of spread of COVID-19:
  - Encourage all employees to carefully consider personal travel plans.

- For employees who travel outside their geographic area or into an epicenter/surge/elevated risk location during their time off and/or become exposed or acquire COVID-19, require quarantine and testing until confirmed COVID-19 negative.
  - Facility should engage Human Resources support for employee health issues.
  - Facility leaders should be alert to clinicians and members of the cancer care team who may experience increased stress due to the COVID-19 pandemic. This can result in the following:
    - Isolation as a result of strict biosecurity measures; physical isolation from family and friends.
    - Worry about own health and health of family, peers, and colleagues.
    - Multiple medical and personal demands; competing demands of typical daily workload and COVID-19 response; changes in family care responsibilities.
    - Difficult choices and challenges in patient care, worry about patients; supporting patients and families during reduced visitation.

  - Facility should provide support and stress management resources for HCP:
    - Maintain social support.
    - Check-in with employees regarding physical and emotional well-being and effective coping strategies.
    - Offer employee assistance or mental health support to address COVID-19 stress.
    - Be mindful of employee's possible feelings of being overwhelmed or signs of harming self/others.

Additional resources:

A segregated-team model to maintain cancer care during the COVID-19 outbreak at an academic center in Singapore
https://www.sciencedirect.com/science/article/pii/S0923753420364103?via%3Dihub

Criteria for Return to Work for Healthcare Personnel with Suspected or Confirmed COVID-19 (Interim guidance)
https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhealthcare-facilities%2Fhcp-return-work.html

ONS Recommendations for Oncology Staff Assignments During the COVID-19 Pandemic
https://www.ons.org/oncology-staff-assignments-covid-19

Standard Precautions for All Patient Care
https://www.cdc.gov/infectioncontrol/basics/standard-precautions.html

Tools for health professional well-being and mental health:

Physician Support Line: a free and confidential support line run by volunteer psychiatrists hoping to provide peer support to fellow physicians.

Crisis Text Line: text HOME to 741741 to connect with a free crisis counselor (US and Canada). UK: text 85258. Ireland: text 086 1800 280.

PTSD Coach: an app created by the VA and DoD to help those who are or may be experiencing effects of trauma.

Doctor On Demand: a telemedicine service focused on behavioral health.

Substance Abuse and Mental Health Services Administration's (SAMHSA's) Disaster Distress Helpline: 1-800-985-5990 or text TalkWithUs to 66746. (TTY 1-800-846-8517)
TalkSpace: offering free online therapy to health care workers fighting COVID

American Medical Association, Caring for our Caregivers During COVID-19

American Psychological Association, Resources for Pandemic

Cates, Gomes, and Krasilovsky. *Bioemergency Planning*, Behavioral Health Support for Patients, Families, and Healthcare Workers

Sources: US Department of Veterans Affairs, Managing Healthcare Workers' Stress Associated with the COVID-19 Virus Outbreak; National Academies, Duty to Plan: Health Care, Crisis Standards of Care, and Novel Coronavirus SARS-CoV-2

Resources and Supplies

Resources and Supplies
- o Assure sufficient inventory of medications, PPE, and cleaning supplies.
- o Centralize inventory storage for security and healthcare facility distribution oversight.
- o Healthcare facility should have policies/procedures to ensure the integrity of donated PPE (e.g., cloth masks) and proper utilization, as well as chain-of-custody of supplies.

Additional resources:

How to Report a Product Shortage or Supply Issue to FDA
https://www.fda.gov/vaccines-blood-biologics/safety-availability-biologics/how-report-product-shortage-or-supply-issue-fda

Facility Considerations

Social/Physical Distancing in Clinical Areas
- o Consider shared spaces with 6-foot distancing or elimination of waiting areas (e.g., patient wait in parking area and called immediately prior to entrance to examination or treatment room).
- o If facility is without parking lots or close public parking, create a "drop off" zone or drive through location.
- o For patients arriving via public transportation, designate an arrival area with team members escorting patients to screening area.
- o Instead of waiting rooms, have patients enter the screening area upon notification of appointment commencing.
- o Remove any materials or communal goods that may be in contact with patients (e.g., magazines, patient education materials on display, snacks, beverage dispensers, prepared beverages such as coffee or bottled water/beverages).
- o Patients should be seen by each provider or team member individually, assuring social/physical distancing.
- o Patients waiting in lines should stand at least 6 feet apart from one another. Facilities should consider placing distance markings on the floor to provide guidance to patients. Waiting in lines can be reduced/eliminated through an alternative workflow (e.g., patient waiting in their car or designated area prior to entering the building; virtual check-in from waiting location; check-out performed in the exam room or patient escorted to check-out when front desk without other patients).
- o Assign a designated location and route of entry/exit for COVID-19 Patient Under Investigation and/or COVID-positive.
- o Identify specific bathroom facilities for COVID-19-positive patients.

Social/physical distancing in administrative and non-patient care areas:
- o Identify essential staff members for administrative and non-patient care duties within the facility. Consider allowing work from home for amenable job responsibilities.
- o Apply social distancing in facility shared spaces (e.g., workstations, work assignment areas, break room/staff lounge) with 6-foot distancing.
- o Block off staff areas from patient access during patient care visits, including the staff restrooms and lounge/breakroom.
- o Shared food areas (e.g., coffee machine, refrigerator, water cooler) should be discontinued. Restrict business and vendor on-site visits, including accepting communal food.
- o All meetings, multidisciplinary clinics, and tumor boards should be converted to online rather than in person.

Facility signage and directions:
- o Segregated areas should be clearly indicated via signage. All signage should be in English, Spanish, and/or other languages as appropriate to the patient population.
- o The facility website should include information about facility policies related to COVID-19 patient care, including those related to both on-site and virtual visits.

Location Services and Hours of Operations

Location Services and Hours of Operations
- o Based on in-office patient care volume and telehealth visit volume, some facilities should temporarily close, with staff available for COVID-19-positive patient care, rotation of staff for work and rest cycles, and remote work, such as telephone triage and medical records tasks.
- o Consider extended hours to allow for influx/surge of in-office patient visits allowing for Patients Under Investigation and COVID-positive patients at end of day if possible.
- o Consider opening new areas for treatment to allow appropriate distancing and/or isolating patients at highest risk of exposure (e.g., injection only rooms/areas and grouping COVID-positive patients in designated areas for care.
- o Consider hours of operations for terminal cleaning procedures.

COVID-19 Surge Planning

Surge Planning
- o Develop an escalation plan for care of COVID-19 positive surge patient care that includes staffing, facility segregation, and deployment of any precautions that may have been lifted with COVID-19 response.
- o Establish a Surge Planning team that identifies data and metrics that trigger activation of escalation plan.
- o Maintain awareness and prepare for impact of staff health, resilience, and availability from COVID-19 impact.

Additional resources:

CDC Information for Healthcare Professionals About Coronavirus (COVID-19) – COVID-19 Surge Tool
https://www.cdc.gov/coronavirus/2019-ncov/hcp/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhealthcare-facilities%2Findex.html

Framework for Healthcare Systems Providing non-COVID-19 Clinical Care During the COVID-19 Pandemic
https://www.cdc.gov/coronavirus/2019-ncov/hcp/framework-non-COVID-care.html

Sanitation Protocols

Sanitation Protocols
- o Follow required healthcare facility infection control practices for cleaning.
- o Current evidence suggests that SARS-CoV-2 may remain viable for hours to days on surfaces made from a variety of materials. A thorough wipe down for disinfection should be done in exam room/treatment area following every patient visit using an EPA-registered household disinfectant.
- o Facility cleaning protocols should include disinfectant to all areas such as offices, bathrooms, common areas, shared electronic equipment (like tablets, touch screens, keyboards, remote controls) used by anyone infected with COVID-19.
- o For end of day terminal clean, include all patient care rooms and equipment (e.g., infusion pumps, vital sign monitoring, linear accelerator). Decontaminate all surfaces and close room

to allow for airflow exchange with disinfectant cleaning afterwards. This should be done before the next day prior to any non-COVID-positive patient treatments/patient care.

o   If specific isolation areas are being used, cleaning procedures must occur immediately following patient discharge from the facility room/area.

Additional resources:

Cleaning and Disinfection for Community Facilities
https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/cleaning-disinfection.html

Support Services

Support Services

Support services should continue during this time. Resources should be provided to patients remotely. Below is a list of resources available to share with patients. Most resources can be located at https://www.cancer.net/.

- o   Financial
    - https://www.cancer.net/navigating-cancer-care/financial-considerations
- o   Nutrition
    - https://www.cancer.net/survivorship/healthy-living/nutrition-recommendations-during-and-after-treatment
    - https://www.cancer.gov/publications/patient-education/eating-hints
- o   Exercise
    - https://www.cancer.net/survivorship/healthy-living/exercise-during-cancer-treatment
- o   Psychosocial
    - https://www.cancer.net/survivorship/follow-care-after-cancer-treatment/asco-cancer-treatment-and-survivorship-care-plans
    - https://www.cancer.net/sites/cancer.net/files/asco_answers_when_doctor_says_cancer.pdf
    - https://www.cancer.net/sites/cancer.net/files/asco_answers_anxiety_depression.pdf
- o   Reproductive and Sexual Health
    - https://www.cancer.net/navigating-cancer-care/dating-sex-and-reproduction
    - https://www.cancer.net/sites/cancer.net/files/asco_answers_fertility.pdf
- o   Spiritual
    - https://www.cancer.net/blog/2016-04/what-role-chaplain-cancer-care

Patient Health and Safety Education

Patient Health and Safety Education
- o   Provide patient education regarding infection control practices in conjunction with each new initial communication to a new patient, during their first office visit, as part of treatment planning, and reinforced with each subsequent visit. Below are examples of such health and safety information:

- Masking is required for office visits.
- Hands should be washed often with soap and water, for at least 20 seconds. If soap and water is not available, use hand sanitizer with at least 60% alcohol.
- Avoid touching your eyes, nose, or mouth with unwashed hands.
- Avoid close contact with others who are ill.
- Cover your nose and mouth with a tissue when coughing or sneezing. Discard tissue and then wash hands.
- Regularly clean/disinfect frequently used surfaces and other objects at home.
- Stay home if you are ill and avoid others.
- Encourage patients to speak to their provider about annual flu vaccines.
- Encourage patients to be proactive about the above recommendations and to call the practice prior to coming should respiratory symptoms occur.
  - o Patient education should include information regarding the practice care delivery changes in response to the COVID-19 pandemic and instructions for virtual/telemedicine visits.
  - o Patient education should address resumption of care and safety questions and concerns regarding risk of COVID-19 exposure.

Additional resources:

Common Questions About COVID-19 and Cancer: Answers for Patients and Survivors
https://www.cancer.net/blog/2020-05/common-questions-about-covid-19-and-cancer-answers-patients-and-survivors

Coronavirus and COVID-19: What People With Cancer Need to Know
https://www.cancer.net/blog/2020-05/coronavirus-and-covid-19-what-people-with-cancer-need-know

National Cancer Institute– Coronavirus: What People with Cancer Should Know
https://www.cancer.gov/contact/emergency-preparedness/coronavirus

Patient Communication Strategies for COVID-19 Conversations
https://voice.ons.org/stories/patient-communication-strategies-for-covid-19-conversations

Telemedicine

Telemedicine (telehealth, telephone E&M, virtual check-in, e-visit)
- o Identify visits that continue to be appropriate for telemedicine (e.g., COVID-positive infection, non-urgent high-risk patient population, symptom management triage – who, what, when, why, and how).
- o Identify practice visits that include a combination of in-office and telemedicine (e.g., identifying appropriate visits for telemedicine and in-office with COVID-19 precautions in place, such as new/consultation, follow-up, on-therapy, surveillance).
- o Utilize telemedicine visits to expand service capacities especially in COVID-19 surges.
- o Telemedicine visit types:
  - Patients not requiring an in-person physical exam, treatment, or in-office diagnostics.
  - Other patient visits: follow-ups, oral oncolytic treatment adherence, survivorship, palliative care, genetic counseling, support services, patient education.

- Telephonic and telehealth interactions for triage and quick assessment of patients.
- Symptom monitoring for high-risk patients.
    o Telehealth visit considerations:
        - Visit performed with audio and visual capabilities.
        - Includes visits equivalent to new or established patient visits, along with other visit types approved by Medicare, Medicaid and other third-party payers.
        - During the public health emergency, for new and established patients.
        - The patient must verbally consent to receive a telehealth visit.
    o Telephone-only visit considerations:
        - Used in lieu of telehealth visit for patients with audio-only capabilities.
        - The patient must verbally consent to receive a telephone-only visit.
    o Virtual check-in considerations:
        - A brief communication with a patient via telephone or other telecommunication modality, such as audio/video, secure text messaging, or email.
        - During the public health emergency, for new and established patients.
        - Communication should be related to medical visit within the previous 7 days and does not lead to a medical visit within 24 hours.
        - The patient must verbally consent to receive a virtual check-in.
    o E-visit considerations:
        - A patient-initiated visit via an online patient portal or other electronic means.
        - During the public health emergency, for new and established patients.

Please note that telemedicine coverage may be subject to frequent updates beyond the publication date of this guide.

Additional resources:

The American College of Physicians has created a tutorial for deploying telemedicine services.

The Federation of State Medical Boards has created a resource to track which states have modified their in-state licensure requirements for telehealth in response to COVID-19.

Additional information from ASCO regarding expanded access to telemedicine may be found on the COVID-19 Government, Reimbursement & Regulatory Updates page.

Medical Oncology

Medical Oncology
    o Patient Management (In-Office)
        - All patients who present with COVID-19 positive infection or who become COVID-positive on treatment should be placed on immediate treatment break or delay while a determination is made about next steps.
        - A request for review to start or continue treatment of COVID-19-positive patients should be considered in the context of medical necessity to start or continue treatment.
        - Only prioritized COVID-19-positive patients should be considered for starting or resumption of treatment (e.g., priority list identifies risk/benefit based on treatment

intent and urgency; i.e., some patients may be COVID-19-positive and still appropriate for treatment).
- Many patients may be appropriate to place on break for a minimum of 14 days and/or until symptom free for 72 hours and tested negative on 2 consecutive tests, 24 hours apart.
- As above, consider a flexible and modifiable hybrid model of in-office and telemedicine visits based on provider determination of patient care (both present and future).
- o Treatment Suite
  - Establish an identified area for COVID-19-positive patient treatment (e.g., outpatient, inpatient).
  - Assign dedicated staff for COVID-19-positive patients.
  - Staff scheduling should include time off for recovery and monitoring for symptoms.
- o Home Infusion
  - Oncologists have shared concerns regarding the safety and appropriateness of home infusion for anti-cancer drug administration and, generally, do not recommend it for most drugs. The decision to administer chemotherapy in this setting should be made by the treating physician in consultation with the patient after consideration of precautions necessary to protect medical staff, patients and caregivers from adverse events associated with drug infusion and disposal and risk of COVID-19 infection.
  - Oncologist providers may consider home infusion for supportive care, such as hydration and anti-emetics.
- o Pharmacy
  - Consider telemedicine for oral oncolytic agent adherence and patient counseling.
- o As practices reopen, they should anticipate the possibility of a surge in patients newly diagnosed with cancer as screening and primary care services increase. Practices may need extended hours to support patient care needs.

Additional resources:

ASCO Coronavirus Resources – Patient Care Information
https://www.asco.org/asco-coronavirus-information/care-individuals-cancer-during-covid-19

Radiation Oncology

Radiation Oncology
- o Patient Management (In-Office)
  - Per facility protocol, Patient's Under Investigation (PUI) and/or COVID-19-positive status should be verified and documented.
  - All patients who present with PUI, COVID-positive infection, or who become COVID-positive on treatment should be placed on immediate treatment break or delay while a determination is made about next steps.
  - A request for review to start or continue treatment of COVID-19-positive patients should be made in the context of medical necessity to start or continue treatment.
  - Only prioritized COVID-positive patients should be considered for starting or resuming treatment (e.g., priority list identifies risk/benefit based on treatment intent and urgency).

- Many patients may be appropriate to place on break for a minimum of 14 days and/or until symptom free for 72 hours and tested negative on 2 consecutive tests 24 hours apart.
- Consider testing for COVID status. If testing not available, physician, radiation oncologist, and infection control should determine if and how to move forward with treatment.
- Designated linear accelerator may be considered for COVID-19-positive patients, if possible.
- PUI and COVID-19-positive patients should be last appointments of the day on the machine and should remain in these time slots for at least 14 days and until after two consecutive negative tests 24 hours apart and 72 hours symptom free.
- If there are multiple PUI and COVID-positive patients on treatment, they should be treated in consecutive slots at the end of day. Facilities should conduct a thorough wipe down of all surfaces between each PUI or COVID-19-positive patient.
- Treatment visits can be performed in the linear accelerator vault or by telemedicine visits.
- Identify private changing/waiting room with a thorough wipe down being done between each patient.
- Consider a flexible and modifiable hybrid model of in-office and telemedicine visits based on provider determination of patient care (both present and future).
  - As practices reopen, they should anticipate the possibility of a surge in patients with newly diagnosed cancer, as screening and primary care services increase. Practices may need extended hours to support patient care needs.

Additional resources:

The Impact of COVID-19 on Radiation Oncology Clinics and Patients with Cancer in the United States. Adv Radiat Oncol. 2020 Mar 27. DOI: 10.1016/j.adro.2020.03.006 [Epub ahead of print]
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7118653/

Ancillary Services

Ancillary Services
- Evaluate ancillary services availability for patient care needs (e.g., elective surgery, physical therapy, physician specialists).
- Oncologist provider may consider care coordination with other services and providers related to patient facility visits and telemedicine visits.

Cancer Screening

Cancer Screening
- Healthcare facilities should follow state and local health authority declarations for resumption of other cancer care services (e.g., colonoscopies, diagnostic radiology, dermatology, dentistry, mammography).
- Some screening may be performed with distancing and masks.

o Biopsies may be performed by interventional radiologists, generally in the Interventional Radiology suites or physician's office and with use of PPE.

Surgeries

Surgeries
o The American College of Surgeons (ACS) has released a new surgical resource document, "Local Resumption of Elective Surgery Guidance," as a guide for healthcare facilities preparing to resume elective surgery once COVID-19 has peaked in their area.
o The guide outlines categories with distinct issues to be addressed before resuming elective surgeries.
o As with all other guidance in this document, this resumption of care is subject to individual state and municipal orders.

Additional resources:

Local Resumption of Elective Surgery Guidance
https://www.facs.org/covid-19/clinical-guidance/resuming-elective-surgery

Clinical Trials

Clinical Trials
o Manage current patients based on sponsor policies and in accord with agency guidance (e.g., FDA Guidance; NCI Interim Guidance for Patients on Clinical Trials).
o Continue treatment on protocol, if possible, maintaining good clinical practice.
o Consult sponsor and IRB (Institutional Review Board) with inquiries regarding deviations from protocol requirements during the COVID-19 pandemic.
o Protocol monitoring modifications may include all study monitoring being virtual visits if the trial sponsor agrees.
o Ensure access to drugs prior to patient visit scheduling.
o Resume screening and enrollment with consideration to COVID-19 exposure. Testing may be appropriate.
o Expand access to clinical trial enrollment as imaging, surgery, and ability to collect biospecimens expand safely for patients and staff.
o Consider discussion with sponsor regarding eliminating nonessential tests needed for study enrollment and remote laboratory testing.
o Contact Principal investigator and/or trial sponsor to get discuss anticipated protocol deviations during the pandemic.

Additional resources:

Early Impact of COVID-19 on the Conduct of Oncology Clinical Trials and Long-Term Opportunities for Transformation: Findings from an American Society of Clinical Oncology Survey
https://ascopubs.org/doi/full/10.1200/OP.20.00275

FDA Guidance on Conduct of Clinical Trials of Medical Products during COVID-19 Public Health Emergency

https://www.fda.gov/regulatory-information/search-fda-guidance-documents/fda-guidance-conduct-clinical-trials-medical-products-during-covid-19-public-health-emergency

The National Cancer Institute (NCI) has issued guidance on the NCI Central Institutional Review Board (CIRB) including advisories and FAQs.
https://www.ncicirb.org/content/nci-cirb-information-about-covid-19

Other Helpful References

- o Centers for Disease Control and Prevention: Information for Healthcare Professionals about Coronavirus (COVID-19)
  https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html
- o Centers for Medicare & Medicaid Services (CMS) Recommendations Re-opening Facilities to Provide Non-emergent Non-COVID-19 Healthcare: Phase I
  https://www.cms.gov/files/document/covid-flexibility-reopen-essential-non-covid-services.pdf
- o Ethics and Resource Scarcity: ASCO Recommendations for the Oncology Community During the COVID-19 Pandemic
  https://ascopubs.org/doi/pdf/10.1200/JCO.20.00960
- o Safety at the Time of the COVID-19 Pandemic: How to Keep our Oncology Patients and Healthcare Workers Safe. JNCCN. Online publication date: 15 April 2020.
  DOI: https://doi.org/10.6004/jnccn.2020.7572

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Flavio Rocha, MD, FACS
Gabrielle Rocque, MD, MSPH
Trevor Royce, MD, MPH
Joel Saltzman, MD
Michael Savin, MD
Dan Sherman, MA, LPC
Lawrence Shulman, MD, FASCO
Samuel M. Silver, MD, PhD, MACP, FASCO
Pam Soliman, MD
Alec Stone, MA, MPA
Preeti Sudheendra, MD
Julie Sussi, MA
Piyush Srivastava, MD

Chee-Chee Stucky, MD
Sana Al-Sukhun, MD, MSc
Ashley Sumrall, MD, FACP
Elitza S. Theel, Ph.D., D(ABMM)
Christian Thomas, MD
Charlotte Tremonti, RN
Praveen Vikas, MD
Victor M. Villalobos, MD, PhD
Daniel Wakefield, MD
Jeffery C. Ward, MD, FASCO
Kimberly Woody, MSN, PPCNP-BC
Robin Yabroff, PhD
Dan Zuckerman, MD, FASCO