COVID-19 and Cancer Updates

COVID-19 Pandemic Education

First Quarter 2021 Panel

The Continued Use of Telemedicine in Cancer Treatment

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Dr. Jack West: Hi, I'm Dr. Jack West and I'm a medical oncologist, an associate clinical professor with a focus on thoracic oncology, working at the City of Hope Comprehensive Cancer Center in the Los Angeles area. And I'm happy to be joined today by two of my colleagues who are also on the board of directors for GRACE, Global Resource for Advancing Cancer Education. I serve as the founder and president, but I'd like to welcome two of my colleagues to introduce themselves. If you can, maybe I can start with you, Jared, if you can.

Dr. Jared Weiss: Sure. I'm Jared Weiss. I'm also the thoracic oncologist at University of North Carolina.

Dr. Benjamin Levy: Yeah, Ben Levy. I'm a thoracic medical oncologist at Johns Hopkins School of Medicine, and primarily based out of Washington DC.

Dr. Jack West: Great. Do you, Ben, have a sense of how either you personally or Hopkins as an enterprise that is a few different campuses, and settings, are going to want to use telemedicine? Because I think in some of the numbers that I've seen at different institutions, there was a rapid surge of use when live in-person visits dropped off a cliff

in March of almost exactly a year ago. So, we're recording now in March, 2021, and it's been almost exactly a year since we suddenly stopped and had to adapt. And for a period of time four, six weeks, sometimes a little longer, the virtual visits were almost the only way to do it, and it was really learning on the fly. And then some of the numbers that I've seen are in the total number of visits in person and televisits have been rising, but are not up to where they were a year ago and, or just before a year ago.

And telemedicine has dropped off from its frantic use by necessity, but is still a component maybe 20%, 20, 30%, but I'm sure it depends on your patient population. I think Jared brings up a great point. That depends on how badly you need to do an exam versus, and also your patient population. Do they have the bandwidth literally? Do they have the hardware? Do they have the techno how? Because, you know, I think if you're seeing a lot of younger patients with EGFR mutations, who would otherwise have to take a, you know, a half day or more off of work, just to confirm, they're still doing great. That's a tailor made for telemedicine. So, what's your, you've been, and what's Hopkins aspire to long-term beyond the time that we have to do it?

Dr. Benjamin Levy: Yeah. I think you hit on some great points in the answered a lot of the questions. So, we actually, I do have the data on this in terms of across the enterprise as of last week, and there's a lot of geographic variability, as you mentioned, and that geographic variability in telemedicine utilization is contingent on sort of the patient population we serve. So, we look at a, you know, an operation in DC and my practice has a large number of EGFR and ALK and driver mutation. You know, the telemedicine utilization for us and not only me, but for other disciplines is around 25 to 30%. You look at a campus like JH a little bit different patient population, a little bit more of a mixed socio-economically. And the telemedicine utilization is around 10 to 15%. So, it really depends.

It's you know, it gives you how, what our catchment area is it's varied, but certainly there are differences based on the, where we are located. You know, so I think that the question still remains. You ask a question that I've asked to leadership on these committee calls we have is, you know, what is the overall vision moving forward? How will this be utilized? What are the financial implications? What is the patient, you know, coordination implications. I mean, these are, unfortunately some of the things we have to ask when we're talking about leveraging telemedicine post pandemic, I think it's. So, Hopkins has not really had a formalized decision on this and how it's going to move forward. I certainly think there's going to be an opportunity to keep it in play. I think ignorant to think that there's not going to be a role for telemedicine for some of our patients.

But I don't know how this will shake out. And if there's going to be a bold statement from any institution that, you know, we need to do X amount of telemedicine. I mean, I

asked this question on the call last week with our institution and the leaders of each of the sites is, you know, what is the message to the physicians at our sites? Is it bring patients back now it's safe or is it, you need to see X amount of telemedicine? I don't think there is a right message here. I think that telemedicine will have a play. I will tell you that I'm making every effort to bring patients back. I have found challenges with telemedicine that relate to coordination of care that I alluded to before with multiple patients, but I think others may find use in it. So that's kind of where we are right now.

Dr. Jack West: That's interesting. I was going to, I'm interested in your, both of your impressions about just what you perceive, what you hear from colleagues. Cause my sense, it's just quite varied that there are many who find it, they have less support than in the live setting. And there's more moving parts, more cracks for things people to fall through in terms of follow-up, etcetera. And as much as I'm a fan of the concept, I think that the reality is that we have had, you know, decades to centuries of time to work on our bedside manner. And just how you do in person medicine. We were thrown into the deep end very quickly and how to do telemedicine. And we haven't perfected any of this. Our website manner is still being worked on in terms of, you know, look at the camera and don't answer email while you're talking with the patients.

And but also just you know, the platforms are not infallible right now, but I also think that doesn't mean that they won't get better because this is a very quick steep, potential learning curve. And, you know, we haven't had much time to optimize the user experience, but I'm just interested. Do you sense that most of your colleagues, because Jared, I think you're also somebody who, if they have their druthers would strongly prefer to have the interpersonal connection in the room? Do you feel that that, that is reflective of the vast majority of your colleagues or that there's an enormous spectrum of telemedicine favoring folks versus those who are more traditionalist about, you got to palpate the spleen?

Dr. Jared Weiss: You don't need to palpate the spleen. In fact, most of us couldn't palpate a spleen even with an enlarged spleen, let's be honest. And when we PET scan our patients every 20 minutes, it's okay. I was laughing while you were speaking earlier, just so you don't think I'm laughing at you, you were talking about, you know, getting this all down and not checking email. Just on Monday, I was on with a patient, fortunately, a patient I know, well, and my twins came and sat on my lap, said hello and asked if they could have a snack. And you know, this is part of doing telemedicine at home. You know, it can be as therapeutic as it can be disruptive, but that's why I was laughing.

Dr. Jack West: Is that a bad thing to humanize, because I think that one of the arguable upsides of this, is you get to see the patient in their home environment, you learn about them. And also, I think we touched on maybe in some prior discussions right now, if we're still

restricting, who can come in with them being able to have their family around them at home versus nobody else. And they're wheeled in a wheelchair by some stranger, I think is suboptimal, but let it get back to you.

Dr. Jared Weiss: So I really agree on, there are advantages here, right? In this comic example, maybe I didn't use as much as I meant to, but I didn't use my patient. Right. And I will shamelessly explain to children [inaudible] cancer patients. I I've done it before. I'll do it again. And you know, it actually, wasn't a bad thing in this situation, but there's another upside that I want to comment upon. Which is that you know, we were talking about volumes before. Like Dr. Levy, I carefully track the volumes in my group. I do it on a monthly basis compared to year before, and we're actually compared to pre COVID. And in diving into what drives that the difference is an increase in video based consultative services. And so I live in a state that is quite large where, you know, patients may be three hours from an academic center.

And what I'm seeing from my community partners is that more patients, a higher percentage of lung cancer patients are getting an academic console. And I think that's a good thing, right? So I saw a patient in practice where, you know, that was described as having EGFR. Had been on osimertinib, as frontline. Was described as having a molecular with no actionable, nothing actionable there, but there was C797S without T790F. that's just one example, but you know, maybe the next patient, I have a trial for them. And the patient after maybe there's a standard of care recommendation, but if you believe that we have something legitimate to offer our community partners and our patients in an academic consultative practice, then at least having one offs or occasional touch points is a beneficial thing. And not every patient, even pre pandemic wanted to drive hours to get to one of us.

There are many people who might benefit from that, but weren't going to do it before that. Now that we're in a video era where that's available are doing it. There are barriers to this, there are people with bad internet, but there are solutions around that. I had a consult a few weeks ago that was a poorer patient, but did have a smartphone. And they were sitting in the parking lot of their local library having a video consult now it's not elegant. I'm sure nobody from UNC, whatever, let me put that on marketing material or as a suggestion, but do I think that was a good thing for that patient? I do. So I think the evolution of the availability of video medicine, not only for our mutated patients who have bandwidth and less need for exam and such, but also for some patients who wouldn't have hit the threshold to get to us.

But might benefit. I see that as a permanent advantage, a legitimate silver lining that COVID has brought us in introducing work, the video era now, before getting online here, the three of us were talking about the issues of licensing and cross state

movement. And I think all of that really needs to be addressed and solved if there's, if there's a patient in North Carolina who wants a consult from Jack West, I think that should be a thing. I think that patients should be able to do that. I think there's a potential advantage to it in terms of care. And I think it's consistent with our capitalist values as a country, whatever you believe in them. And those are kind of our core values. So I think we need to address some of these licensing issues to give patients access to consultative services wherever they so choose.

Dr. Benjamin Levy: I just want to piggyback one thing. I agree with Jared fully. I think he elegantly stated some of the advantages that what I call community outreach of telemedicine or expanding our area that and our expertise. You know, not only for just routine scenarios where there may be questions, but we've had some success ramping up our clinical trial portfolio in reaching clinical trials to some of these patients who would otherwise not travel. And at least you can't sign the consent on the first visit, although we're working on that.

Dr. Jared Weiss: But you can get them to know that it exists right. Presented as another.

Dr. Benjamin Levy: Exactly. Get them to know that it exists. And we've had some success recently, and it's been a win for the patient. And, you know, some of this is a political navigation with the primary oncologists, you know, to make sure that they are still involved. When you're talking to patients that you're seeing from 90 miles away about a trial that requires them to come in every other week or every three weeks. But you know, this is, I think one of the advantages that I think will stick around. It's not only a win for good patient care. It may be a win for, you know, enhancing the accrual on a clinical trial.

Dr. Jared Weiss: I agree really strongly. I mean, right, there are a lot of patients who get diagnosed inpatient at UNC and the right thing for their values is local care. And I happily refer them to get their Pem carbo, pembro locally. There are other patients who are distant, who want to at least know what all of their options are. And I think, you know, not every patient, a trial isn't right for every patient, but if they're eligible, every patient should at least know the options that exist for them. So they can consider it in parallel with their local standard of care options.