

July 30, 2020

Roxanne E. Jensen, PhD
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9609 Medical Center Drive, Rm. 3E512
Rockville, MD 20850

RE: Request for Information (RFI) NOT-CA-20-080: Seeking Stakeholder Input on Scientific Gaps and Research Needs Related to Delivery of Cancer-related Care via Telehealth

Dear Dr. Jensen:

On behalf of the American Association for Cancer Research (AACR), the first and largest scientific organization in the world dedicated to the prevention and cure of all cancers through research, education, communication, collaboration, advocacy, and funding for research, we sincerely thank the National Cancer Institute (NCI) for the opportunity to provide feedback in response to the request for information on scientific gaps and research needs related to the delivery of cancer-related care via telehealth. The membership of the AACR includes more than 47,000 basic, translational, and clinical researchers; population scientists; other health care professionals; and patient advocates working in academia, government, industry, and other cancer organizations in 127 countries. We deeply appreciate the NCI's interest in building on the dramatic uptake of telehealth due to the COVID-19 pandemic to better serve patients with cancer, whose survival depends on the continuity of access to care. The expansion of telehealth will help patients with cancer by facilitating regular communication with providers and enabling access to timely information about their care.

At the recent [AACR Virtual Meeting: COVID-19 and Cancer](#), experts from across the spectrum of scientific and medical disciplines came together to present the most current data and discuss pressing issues at the intersection of these two diseases. Challenges, opportunities, and lessons learned during the pandemic around telehealth were enumerated in various sessions and are outlined below:

Addressing inequalities in access to, acceptability, and/or receipt of telehealth services

Telehealth-related inequalities will differ by setting, whether that means limited connectivity, financial hardships, language barriers, lack of familiarity with the internet, or combinations thereof. Regardless of location, however, healthcare inequalities including those around telehealth disproportionately affect Black, Latino, and Native American communities. When designing and implementing telehealth services, care must be taken to account for the specific needs of the populations to be served. The inclusion of community leaders and educators in the design and rollout of telehealth and mobile health services could help identify potential impediments to adoption and increase use by those who would benefit most.

Using patient navigators early in the care setting to assess hardships, financial and otherwise, will help providers determine and work to meet patients' needs. Hospitals and health systems should anticipate that hardware (e.g., smartphones or tablets) will be needed for many low-income patients and plan accordingly to acquire serviceable equipment for distribution. Refurbished smartphones or single-purpose "burner" phones, for example, can be obtained for roughly \$100 per phone. In rural areas with limited cell and broadband coverage, patients may not be able to use even these devices. Therefore, telehealth programs in these areas

should be set up to accommodate voice-only (no video) visits, and physicians should be trained in administering care using this approach.

Creating a simple, streamlined portal for accessing the telehealth platform is key for increasing acceptability. The fewer downloads needed, the fewer clicks to get to the right page, the better. Additionally, designers should account for use by older patients who may have deteriorating sight and/or motor function, and work to incorporate fewer and bigger buttons/targets to push, bigger font, and brighter and more contrasting colors into the platform. Finally, ensuring compatibility of mobile health platforms with multiple operating systems (for example, Android is used by more mobile devices than iOS) will increase the usability and reach of telehealth services.

Using telehealth services to reduce inequalities in access to and/or receipt of cancer-related care

The Veterans Health Administration has a long history of using remote visits to provide Veterans with access to medical specialists. The cancer field could adopt a similar strategy, allowing patients to utilize telehealth services to see oncologists and specialists for second opinions on diagnoses and even some treatment-related visits. To further enhance access, internet-enabled kiosks could be set up in primary care settings such that patients could set up virtual visits with oncologists while having blood draws for laboratory work and other low-risk procedures done close to home, reducing travel burdens. Another strategy would be to involve multi-disciplinary care teams in telehealth visits just as is done for in-person visits to maximize the value of these visits for both patients and providers.

Additionally, even accounting for potential inequalities in access to equipment and services, telehealth goes a long way toward alleviating disparities in cancer-related care for those lacking access to transportation and/or those for whom going to an in-person visit would cause undue burden. For patients with cancer who don't own a car and don't feel comfortable using public transportation, don't live close to major medical centers, don't have alternative means of child care, and/or cannot take time off work, telehealth offers an opportunity to initiate or continue life-saving care when in-person visits are not possible.

Improving the patient care experience and patient-provider communications using telehealth

Seemingly small behaviors can have a huge impact on patients' telehealth experiences. When providers take care to look into the camera when talking, instead of at the screen, patients are more likely to report satisfaction with their care. Providers should also prepare for and take notice of poor internet connections, making efforts to talk more slowly and remain patient in the face of service disruptions. Interpreters should be brought in when patients have limited English-speaking and comprehension abilities, but providers should remember to talk to the patient (i.e., the camera) and not the interpreter. When possible, family members should be encouraged to take part in telemedicine visits as this can increase comfort levels for patients who are less facile using the internet or who have difficulties understanding and speaking English. Having family present to ask questions and advocate on the behalf of patients could help improve health outcomes.

Improving patients' knowledge and skill in using telehealth services

Now that clinics and physicians' offices are beginning to reopen, providers should ask each patient seen in-person about his/her interest in using telehealth services for future visits. Office staff could then guide him/her through the set up—helping to create an email address and log on information, and to download any apps—and the use of the platform. Having interpreters, family, and/or caretakers participate in these sessions would help address issues with language comprehension and familiarity with technology, and increase uptake among older patients and in minority and/or immigrant communities.

Using telehealth to improve health outcomes (e.g., clinical outcomes, patient-reported outcomes, and/or healthcare utilization)

Employing risk stratification, setting guidelines for which patients are at the greatest risk of harm by not having an in-person visit, will go a long way to improving health outcomes for both cancer and COVID-19. Telehealth can likely be safely utilized for symptom evaluation and management and for survivor visits. This list will expand as more types of at-home physical exams and sample collection become accepted. However, patients with cancer undergoing active treatment should continue those treatments in person unless alternative arrangements can be made.

Incorporating wearable devices and tracking apps for recording vital health information into the telehealth experience will also help improve health outcomes. This would give providers access to information that could prompt additional questions and aid in decision making during virtual visits. For patients with certain conditions or taking certain drugs, apps to facilitate tracking of condition- or drug-related symptoms or side effects—through questionnaires, text boxes for patient-reported outcomes, or other mechanisms—would help offset the limitations of not doing physical exams. As mentioned above, designing a simple and intuitive telehealth platform that houses all elements of the care experience will be key to enhancing uptake and utility.

Finally, recent changes to the conduct of clinical trials, necessitated by the COVID-19 health crisis, that accommodate aspects of telehealth and decentralized trials should be adopted permanently to improve outcomes for individual patients and the larger cancer community. Making available remote consent processes, video follow up visits, symptom capture apps, home delivery of study drugs, and utilization of local labs for blood draws to all eligible patients will greatly increase clinical trial access, enrollment, and the information gained.

Identifying and understanding provider preferences for in-person vs telehealth delivery of cancer-related care

In a survey of providers in a managed care consortium (Kaiser Permanente Northern California) on their utilization and perceptions of telehealth services, medical oncologists reported dramatic decreases in office visits and concomitant increases in telephone and video visits from December 2019 through May 2020. They signaled high satisfaction with the advantages conferred by utilizing telehealth to care for patients (e.g., staying on schedule, more autonomy) and many indicated they would maintain or increase their use of telehealth into the future. The negative aspects of telehealth use identified by medical oncologists included the requirement of an internet connection and device for both patient and provider, the lack of staff support, and, in some cases, the need for in-person visits even after the virtual visit. Of responding oncologists, roughly half thought that new cancer diagnoses and end-of-life discussions should only be conducted in person, and one-third thought palliative care and clinical trial enrollment should be done in person. Half of the respondents thought video visits (but not phone) would be acceptable in all these situations. Authors of the survey are currently determining whether and how they could assess patient views across the same/similar measures they used for providers to have data on that valuable viewpoint.

Identifying emerging and impactful research questions in cancer-related telehealth

Important research questions to be addressed include:

- How can we compare and contrast the effectiveness and relative impacts of different telemedicine mechanisms (i.e., telephone visits, video visits, email communication)?
- Do healthcare apps and the daily monitoring they facilitate improve health outcomes?

- What is the best frequency with which to administer surveys through health apps, how long they should be, and what features improve response rates?
- How best to integrate caregivers into telemedicine visits, including mechanisms for education, and how to assess effects on patients' health outcomes?
- How do stress levels of providers using telehealth to see some/all patients compare to those of providers who eschew telehealth, and the same for patients?

The AACR is eager to work with the NCI to research and implement innovative changes to cancer care, including telehealth, that will transform patient access to treatments. If you have questions, please contact Jon Retzlaff, MBA, MPE, Chief Policy Officer and Vice President, Science Policy and Government Affairs for the AACR at jon.retzlaff@aacr.org.

Sincerely,

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