Scott Redding: Welcome to the Three Ps of Cancer Podcast where we'll discuss prevention, preparedness, and progress in cancer treatments and research, brought to you by the University of Michigan Rogel Cancer Center. I'm Scott Redding.

We're here with Associate Chief Clinical Officer for cancer services, Dr. David Smith, to talk about the changing clinical care for patients that has been happening for a while. But due to the pandemic, has sped the changes out. Dr. Smith is a medical oncologist on the urologic oncology team at the Rogel Cancer Center and has been practicing at Michigan Medicine for more than 20 years. Welcome Dave.

Dr. David Smith: Thanks, Scott.

Scott Redding: Let's start with, how has clinical care changed with the COVID pandemic?

Dr. David Smith: Well, I think we need to break that down into two big areas. One is what we're doing in terms of keeping people safe and what we're doing to make sure that people get the care they need. The first part is actually a pretty straightforward now 10 months into this pandemic. We are working hard to make sure that we maintain our social distancing, that everybody wears masks, that we've got effective cleaning of our areas in place and in doing so, I think we've demonstrated that we can certainly deliver care safely for cancer patients in the cancer program at Michigan Medicine.

The second part of that is how the pandemic has really accelerated consolidation of medical care across the state. The first of those is an emphasis on virtual care, and that also plays into our safety measures. We're trying to do as many visits by our virtual care platform as we possibly can so that we can keep people safe in their homes rather than having them come in to the cancer center. That said, a significant number of our patients still need to come in and to be seen and to receive treatment.

The second part of how cancer care is changing is we really are trying to make sure that patients get the care they need in the fewest number of visits and see the doctors and nurses that they need to see on those visits. So we're emphasizing the multidisciplinary nature of the care and working hard to begin transforming our clinics from really single specialty to multidisciplinary wherever we can. Now that doesn't mean every patient needs to see a surgeon, a radiation oncologist, and a medical oncologist. But in the cases where that is true, we're trying to make that easy and improve the access to those complex cases. So those are really the changes that are underway right now in cancer care.

Scott Redding: You mentioned something that I'd like to maybe explore a little bit more. You mentioned single specialty to multi-disciplinary in the clinic setting. Does that mean that a patient would be seeing one type of specialist, obviously with a

single specialty, but does that mean that they might be seeing physicians that see multiple cancers or are they still seeing specialists around that cancer type?

Dr. David Smith: Actually, it's more the specialists around the cancer type. Let me give you an example. If someone is diagnosed with a bladder cancer, the current best treatment for muscle invasive bladder cancer in patients who can tolerate it is to first give chemotherapy, it makes all kinds of theoretical and practical sense to do that. Patients will tolerate the chemotherapy better before they have their bladder out and they will also treat the disease that is most likely to cause them trouble down the road, which is disease that's spread outside the bladder at the earliest possible time. So in those situations, what we try to do is arrange for patients to see both the urologist and the medical oncologist, wherever possible.

There are other situations, for instance, prostate cancer, where it makes more sense for them to see a radiation oncologist and a urologist in the same visit. And the medical oncologist really has no role. So we need to tailor that to the specific disease that the patient has whenever we can. What we're trying to do is to make it as convenient as possible for the patient and to get them in as early as possible. So they're not sitting at home wondering how am I going to get this cancer taken care of?

Scott Redding: So you kind of touched on a little bit, but can you explain more about what an overarching multidisciplinary clinic might look like?

Dr. David Smith: Probably the best example, Scott is offered by our breast care center, where if a woman is diagnosed with breast cancer, she will first come in and be evaluated and we will gather all the information about the cancer that she's been diagnosed with. That information is then presented at a multidisciplinary conference where based on a review of the pathology, the radiology, and what we at that point know about the woman, a recommendation will be made as to how to proceed. Following that conference, then those physicians who are going to deliver the care, go and meet with the woman and make a recommendation and explain why the plan of care has been recommended and how it would be implemented. So in that situation, the woman may meet first with a surgeon, then with a radiation oncologist who may provide additional care and a medical oncologist, who then would guide any systemic therapy or follow up care. That's sort of a classic example of a multidisciplinary approach to a malignancy.

Scott Redding: And does having access to a multidisciplinary team like that, does that improve outcomes or improve care for patients?

Dr. David Smith: Well, the data would suggest that patients treated in this fashion do have better outcomes, but I'm going to be honest with you. That's hard to prove because in most situations you're going to be able to get access to all of those opinions, but it may not be in one single setting. The true benefit of this though, is in the

patient experience that patients are taken care of in as quick and as thorough fashion from the beginning as possible.

Scott Redding: You've talked a little bit about how the care has changed during and the goals with making sure cancer patients are getting what they need during this pandemic. Before the pandemic started, how was cancer care in the process of changing for patients?

Dr. David Smith: Probably the biggest change is that we are working hard to try and deliver care much closer to the patient's home. So in many ways, the model of cancer care for many years has been that the patient travels to the cancer center and gets their treatment there. That's not a great experience for a lot of patients who have to spend a lot of time in the car, who have to deal with the side effects of therapy while they're riding back and forth. And so one of the things that is emerging is an emphasis on trying to begin providing care much closer to the patient's home, so that we're really taking the care to them instead of bringing the patient to the care. That is going to be a point of emphasis going forward. And I think that the pandemic has actually accelerated that process. I think this is a good thing.

There's really not a compelling reason that a patient who is going to get standard of care chemotherapy, but lives near one of our regional sites should not actually get that chemotherapy at the regional site, provided that it's safe and we can provide the same level of care at the regional site. We are working hard to try and make that happen and I think we're having some success in that.

Scott Redding: In reality, your cancer care is more than just a building.

Dr. David Smith: Absolutely. The cancer center is more than just a building. In fact, the cancer center is really sort of an organizing entity that extends our cancer care to all of the sites at which we'd like to deliver it. So right now, though, if you go to the Brighton Center for Specialty Care, you'll see a sign that says Rogel Cancer Center. So that's the Rogel Cancer Center at Brighton Center for Specialty Care. And that is really our goal is to have it be the Rogel Cancer Center at any of our locations where we deliver cancer care.

Scott Redding: How else is clinical care changing for patients and the staff that they see?

Dr. David Smith: Yeah, I think that the next level of that is a little bit less tangible if you will, in that one of the things that we're working hard on is trying to facilitate how we can improve care at locations that are distant from Ann Arbor. So for instance, we are right now working very hard to help create the Cancer Network of West Michigan, which is a collaboration between Metro Health, St. Mary's in Grand Rapids and Mercy Muskegon. And in that collaboration, we're trying to bring together a network of three hospitals to raise the level of cancer care in West Michigan. We will do that by creating specialty oriented care organized around

this multidisciplinary concept. Now you might say, well, why do we want to create something that competes with us in West Michigan?

Well, the idea here is that we're not going to compete. What we're trying to do is improve the care for patients who live in West Michigan and provide support for Michigan Medicine to do that. If we're able to do that, I think will improve the level of cancer care across lower peninsula Michigan. From there, we can extend it further and have affiliations with other hospitals within the region to really work on providing excellent care across the board. What we'll do then is those patients who need to come to Ann Arbor can be cared for here in Ann Arbor, but wherever possible, we'll try to deliver care closer to home. So it's an extension of the same idea that we're using with our regional sites, but here it's a little bit sort of less of our hands on and more of our trying to help and influence care at those sites.

Scott Redding: Obviously you've talked a little bit about what's happening moving forward, but how do you see the future of clinical care once this pandemic is over?

Dr. David Smith: That's a great question. It's hard to see past what's right in front of you. And when you've been dealing with something for 10 months, it seems to be all consuming it. I mean, between rolling out the vaccines right now and dealing with the patients with COVID in the hospital, it seems to take all our time, but the bottom line is that going forward, we will have improved access for patients because we've learned a lot from the pandemic. We've learned how to use virtual care, we've learned how to deliver care outside of our own cancer center building, in ways that we frankly knew were coming, but hadn't thought through and thought possible. And the pandemic has pressured us in ways that has forced us to adapt. And we will have learned a huge amount about how we deliver care.

So my guess going forward is that we will see increasing numbers of patients taking care both with cancer and with other diseases in our regional sites. And what we'll see is that the patients who are coming to Ann Arbor are those who really do need to come Ann Arbor to get the level of care that we provide here. That doesn't mean that those who are cared for in the regional sites will be getting a lesser level of care. It's just that they will get the level of care that they really need, and they'll get it in their communities. I think that is what's going on in most health systems across the state.

Scott Redding: I want to go back for a second as we talked about multidisciplinary care, and we talked about the care delivery with seeing the different specialists and trying to streamline those clinic visits. What other avenues are there? So maybe a patient doesn't see all the specialist at a visit, but do all the specialists review and look at a patient's case before a treatment option is determined?

Dr. David Smith: That's a great question. And it really comes down to sort of the individual situation. In those unfortunate cases where we have a patient whose cancer has already spread, or who is coming to us for a second opinion, having received

their surgery or radiation elsewhere, then no, we would not necessarily present every case to the multidisciplinary group because the patient gains nothing from, at that point, seeing another surgeon or having a radiation oncologist talk about the treatment of their primary tumor, if that treatment's already been done. In that situation, they might see a medical oncologist alone. But there are situations then where the medical oncologist, if there is a need for consultation with a radiation oncologist or a surgeon, will either pick up the phone or send an email or send an in basket message in our electronic medical record to ask the other specialist to take a look at it.

Same thing happens with patients who initially see a surgeon and then are not surgical candidates. They'll often be referred to medical oncology or radiation. So we do work hard to have coordination of the care. Is a true multidisciplinary consultation on the right thing for everyone? No, it's not. There are certain situations where all that does is slow down the patient getting the care they need. And so we've developed pretty clear algorithms for who as a general rule needs to go to see which type of physician. Are those written in stone? No they're not, we will always make exceptions if there are the possibility of benefiting an individual patient.

Scott Redding: Can you talk a little bit more about kind of what that algorithm might look like or what some of those determinations might be? I know you mentioned about if someone has a recurrence or an advance answer.

Dr. David Smith: Sure. Let's take for an example, a patient with colorectal cancer. Often those are found and are localized and all that patient really needs is to have the cancer removed. And then often they will see a medical oncologist for an opinion as to whether they should have agiment chemotherapy. That is a patient that typically is going to take the route of seeing the surgeon, probably seeing the surgeon alone initially, and then being referred to medical oncology after the surgery.

Contrast that with the patient with metastatic disease to the liver, which is the most common place that colorectal cancer spreads. That patient will get a multidisciplinary consultation for several reasons.

Number one, you need the surgeons who deal with the primary lesion in the colon, but you also then need a surgeon who would typically operate on the liver lesions, because there are some patients who can be cured by having their liver metastasis resected.

Similarly, that patient may need a consultation early with a medical oncologist because the medical oncologist may be able to give what's called neoadjuvant chemotherapy, which would shrink those liver lesions and make the surgery both easier and more effective.

Finally, in the case of rectal cancer, which is really a different disease, you would use all three modalities. You would use radiation in combination with chemotherapy first and then surgery to take care of the disease.

So it really depends a lot on what the disease is, number one. What the extent of disease is, number two. And how the patient wants to approach it. That's always the most important factor in this.

Scott Redding: One thing that comes up quite often when it comes to treatment for patients is clinical trials. And since we started this off talking about COVID, how has COVID affected clinical trials or has it helped bring more awareness to patients to consider?

Dr. David Smith: So quite frankly, the pandemic has been a disaster for cancer therapeutic clinical trials. We've had to basically recreate an entire infrastructure with staff working from home, with trying to keep patients away from the clinical setting, where they would be exposed to COVID and in doing so, we, in essence, shut down the clinical trial operation in the early part of 2020.

The good thing, if there is a good thing about this is that it's forced us to create new pathways, which as we emerge from the pandemic, I think are going to make it easier for patients to access clinical trials and for us to get those clinical trials available to patients in a much wider scope than just coming to Ann Arbor. So for instance, we can now talk to patients about clinical trials, provide them information and obtain consent through a virtual process, which we never had before. Clinical trials still require a time commitment on the part of patients, but it is been modified significantly. And it's not a nearly as onerous a task in some ways, as it was before, to participate in a clinical trial. Again, as we go further out to the regional sites to deliver standard of care, we will be extending that clinical trial infrastructure to improve access to clinical trials for all patients with cancer.

Scott Redding: Would that just be at our regional sites? Or would that include as time moves on into some of the cancer network and or affiliates as well?

Dr. David Smith: Ideally, yes. Unfortunately, there are a number of sort of regulatory hurdles we have to get over because these experimental drugs are very tightly regulated by the FDA as they should be so that we can maintain the trust and in the safety apparatus, and to make sure that the trial is conducted properly. As we learn how to extend that infrastructure into networks, I think this'll be easier. But right now, our focus is really at the regional sites to begin trying to at least provide access. Now, even some of the patients who are the regional sites, if their clinical trial that they're participating in has requirements for certain measurements or certain investigational drugs, may need to come to Ann Arbor to get those. But we're working hard to try and limit that. And also trying to identify trials that can actually be conducted at the regional sites.

Scott Redding: I really appreciate the time. I think this has been really informative of how we're taking something that's not the greatest with a pandemic and being able to shift care that it can be more beneficial. As we wrap up, is there anything that you want to make sure that people walk away with from this talk?

Dr. David Smith: I think that there are really two things. One is don't ignore the signs and symptoms that you've been taught as warning signs of cancer. If those are occurring, you need to get in, see your physician. If you can't get into your physician, give us a call and we'll try and figure out a way to get you in at Michigan Medicine.

The second part of that is that clinical care is ongoing and we're using some of the lessons in dealing with a pandemic to try and improve it. And that we will emerge from this with a continued emphasis on providing the best possible care for patients.

Scott Redding: Great. I really appreciate it. Thank you very much.

Dr. David Smith: Thank you, Scott.

Scott Redding: Thank you for listening and tell us what you think of this podcast by rating and reviewing us. If you have suggestions for additional topics, you can send them to cancercenter@med.umesh.edu or message us on Twitter at UM Rogel Cancer. You can continue to explore the Three Ps of Cancer by visiting rogelcancercenter.org.