Ontario Health
Cancer Care Ontario

UHN Princess Margaret Cancer Centre

Pandemic Planning Priority Classification for Patients with Cancer

	RADIATION	SURGERY	MEDICAL	SUPPORTIVE CARE
PRIORITY A DESCRIPTION	CCO Priority Categories 1 and 2 All emergency and urgent patients where alternative management to radiotherapy is not possible, Patients with rapidly progressing, potentially curable tumours. Patients already on treatment.	WTIS Priority Categories 1 and 2 and some Priority Category 3,emergent and very aggressive tumours. Patients in whom a delay in surgery would result in either an immediate threat to life or limb, or would significantly alter the patient's prognosis.	Those patients being treated who have aggressive tumours. Patients with life-threatening situations. Some patients already receiving treatment.	MOT Priority Emergent or OHPIP Priority Level Emergent cases: Patients who are deemed critical, whose condition is immediately life threatening. Their immediate need is greatest and Regional Programs must find ways (either within the geographic area of the pandemic or elsewhere) where treatment can be instituted or continued expeditiously.
PRIORITY A EXAMPLE	Patients with cord compression not amenable to surgery would need to be treated but patients with bone pain might be able to be managed temporarily with adjustments to pain medication.	Patients with obstructions, bleeding or perforations requiring immediate surgery. Other patients would be those with a narrow window of opportunity for definitive surgery, such as those who have been on neoadjuvant protocols. A significant delay for the neoadjuvant patients could negatively impact on their outcome by allowing for recovery of residual cancer and thus losing the benefit	Some leukemias, lymphomas, CNS, or transplant. Leukemic leucostasis, or medical emergencies such as febrile neutropenia and hypercalcemia.	Palliative Care • Patients with select ESAS scores ≥7 (pain, nausea or shortness of breath) • Patients on or requiring CADD pumps, methadone or other interventions requiring specialist palliative care orders • Patients exhibiting signs and symptoms

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		invested in the neoadjuvant approach.		of possible opioid toxicity • Patients with symptoms suggestive of an oncologic or non-oncologic emergency (e.g. spinal cord compression, bowel obstruction, SVC obstruction, PE, catastrophic bleed, refractory terminal agitation) Psychosocial Oncology • Active suicidal ideation • Delirium
	RADIATION	**SURGERY**	**MEDICAL**	**SUPPORTIVE CARE**
PRIORITY B DESCRIPTION	CCO Priority Category 3 All other patients with cancer needing radiotherapy. Within this priority level, subcategories would be determined using the local priority methodology (as described above). Patients should be followed by telephone where possible	WTIS Priority Category 3 and some Priority Category 4 tumours. Patients for whom a delay of <4 weeks from target would not be anticipated to impact significantly on survival or outcome	The majority of patients requiring chemotherapy will be priority B. For patients starting therapy, recognizing that there are little to no data supporting long delays, this will be a judgement call for each patient. Patients already receiving therapy will need to be assessed as to whether they require	MOT Priority -Urgent and Semi- Urgent* or OHPIP Priority Level Urgent cases. Patients who are deemed urgent and who need service within 14 days. It may be possible to defer these services for a few days, but not for the length of a pandemic wave.

	to ensure they have not progressed to Priority A.		ongoing treatment and should be considered Priority A. Those patients that can possibly wait weeks before continuing treatment should be considered Priority B.	Physicians will determine that these patients are not put at undue risk. If their situation changes they will be moved to priority A.
PRIORITY B EXAMPLE		Most solid tumour cases (e.g., breast, colon, lung, GU, gyne, head and neck, GI), provided delays were in the range of 4 weeks.		Palliative Care • Patients with ESAS scores ≥7 not included under Priority A • Patients with select ESAS scores ≥4 but <7 (pain, nausea, shortness of breath) • Patients requiring assessment or management of ascites, where POCUS may be provided in clinic • Telephone/OTN consultations will be offered initially where possible for all ambulatory patients Psychosocial Oncology • Self-neglect or anxiety impairing engagement in cancer treatment • New consults for

				ESAS-r anxiety or depression ≥ 7 • Almost daily panic attacks • Significant emotional distress near end of life • Assistance with an income support document due to language, communication issues not amenable to phone contact, lack of internet access. Cancer Rehabilitation and Survivorship • Patients who are receiving radiation or have it pending but have ROM issues impacting their ability to get into the correct position for radiation treatment • Urgent referrals for lymphedema, pain, difficulties with ROM • Telephone/OTN consultations will be offered initially where possible and collect PROs via e-mails
-	**RADIATION**	**SURGERY**	**MEDICAL**	**SUPPORTIVE CARE**
PRIORITY C DESCRIPTION	Includes the rare patient with benign disease	WTIS Priority Category 4, indolent tumours.	Patients receiving oral hormone therapy,	OHPIP/MOT Priority Level: Elective

	needing radiation treatment, such as pituitary adenoma and meningioma. It may be possible to delay these cases until the pandemic is over. Referral information will be reviewed by the oncologist or designate and a decision made as to whether their consultation can be delayed. Patients on follow up should be grouped into low risk and high risk, and the low risk patients rescheduled to an appointment after the pandemic is over. Telephone follow up for high risk cases should be utilized as far as possible.	Patients for whom a delay of 2 months would be unlikely to affect outcome	especially in the adjuvant setting. Patients receiving follow up care Patients on IV bisphosphonates if that is the only IV treatment required.	Elective Cases- Patients whose conditions is deemed non-life threatening or can be managed with medication and for whom services can be deferred until the end of a pandemic wave (i.e. six to eight weeks**.)**
PRIORITY C EXAMPLE		Well differentiated thyroid cancers, early prostate cancers and non-melanoma non- squamous cell skin cancers.		Palliative Care • Ambulatory patients who are stable seen in ongoing follow up • Early palliative care referrals, e.g. study patients, patients with ESAS scores <4. • Telephone/OTN consultations will be offered initially where possible for all ambulatory patients

				Psychosocial Oncology
				• New consults with ESAS-r anxiety or depression <7
				  ○ Telephone/OTN consultations will be offered
				• Stable patients seen in ongoing supportive follow-up
				• Neuropsychiatry assessments
				• New recruitment for psychosocial research studies
				
				Cancer Rehabilitation and Survivorship
				• Non urgent referrals to CRS
				• Follow-ups CRS appointments
				  ○ Follow-up appointments will be re-booked as OTN/telephone when possible
				  ○ All newly referred patients will be called and

				○ screened over the phone. ○ When possible, assessments will be booked as OTN or phone intervention otherwise patients will be offered patient ed resources via e-mail (links to the websites) and e-modules and classes where appropriate ○ CaRE@ELLICSR and CaRE-AC groups will be moved to CaRE@Home
	RADIATION	**SURGERY**	**MEDICAL**	**SUPPORTIVE CARE**
SPECIAL CONSIDERATIONS	It should be possible to determine, at the time of consultation, whether the risks of the pandemic infection outweigh the risks of delaying treatment for that individual patient. It	1.It is important that all patients are listed in the Wait Times Information System (WTIS) to allow the hospital and province insight to significant delays. 2. As Priority A patients will represent the sickest of our	Patients who fall into Priority A should continue to be seen to determine if treatment is urgent/ curative. Local disease site teams will determine which patients	

	should be noted that a delay in instituting radiation treatment should be as short as possible. Evidence suggests that there is no safe delay period, so the decision rests on an assessment of relative risks for an individual patient. Patients on follow up should be grouped into low and high risk and the low risk patients rescheduled to an appointment after the pandemic is over. Special consideration will need to be given to patients who need to travel between cancer centres for portions of their treatments e.g. Brachytherapy for cervix/prostate cancer given in one institution and external beam treatment given in another. With the regionalization of cancer care, not all centres treat all disease sites e.g. Sarcoma. If one of the specialized centres were unable to accept new	population, there will be requirements for ICU and step-down care for post-operative management of some of these patients. Of which these beds may be in high demand during a pandemic. 3.All priority patients, especially Priority B, would have to be followed clinically as excessive delays, evidence of unexpected progression, or the onset of symptoms (e.g., bleeding, obstruction) would mandate escalation to Priority A.	are deemed curative and/or urgent. Patients who fall into Priority B can be deferred for several weeks. A mechanism is required (e.g., by phone) to ascertain that new problems have not developed if the decision is not to treat urgently, and for patients to contact the treatment centre to be assessed if problems arise. In situations where there are insufficient resources to treat all Priority A curative and/or urgent cases, patients with life-threatening symptoms who have potentially curable cancers will be given priority. In situations where there are no hospital beds, ambulatory treatment strategies may be required where inpatient care is the normal approach	

	cases, this would require special attention .			