The Next Step in Tumor Board Evolution: Optimizing Care Coordination and Integration

Editorial on “Integrating a Disease-Focused Tumor Board as a Delivery-of-Care Model to Expedite Treatment Initiation for Patients with Liver Malignancies”

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The multidisciplinary tumor board has been an important part of cancer care for decades. In the traditional model, the treating physician, usually a surgeon or medical oncologist, evaluates the patient then presents the patient to the tumor board and a multidisciplinary treatment plan is developed. This approach is considered to be at the center of high-quality cancer care and is one of the features that American College of Surgeons Commission on Cancer surveyors verify as they assess clinical cancer programs for accreditation by the Commission on Cancer.¹ Since this model was developed, cancer care has changed dramatically. The routine utilization of advanced imaging techniques for staging, combined modality therapy, and molecular profiling have all combined to make the work of tumor boards even more important, yet difficult to execute in a coordinated sequence.²

In their manuscript, “Integrating a Disease-Focused Tumor Board as a Delivery of Care Model to Expedite Treatment Initiation for Patients with Liver Malignancies,”³ Esab and colleagues show that, although the traditional model does provide a reliable mechanism for clinical decision-making, the typical tumor board model is inefficient and does not necessarily provide an optimal patient experience. The traditional program relies on a sequential path for patients through the cancer care system.

This involves evaluation by a primary clinician, additional visits for staging and evaluation, tumor board presentation, and then further visits with other oncology specialists. Patients frequently experience this process as a disjointed set of visits, tests, and procedures. The resulting care fragmentation creates anxiety and delays.⁴ Many centers have worked to optimize the process of care coordination through patient navigation services and other supportive interventions.⁵

Esab and colleagues at the Moffitt Cancer Center have implemented a centralized intake process for patients with hepatobiliary malignancies, which is linked to a disease-focused tumor board. The structure of this process prioritizes the collection of a set of minimal information required (MIR) for clinical assessment. After the requisite clinical data are obtained, patients are then scheduled for review in a multidisciplinary tumor board. A series of linked specialty visits are scheduled to follow the tumor board. The authors demonstrate that this process consolidates the total number of visits before treatment initiation. Most importantly, this process significantly reduces the time to treatment initiation from a median of 24 days to 17 days. Similarly, the disease-focused model minimizes the patient travel burden for multiple visits before treatment is initiated.

This team should be commended for this important work. They have demonstrated that, when organized properly, a tumor board is more than a forum for multidisciplinary decision-making. They show that a disease-focused tumor board may be a mechanism for integration of clinical services. This clinical integration is all about providing access to the right mix of specialists to develop a comprehensive evaluation and treatment plan. In addition,

this tumor board also improves care coordination. In this regard, the timing and logistics of clinic visits, tests, and procedures are optimized for efficiency and patient service. Extending tumor boards to improve care integration and coordination is the next step in multidisciplinary treatment planning that should be the aspiration of all cancer programs.

It is important to recognize that this tumor board model requires a degree of multidisciplinary collaboration and a business structure that is not common to all cancer care centers. In many centers, referrals are made from diagnosticians (internists, gastroenterologists, pulmonologists) to an individual medical or surgical oncologist. These oncology specialists then see the patient and present the patient in a multidisciplinary tumor board. The administrative work of onboarding the patient into the system falls to the practice that will be taking the initial role in the patient's care. To be successful, the disease-focused tumor board places the priority on a *coordinated* intake process in which the patient is under the care of a team rather than an *individual* clinician. These authors have demonstrated the benefits of this approach. This should be seen as an invitation to cancer care programs to develop practice structures that foster team care more than the productivity of individual clinicians. To be successful in this regard, organizations must implement practice models that create a shared intake structure that provides clinical intake services that are supported by the central organization and are designed to support all the clinical practices involved in the management of the patients. This can be challenging as the billing processes in most organizations are specialty specific. The allocation of these costs across practice units can be complex but must be negotiated to institute a sustainable business model⁶.

Although developing standardized approaches is essential to quality cancer care, it is important to realize that care must remain focused on meeting the needs of individual patients. The concept of “meet the patient where they are” should always be at the heart of clinical oncology⁷. To achieve this objective, it is necessary to maintain a degree of flexibility in delivering cancer care. This is particularly important as we consider the needs of diverse patient populations⁸. In this regard, timely access to individual clinicians may be the most important piece of managing a

cancer diagnosis. Sometimes patients are confused, frightened, and uncertain, and what they most desire is to be seen as soon as possible by an experienced clinician. They are less concerned about a fully developed treatment plan. What they want and need to hear is that their problem is treatable and that a comprehensive plan will be developed.

Esab and her colleagues have provided a strong model, which should inspire others. While we acknowledge that there may be a small number of patients who will be best served by a first visit with an individual clinician, the disease-focused tumor board is a strategy that provides cancer patients with access to multidisciplinary care in a way that optimizes integration and coordination, and almost certainly provides an optimal patient experience.

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