

# Establishing Optimal Care Coordination In Localized Bladder Cancer In The United States: A Modified Delphi Consensus Study

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### Key Takeaway

With ongoing developments in localized BC care, more work needs to be done to promote multidisciplinary collaboration and ensure standardized, equitable, and personalized treatment options to improve patient outcomes.

- ### Expert recommendations
- To achieve optimal and equitable clinical care, patients with BC must have **access to treatment provided by experienced practitioners** adhering to established guidelines
  - As part of delivering optimal and equitable clinical care, there is a need to **develop and implement standardized national BC care pathways**
  - Optimal care for patients with BC requires **coordinated multidisciplinary teams** who have the capacity to provide patients with a variety of tailored treatment options
  - BC care centers should aim to develop effective multidisciplinary teams which have clear and ongoing **provider-to-provider communication** to maximize patient outcomes
  - As part of the multidisciplinary team, BC care centers should have **at least one clinician navigator** highly trained in BC treatments
  - Patients with BC should be provided with a **centralized touch point** (e.g., clinical oncology nurse or nurse navigator) to provide them with **treatment education**, including monitoring and reporting of adverse events
  - Appropriate treatment selection of BC patients should be based on **risk stratification for NMIBC or MIBC BC at diagnosis and re-evaluated in subsequent visits** (e.g., using cystoscopy, transurethral resection, and appropriate cross-sectional imaging)
  - Complete **transurethral resection of the bladder tumor (TURBT) is a critical step** in managing NMIBC and MIBC and should be carried out as part of **risk stratification at diagnosis**
  - Clinicians need to be conscious of the factors constituting **Bacillus Calmette-Guerin (BCG) failure** and the broader treatment options which are available to patients
  - All patients with BC should be **educated on treatment options** so they can be actively involved in decision making, taking into consideration potential side effects, transportation needs, access to funding, and cultural beliefs and norms

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## Introduction

- In the United States (US), Bladder Cancer (BC) is the **6th most common cancer**, accounting for 4.5% of new diagnoses<sup>1,2</sup>.
- Despite established guidelines for managing BC, **social and systemic barriers** exist, resulting in disparities in care and suboptimal outcomes<sup>3,4</sup>.
- With emerging novel treatments and evolving standards, **effective communication and coordination** across specialties is crucial.

## Aims

- Build consensus on the **optimal management and coordination of care** for localized BC originating in urology.
- Develop recommendations to help **promote seamless coordination** of BC care.

## Results

- 300 responses** were received from relevant individuals working in BC across the USA (Figure 1).
- 117 (29%) responders had **more than 10 years of experience** in role.
- 38/46 (83%)** statements achieved **very strong** (≥90%) agreement.
- 8/46 (17%)** statements attained **strong** (≥75% but <90%) agreement.
- No statements fell below the consensus threshold.
- Based on the results obtained, the authors developed a **series of 10 recommendations**.

Figure 1: Respondents by role (N=300)

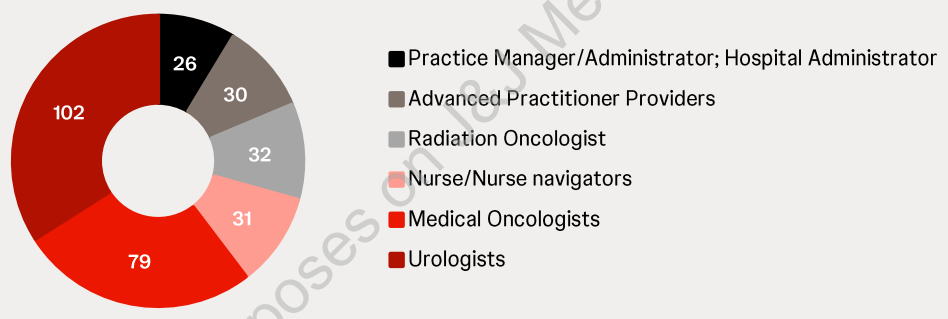
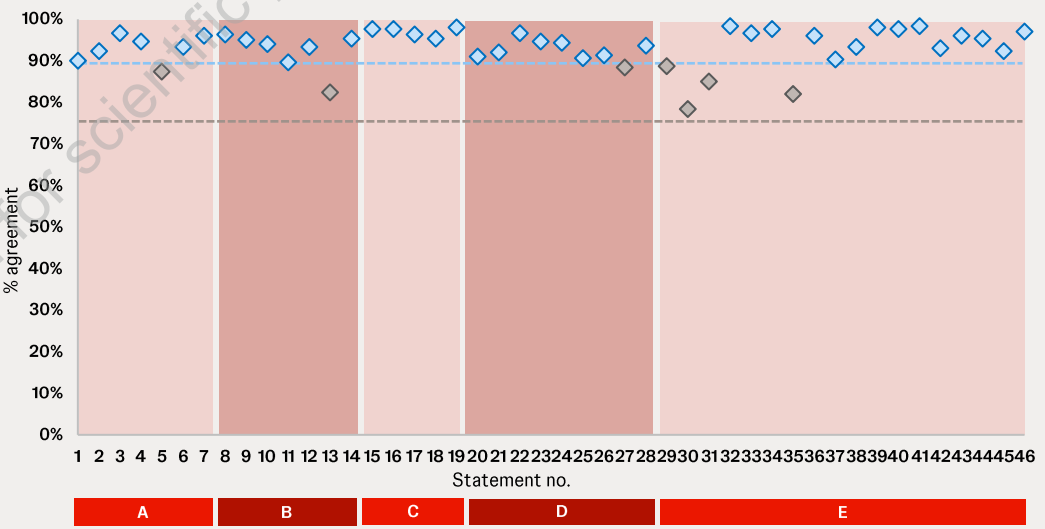


Figure 2: Consensus agreement levels by statements



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## Methods

- The project used a **modified Delphi method**.
- A steering committee (SC) consisting of 10 members experienced in BC care coordination (including **urologists, medical and radiation oncologists, advanced practitioners, and administrators**), convened to discuss issues in BC care, developing a series of consensus statements.
- A set of **46 statements** were used in a 4-point Likert scale survey, disseminated by a third-party to healthcare practitioners with active roles managing localized BC in the US.
- The consensus threshold was set at **75% agreement**.
- The SC then reconvened to discuss the results and **formulate recommendations** based on the consensus achieved.

Table 1: Consensus statements and level of agreement (%) Key: Agreement score ≥90% Agreement score ≥75% but <90%

#	Statement	%
<b>Domain A: Burden of BC and the evolution of management strategies</b>		
1	BC is a heterogeneous disease with varying treatment approaches across the US	90
2	Sociodemographic factors (e.g., gender, race/ethnicity, income, geographic residence and insurance) are associated with worse survival outcomes in BC in the United States	92
3	BC care services should be equitably available to all US patients	97
4	BC is a condition which requires lifelong surveillance	95
5	BC represents a significant financial and resource burden for US healthcare systems	87
6	BC represents a significant financial and resource burden to US patients and families	93
7	Implementing optimal clinical staging practices including cystoscopy, transurethral resection, and appropriate cross-sectional imaging is critical in selecting the appropriate treatment for BC patients	96
<b>Domain B: Care coordination with respect to referrals and scheduling for IV infusion or medication administration</b>		
8	Physicians and hospitals caring for BC patients in the US should be aware of the distinct clinical burdens associated with the management of NMIBC and MIBC and ensure appropriate access of NMIBC and MIBC to oncologists, urologists, radiation oncologists and clinical support are in place	96
9	Close collaboration between urology and medical oncology is vital in the delivery of BC care	95
10	National BC care pathways should be used to inform local practice patterns (including referrals) to improve the standardization and coordination of BC care in the community setting	94
11	Patients with muscle invasive BC would benefit from both medical oncology and radiation oncology referrals	90
12	Dedicated experts within the practices should be identified to develop and revise pathways, and disseminate knowledge of the evolving BC treatment landscape	93
13	Clinicians in larger volume treatment centers have more experience and dedicated support in treating BCs than smaller volume centers	82
14	Creation of multidisciplinary teams, working groups, and tumor boards will help facilitate an ideal multidisciplinary environment for the care of BC patients	95
<b>Domain C: Adverse event (AE) management of PD-1 inhibitors</b>		
15	Treatment providers must proactively monitor and appropriately manage AEs for patients receiving BC treatment	98
16	Patients receiving systemic immunotherapy for BC and their loved ones must be educated so that they fully comprehend their personal risks for AEs	98
17	Diligent review of new therapies through continuing medical education is key to monitoring and managing AEs for patients receiving systemic treatments	96
18	The patient and the practice should have a centralized touchpoint dedicated for triage, monitoring and management of immune-related AEs	95
19	Timely and regular follow-up of patients with BC throughout their treatment is vital to improve outcomes	98
<b>Domain D: Communication between multidisciplinary clinicians throughout the patient journey</b>		
20	A multidisciplinary team (comprised of urologists, medical oncologists, radiation oncologists, pathologists, patient counsellors, specialty nurses and care navigators) communicating regularly to review BC patients is essential for optimal patient outcomes	91
21	All BC care centers in the US should deliver effective multidisciplinary care, independent of the center type (private practice, community hospital, or academic center) or low/high patient volume	92
22	Clear and ongoing provider-to-provider communication is essential to maximize outcomes in patients with high-risk BC	97
23	Electronic technology should be utilized effectively to improve communication between MDT members throughout the BC patient journey	95
24	The formation of multidisciplinary tumor boards, where clinicians can discuss treatment options online or in person, will help to improve patient outcomes	94
25	BC care navigators are a valuable resource in supporting consistent communication between clinicians and ensuring patient compliance and education throughout the patient journey	91
26	BC care navigators are important in providing tangible support along the patient's treatment journey including accessing funding and information	91
27	Every BC care center should have at least one clinician navigator highly trained about BC treatments	88
28	If BC care centers do not use the same electronic records system, clinicians and/or care navigators must have a reliable shared mode of communication	94
<b>Domain E: Treatment decision making</b>		
29	All BC care providers should acknowledge conscious and unconscious bias in order to mitigate their conscious and unconscious biases of how their treatment decisions are made	89
30	Ongoing bias training is important in healthcare to ensure equitable and quality care for all individuals	78
31	Ensuring diversity, equity, and inclusion in BC care is vital for improving patient outcomes, reducing healthcare disparities, and promoting equal access to quality care for all individuals regardless of their background, race, ethnicity, gender or socioeconomic status	85
32	Appropriate treatment selection of BC patients should be based on risk stratification for NMIBC or MIBC at diagnosis and reevaluated in subsequent visits	98
33	Standardized risk assessment related to treatment should occur prior to any treatment initiation	97
34	Modifiable disease risk factors (e.g., smoking, alcohol consumption, diet) should be assessed and addressed for all BC patients	98
35	Lack of clear understanding of what constitutes Bacillus Calmette-Guerin (BCG) failure are limiting treatment options for patients with high-risk NMIBC	82
36	BCG treatment alone may not be sufficient in preventing recurrence and progression in high-risk NMIBC and providers need to be aware of other options	96
37	Complete transurethral resection of a bladder tumor (TURBT) is the most critical step in effective management of NMIBC and MIBC	90
38	Clinicians should consider clinical research trials as an option for treating NMIBC and cisplatin ineligible MIBC	93
39	All treatment decisions should be made with the patient, taking into consideration potential side effects, transportation needs, access to funding, and cultural beliefs and norms	98
40	All patients should be educated on all the available treatment options (including clinical trials) for their BC, so they are empowered to make informed decisions	98
41	All patient materials should follow plain language guidelines to facilitate easy-to-understand information for all patients	98
42	All BC patients should receive a copy of their treatment schedule to help manage their expectations regarding treatment frequency and duration	93
43	BC patients should be supplied with patient specific resources that can assist in their research and understanding of their treatment options	96
44	All BC patients should receive patient-centric educational materials which explain how each of their treatments work	95
45	All BC patients should receive details of BC patient advocacy and support groups	92
46	Non-financial barriers to access treatment should be identified and addressed to ensure adherence for BC patients	97