Peer Review File

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Review comments

Thank you for the invite to review the "Pivoting to Telemedicine in a Single-Day Multidisciplinary Liver Tumor Clinic During COVID-19: The Texas Liver Tumor Center Experience"

Summary and points of strength: This is a discussion of the experiences from Texas Liver Tumor Center (TLTC) during the time when patient care was switched to partial telemedicine when COVID restrictions were imposed. The authors have a unique experience providing all assessments in one day. I did not find any other points of strength.

Major weak points:

Comment 1:
I am not sure how this article is suited for a journal dealing with palliative medicine.

Response:
Most if not all cancer patients will benefit from palliative care. Palliative care physicians should have knowledge of multidisciplinary care models and palliative treatments (i.e., radiation, chemo, locoregional options) for patients with advanced HCC (hepatocellular carcinoma). This is particularly important as most patients present with late-stage disease. Having palliative care physicians incorporated into the single-day model is unique and allows patients to have an early introduction to palliative care. This is addressed in our paper in the statements below.

1. Cancer guidelines recommend that all patients with hepatocellular carcinoma (HCC) have an evaluation by a multidisciplinary team to assess liver health, stage the cancer, and discuss treatment and palliative options.

2. NCCN guidelines support increasing and improving access to palliative care (10). Texas Liver Tumor Center (TLTC) allows for the early integration of palliative care services. Conversion to telemedicine has been essential to caring for patients with all stages of cancer without additional delays.

3. A one-day clinic model with an incorporated tumor board decreases the burden of separate patient visits, may expedite the time from diagnosis to first treatment, facilitates the early intervention of palliative care specialists, and allows for optimal screening for clinical trials.

4. Palliative care can be introduced to these patients at the initial evaluation to provide support at any stage of the disease process. Clinicians collaborate in real-time during and after the tumor board increasing quality and continuity of care.

The authors mention their routines and briefly mention the percentage of staff who enjoyed the virtual meetings. However, it became clear that as soon as restrictions were lifted the center switched back to clinical/personal meetings without any explanations. Why was the pivot temporary?

Response:
Due to institutional mandate after October 2020, return to in person visits was allowed with restrictions regarding number of people in the clinic. Only one support person allowed per patient and additional staff such as dietician and social worker remained remotely located. Physicians were allowed to conduct in person visits. TLTC would pivot from hybrid to fully virtual as required by hospital policy.

In late 2022 most insurance carriers warned that new patient telemedicine visits would no longer be covered while follow up telemedicine visits would be covered. Insurance coverage was another principal factor in the conversion of the fully virtual and hybrid TLTC model back to an in-person model. Additionally, it was noted by scheduling staff that when offered the option of a webex visit or in-person visit, patients chose to attend the clinic in-person.

The above information has been added to the paper in the Virtual TLTC section in order to clarify why the pivot was temporary.

Comment 3:
The definition of what constitutes telemedicine is not clear in this context. It seems that the emphasis is on patient communication only? My colleagues and I have had decades of experience with "telemedicine." In some regions there is collaboration over much larger areas where clinicians from smaller units discuss the options with more experienced colleagues from university centers. In that regard, telemedicine is more teleconference.

Response:
The statement below from our paper should clarify that the TLTC telemedicine visit involves each clinician and allied health staff interacting virtually face to face with the patient individually. Each patient is required to have their camera and microphone on

for the duration of the visit. Each clinician treats this time as if the patient is being evaluated in the clinic.

The word "seen, line 198, has been replaced by "evaluated" in order to provide clarity. The phrase "with camera and microphone on" has also been added (line 197 The patient is instructed to log into the visit on the appointed date and time with camera and microphone on and remains in the visit until ~~seen~~ evaluated individually by the transplant hepatologist, transplant surgery physician assistant, social worker, and dietician. Clinicians rotate in and out of the virtual clinic room as directed by the AA (Administrative Assistant).

Comment 4:
The authors seem to emphasize that telemedicine was mostly in regard to patient contact. While some patient interaction can be substituted by video contact not all necessary information can be obtained by just video calls. **For instance, how is ECOG or similar determined?**

Response:
"Disadvantages focused on technical issues related to poor sound quality, poor connections, or inability to screen share (8)." The authors of the cited study do not elaborate on the technical issues.

This statement is related to virtual tumor boards only and not to virtual patient visits. If radiology cannot share their screen during in person or virtual tumor board, the board review cannot move forward. Reading imaging reports is not adequate for the multidisciplinary team to make decisions regarding surgical intervention or transplant evaluation and this is a part of every patient's review at TLTC. The TLTC board can proceed with recommendations if pathology cannot share the screen as the pathologists can speak to the findings and seeing the slides is not required.

We agree there are limitations to video visits versus in-person visits at the TLTC; however, this is true for most oncology and palliative care visits, which also transitioned to video during the pandemic. ECOG is usually determined by asking the patient questions about their functional activity, which can be asked via video. This is an initial visit, so if further assessments were needed to determine eligibility for treatment, patients were assessed in person in the follow up visits.

Comment 5:
Table 3 needs more explanation.
Response: We have added more detail to provide more information and clarity.

Table 3: Summary of Benefits and Limitations of the Virtual Single-day

Multidisciplinary Clinic

Benefits	Limitations
One-day clinic model improved access to cancer care and patient navigation.	Coordination of clinicians for a one-day clinic can be challenging given scheduling conflicts and limitations
One-day clinic model increases access to timely liver transplant evaluation.	In the virtual format, can limit patient access due to lack of access to technology or unfamiliarity with technology
One-day visits with all liver cancer specialists results in patient convenience and expedited care plan.	A one-day visit results in a longer visit day for the patient and the volume of information from all the specialists may be overwhelming.
One-day clinic fosters real-time clinician collaboration.	The multi-disciplinary clinic requires a high-level of staffing due to the coordination required, and thus, is limited to a high resource setting.
Expediting assessments by all specialties leads to downstream revenue generation (i.e., increased procedures, surgeries)	Insurance may be a barrier to access as some insurance companies do not approval multi-specialty visits in one day or require multiple referrals, which delays the visit.