Developing a Multidisciplinary Thoracic Oncology Clinic

THE EDWARD HOSPITAL EXPERIENCE

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In February 2009, while discussing with a medical oncologist the case of a patient with lung cancer who required neo-adjuvant treatment, our thoracic surgeon suggested holding a weekly conference to discuss such cases to better coordinate the care of lung cancer patients at Edward Hospital. The other involved disciplines—including radiation oncology, pulmonology, radiology, and administration—discussed the possibility of such a multidisciplinary conference, and agreed that the clinic was a good idea. Since these clinics are often held in university oncology programs, plans for the clinic focused on translating such a program to the community setting. One of the first decisions: a nurse practitioner would serve as the coordinator for this multidisciplinary conference.

On March 11, 2009, our thoracic oncology clinic saw its first patients. To spread the word about the clinic opening, letters were sent to all the primary and family care physicians and pulmonologists on staff at the hospital and in the surrounding communities. The hospital marketing team ran ads and stories in local and regional newspapers, in addition to marketing the clinic on the hospital's website and intranet. The clinic began slowly but ramped up quickly, with a rapid increase in the number of patients seen per month once people became aware of the clinic.

Performance Improvement Goals

Once our clinic was established, our team developed several performance improvement (PI) goals for the clinic:

- All patients would be offered an appointment within five business days of calling for the appointment.
- Treatment would be assessed in a timely manner, with a goal of two weeks from first visit to first treatment.
- The percentage of patients that had post-treatment surveillance scans would be performed according to National Comprehensive Cancer Network (NCCN) guidelines.
- Recruitment and retention data would be collected. Specifically, we could assess how many patients diagnosed at Edward Hospital stayed for treatment at Edward Hospital and how many patients diagnosed elsewhere and seen for another opinion remained for treatment at Edward Hospital.
- Develop a process that would help increase our percentage of matching clinical with pathologic staging. These percentages have been tracked now for several years.

Table 1 shows how we did in meeting those PI Goals.

Growing the Clinic

Our thoracic oncology clinic has grown substantially over the past three years and now includes pathology, interventional pulmonology, nursing (both medical oncology and radiation oncology), CT technicians, a dietitian, a tumor registrar, and social work. We hope to incorporate a palliative care physician in the near future.

In 2012 we used this framework to initiate a lung screening program to ensure patients meet NCCN screening criteria. In brief, here's how our process works. The Edward multidisciplinary thoracic oncology clinic (EMTOC) team reviews all screening CT scans. The thoracic oncology clinic navigator then calls each patient to discuss the results and treatment recommendations, if any. A letter with the results and recommendations is also sent to the patient's physician providers. The thoracic oncology clinic navigator sends a letter one month prior to the date of the recommended follow-up scan—both to the patient and his or her physician. Our

Table 1. Data on PI Goals

MATRIX	GOAL	2010 DATA	2011 DATA	2012 DATA
Appointment within 5 days	100%	97%	99.5%	98%
Time from first visit to first treatment	2 weeks	82.5%	89.5%	88%
Surveillance scans per NCCN guidelines	100%	100%	98.5%	98%
Percent of patients diagnosed and treated at Edward Hospital	90%	86.5%	86.3%	85%*
Clinical correlation with pathologic staging	90%	40%	83.3%	85%*

*Based on Cancer Registry data to date

multidisciplinary team reviews all follow-up scans per NCCN guideline recommendations.

Patient & Provider Response

Our patient satisfaction scores for the thoracic oncology clinic are excellent. Patients appreciate that they can see all their doctors in one visit and that they leave with a care plan in hand. One grateful and generous patient left a portion of his estate to the program, which allowed Edward Hospital to develop an endoscopic ultrasound program.

Referring physicians also have a great deal of satisfaction with the clinic, as they feel patient care is more efficient and that all providers and the patient are on the same page regarding the plan of care.

In the beginning physician attendance was sporadic, but after a few months, physicians cleared their schedules to participate and are disappointed when they cannot be in clinic.

Initially, clinic referrals came primarily from the physician participants. Today primary care physicians refer patients directly to the clinic. The primary care physicians appreciate the performance of appropriate diagnostic procedures and that patients receive the appropriate care in an efficient manner. Referring physicians are updated on the plan of care after the conference—either by email or phone—so that they know what the plan is and can ask questions. Several primary care physicians have attended the multidisciplinary conference or have called in to the conference to hear the discussion and to provide insight into the patient and their co-morbidities and social situation.

In addition, several patients have self-referred after learning about the clinic from the Internet or hospital website.

We have also established partnerships with several of the local academic facilities that have referred their patients to us so they may receive care closer to home.

Looking Ahead

Our thoracic oncology clinic currently reviews approximately 20 to 25 new cases per month, with 55 to 60 follow-up cases. The multidisciplinary team sees patients in the clinic and also cases that are referred to the conference for recommendations when the patient cannot be in attendance.

All new patients are seen by one of the physicians and their case is then reviewed in conference. The physicians involved in the treatment plan also see the patient prior to discharge from clinic. The follow-up cases receive a review of recommended scans and evaluation of treatment progress. We have conducted 15 lung screenings—all requiring future follow-up.

All current smokers receive information on smoking cessation and support groups. Our next endeavor is to initiate a smoking cessation clinic that will be run by a nurse practitioner. Patients will be referred to this clinic from the cancer center, as well as from physicians outside the cancer center and hospital.

On February 20, 2013, we hosted a half-day symposium on lung cancer, highlighting our thoracic oncology clinic. To illustrate the inner workings of the clinic to physicians and healthcare professionals, cases were presented as if it were in the multidisciplinary conference.

The thoracic oncology clinic was such a successful endeavor that Edward Hospital subsequently developed a neuro-oncology, GU oncology, breast clinic, and an oncology genetics clinic. In the future, we will look to add a GI multidisciplinary clinic and a survivorship clinic.

While each clinic has a slightly different format, our hope is that the positive outcome for patients and physicians will be the same.

As the nurse navigator, it is a challenge at times to ensure completion of diagnostic testing and to ensure that patients and their families have a good understanding of the plan of care so that no one falls through the cracks. A trigger on our new electronic medical record has made it easier to track testing and follow-up. We continue to explore ways to improve our thoracic oncology clinic for patients and providers, including keeping a close eye on future technology and clinical trial results. OI

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