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The McAuley Cancer Care Center

Work Groups and Multispecialty Clinics

"We differ from other cancer centers in that we have been extremely successful in developing multidisciplinary work groups as a prelude to specialty clinics in a private practice environment," said Philip J. Stella, M.D., Cancer Program Medical Director at McAuley Cancer Care Center.

In his quest for more efficient patient care, Stella is using multidisciplinary work groups of physicians to design guidelines for managed care. These guidelines have made for more cost-effective, standardized care and have led to increased protocol utilization.

In 1992, starting with one cancer site—lung cancer, Stella helped assemble a group of medical and radiation oncologists, pulmonologists, cardiothoracic surgeons, radiologists, and pathologists. This multidisciplinary team met to review literature and to discuss clinical trials and research protocols. They were able to develop a standard framework for managing patients with non-small cell lung cancer and focused on providing state-of-the art, coordinated care in the community hospital setting. Today, lung, breast, and GI cancer work groups are up and running.

Physicians find the work groups worthwhile, intellectually stimulating, and fun. "They come in at 7 o'clock in the morning to hammer out the basics of treatment and develop a consensus. Their enthusiasm is infectious," said Stella. Work groups are a means of communicating new technologies and therapies and allow physicians to discuss problem cases that might not fit into any guidelines. Group members like the idea of putting patients on clinical trials, being able to coordinate treatment, and providing state-of-the art care.

To make the concept work, Stella had to make the meetings appealing in terms of interest and time. The thoracic surgeons came to enjoy the lung cancer work group because it

Established in 1911, the Catherine McAuley Health System in Ann Arbor is a division of the Sisters of Mercy Health Corporation. The McAuley Cancer Care Center at St. Joseph Mercy Hospital, a unit of the Catherine McAuley Health System, serves cancer patients throughout southeast Michigan.

The Center houses up-to-date treatment facilities, including sthe Robert H. and Judy Dow Alexander Cancer Care Center for oncology outpatient services, an inpatient oncology unit, and the Fred and Sally Palma Radiation Oncology Treatment Facility.

VITAL STATISTICS

- Total institution bed size: 570
- Dedicated cancer unit beds: 20
- New cancer patients seen each year: 1,900
- Annual number of patients on NCI-approved protocols: 60-65
- Community served: 913,000 people
- Approximate market share: 31 percent
- Percent managed care of market penetration: 35–40 percent

SOCIAL SUPPORT SERVICES

- A Chronic Pain Clinic, which provides physician evaluation and treatment for patients with a wide range of pain problems
- Cancer counseling
- Numerous support groups: a Share & Care support group, an "I Can Cope" education/support group, two breast cancer support groups, a prostate cancer support group, a children of cancer patients support group, and a bereavement support group
- A grief recovery program, presented in conjunction with Hospice of Washtenaw.

enables them to get a quick opinion from radiation oncologists and pulmonary specialists. "The thoracic surgeon could send a difficult patient to four different offices over a period of two weeks. Or, he could present the case at the work group, receive immediate feedback, and get the patient tracked into treatment quickly. That is a huge advantage for the physician as well as for the patient," said Stella.

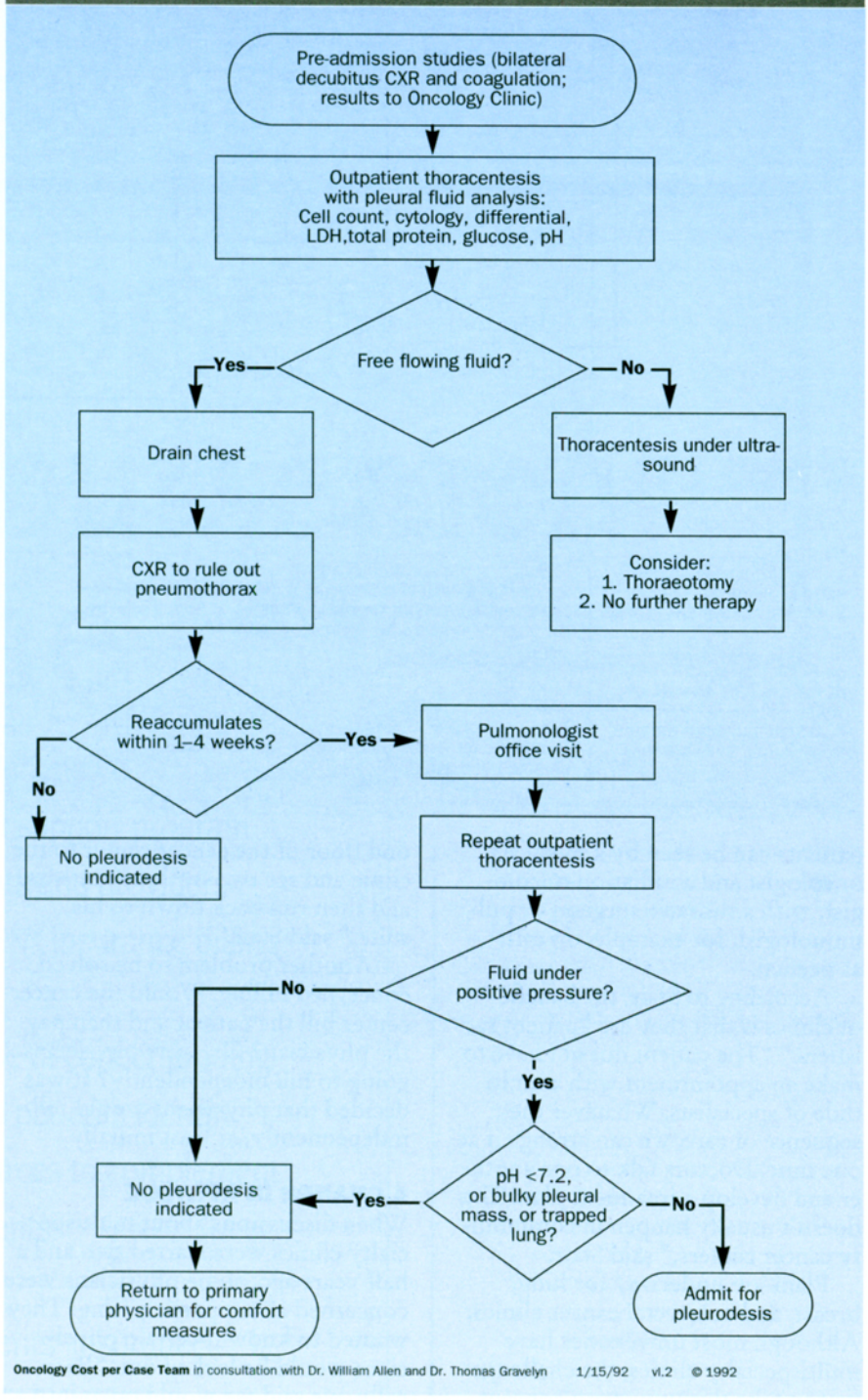
When members of the work group reviewed inpatient stays for lung cancer, they couldn't come up with a critical pathway; patients were not similar enough, and not everyone had primary lung cancer. The group did find that a number of patients died because they were admitted with late-stage disease and were in acute respiratory distress. And they found that no matter the primary site, many came in with plural effusions.

"So, we did two things," said Joy Stair, M.S., R.N., Cancer Program Administrator. "We worked with the pulmonologists to develop a decision-making tree [algorithm] for the patient with pleural effusion. Those patients admitted for pleurodesis follow a critical pathway, so that we now have a plan for day one, day two, and so on." (See Figures 1 and 2.)

Another benefit of the work groups is that they have significantly expanded the hospital's ability to put people on clinical trials. "It has always been hard to get people on cancer control trials," said Stair. "Certain things need to happen if you want to put a patient on a national protocol. A surgeon, for instance, would have had to perform the surgery in a certain way. For example, we worked on getting the cardiothoracic surgeons on board, so they know, when operating on a patient with a certain kind of lesion, what needs to be done with regard to node dissection to make patients eligible for clinical trials."

Another group, the Quality Improvement Team (QIT), works at cutting costs while improving quality. This multidisciplinary work group, composed of physicians, nurses, the program pharmacist, and the program administrator, initially examined the use of antiemetic drugs. These drugs, administered during the peri-chemotherapy period, were found to be given in suboptimal

Figure 1: Clinical algorithm for outpatient thoracentesis and pleurodesis decision-making

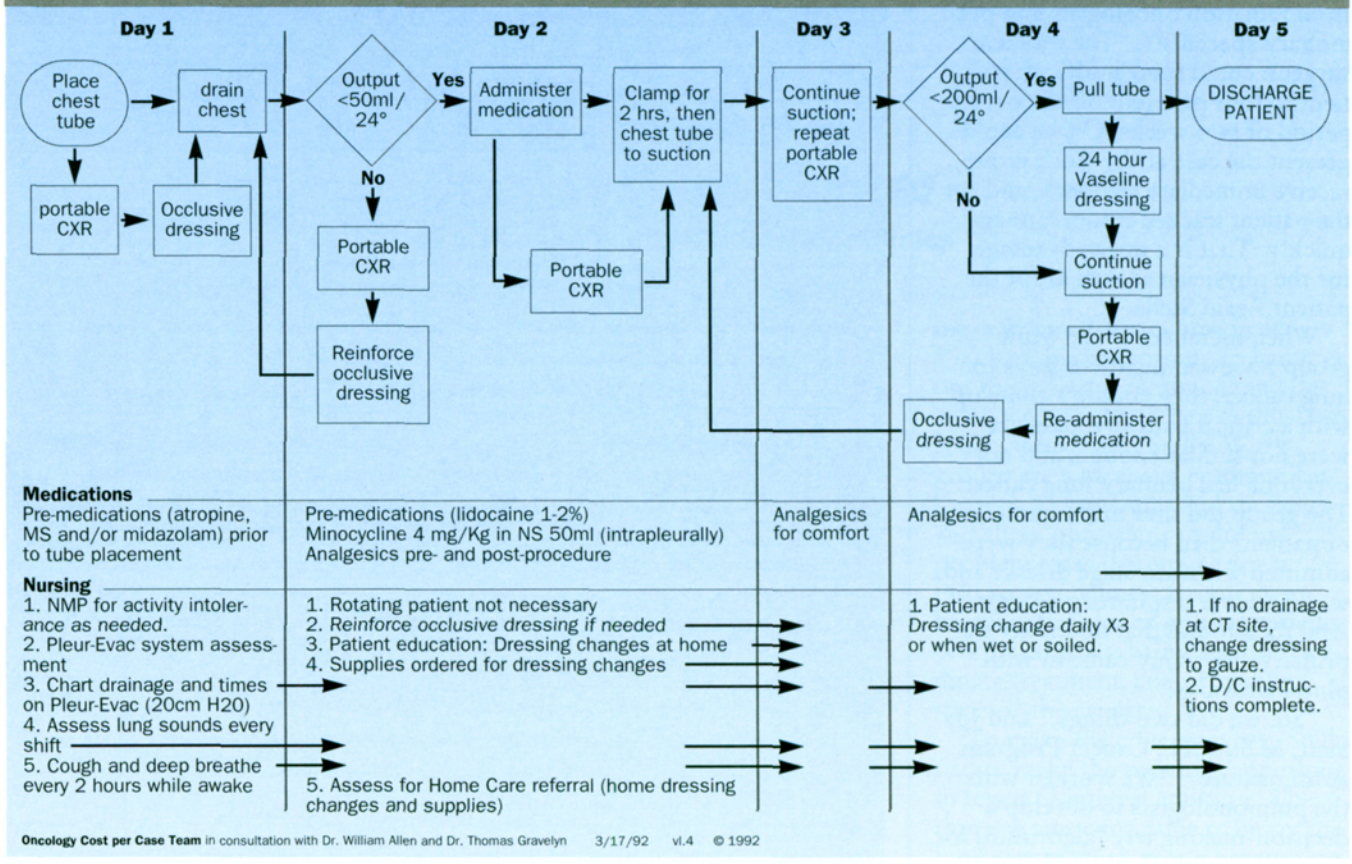


"Ineffective antiemetic therapy was not only distressing to the patients, but was also wasteful of some expensive pharmaceuticals and prolonged the length of stay," said Stair. In this case, the QIT first achieved consensus on two antiemetic regimens. The clinical algorithm and medication administration record for antiemetic therapy became a single record in the medical chart; the physician simply orders "Algorithm A" or "Algorithm B." Although Algorithm A, has been eclipsed by a new, more effective (but much more expensive) antiemetic called Zofran, Algorithm B continues to be used for those patients whose chemotherapy is not severely emetogenic. The QIT also became the forum for discussion and development of criteria for the appropriate use of Zofran.

MULTISPECIALTY CLINICS

Work groups at McAuley Cancer Care Center are a predecessor to multispecialty clinics, where

Figure 2: Critical pathway: pleurodesis



patients can be seen by a medical oncologist and a radiation oncologist, with a thoracic surgeon or pulmonologist, for example, on call as needed.

According to Stair, the benefit of clinics is that they are "patient satisfiers." "The patient doesn't have to make an appointment with a multitude of specialists. Whatever the sequence of care, we can arrange it at one time. Doctors talk to one another and develop a treatment plan. This doesn't usually happen in community cancer centers," said Stair.

Plans are underway for lung, breast, and colorectal cancer clinics. Although most universities have multispecialty clinics, the challenge was to take this university concept and put it into practice in a community setting.

The first step was to overcome logistical problems, such as where the clinics should be located and how they should be staffed.

Instead of building a multidisciplinary suite as first envisioned, a decision was made to hold the clinics in the medical oncologists' offices in the cancer center in order to make the most efficient use of staff and space. "It doesn't make sense for a physician to run up to the second floor of the cancer center to the clinic and see two or three patients and then run back down to his suite," said Stair.

Another problem to be solved concerned billing. Would the cancer center bill the patient and then pay the physician? Or, were physicians going to bill independently? It was decided that physicians would bill independently, at least initially.

A CHANGE IN ATTITUDE

When discussions about multispecialty clinics were started two and a half years ago, some physicians were concerned about participating. They wanted to know if certain physicians would be locked out. "Basically, we said we would open it to everybody. We can't tell a surgeon on our staff who works with breast cancer patients that he can't be part of it," said Stair.

However, if physicians want to participate in the clinic, they have to meet the standards of care that came out of the work group meetings. "We are working to come up with a consensus about patient care," said Stair. "When we set up our prostate clinic, for example, we will not have a urologist who is off doing cryosurgery without the patient being on a research study and carefully followed up."

Both Stair and Stella have seen a major difference in the interest levels of physicians over the last two years. Perhaps some of the change in attitude is just the process of living with work groups for a couple of years, catching the enthusiasm of case discussions among the team, and seeing the development and implementation of critical pathways and multispecialty groups. Or, it may be that physicians are jumping aboard because they see managed care on the horizon.

Whatever the reasons, the success of work groups at the McAuley Cancer Care Center depends on a good working relationship between the hospital and its physicians. The physicians have been good to the hospital, and the hospital, in turn, has been responsive and committed to working with the doctors.

"In this environment," said Stella, "we have been able to create guidelines. We have been able to fit our research protocols into those guidelines. And we have been able to position ourselves in a very good spot for managed care when it comes down the pike." ■