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Comprehensive Lung Program

Thynk Health would like to help your facility have a comprehensive Lung Cancer Program. We would like to support you and your program by having a center of excellence built around a quality patient-centered structure.

Starting and streamlining your program requires you to think about what services and strengths you currently have and what your stakeholders' goals may be. By using this as a guide, it will help you think and plan on what components you have, what you may need to secure, your physician strengths and culture, creative ways to offer services, and areas your team may want to partner with other organizations. Before beginning or as you are streamlining there are three key components that are needed: respected physician champion, dedicated administrative support, and respected lung navigator.

This core team consisting of a physician, administration, and lung navigator can begin initial program planning together and create a lung program leadership. Your leadership team should include your multidisciplinary team members with the addition of a representative from IT and a primary healthcare provider. If you have a successful breast program, trying to mimic some components of that program which will help with your physician culture, mainly referring primary care providers. From having set goals, charter, and structure of your meeting similar to breast program leadership required by the National Accreditation of Breast Programs that will give you a dashboard of metrics to follow and measure along with approval of your program and policies in case pushback from other physicians occur. Also, within a screening and incidental findings program, using the follow up and similar language as the mammography letters will help lessen confusion on the already overloaded PCPs. If your facility would allow, have a predetermined flow for patients needing follow up with the parameters set, then by having PCP's sign and approved specialty physician's referrals will help the flow for the patients and the PCP's office.

As you go through the question guide, think of your goals. Is it to start or expand your Low Dose screening program, start an incidental findings program, have a dedicated lung nodule clinic, have a multidisciplinary tumor conference (will this be all encompassing from nodules identified, newly diagnosed, molecular tumor conference, reoccurrence, and/or metastatic), thoracic surgery focus, increasing utilization on Stereotactic body radiation therapy, tumor specific focus on treatment via infusions and oral targeted therapies, survivorship, supportive care, and/or appropriate referrals to hospice. Within the entire program, many Commission on cancer quality initiatives can be studied and implemented.

Physician Overview Survey:

*Engaged respected physician champion (help with policies/procedures and have your back when other physician pushback, many meetings may be needed from this crucial team member)

Emergency room physicians engaged in quality initiatives (incidental findings)

Hospitalists engaged in quality initiatives (incidental findings)

Do you have interventional pulmonologists, pulmonologists that will perform interventional bronchoscopies, thoracic surgeons, or interventional radiologists who will work patients up quickly instead of continued watch and wait?

Do you have radiologists (are they champions and help with early diagnosis)?

How receptive is your radiologist in starting a lung program? (Will need to help with screening, extra tumor conferences-possibly both Lrads 3 and 4 in addition to general lung tumor conference)

Do you have a thoracic surgeon or a surgeon engaged in lung cancer? (Need to be engaged and committed to attend leadership meetings plus lung specific tumor conferences)

How engaged are your pathologists? (Will they be in attendance or a cyto path technologist be available at time of tissue retrieval (ROSE), extra tumor conference (possible molecular tumor board), and leadership meeting.

How engaged are your medical oncologists? (Will need to attend extra tumor conference and leadership meetings, would they be interested in a molecular tumor board)

How engaged are your radiation oncologists? (Will need to attend extra tumor conference and leadership meetings)

Consider how many physicians are employed and how many are independent. Then determine how to structure referrals (if all are employed, may be able to agree on standardized patient flow; otherwise, may need to let the PCP determine who next physician to oversee the patient care will need to be; by letting the PCP determine either by calling their office or by written preferences, it helps protect the navigator)

Facility Overview Survey:

*How engaged is your administrative team? (Need to see the vision and strategy for the entire continuum of care lung program providing resources needed to make it come to fruition)

*Dedicated lung navigator (need at least a dedicated clinical navigator to start a program and can add ancillary staff as the program grows)

Do you have a dedicated area to focus first? If so, is it screening and early detection or treatment? (Pick one area to start, cannot do it all at the same time)

*Do you have a thoracic or lung program leadership/steering committee? (Very important as this group could report to the cancer committee who reports to the CMO so policies and procedures can be approved; also monitors quality reports and measures for the continuum of lung cancer care)

Are you monitoring lung specific quality data? (Commission on cancer is beginning to add surveillance data and other lung cancer specific measures in addition to the ACR requiring data and follow up for the LDCT screening; The GO2 Foundation for Lung Cancer offers a Care Continuum Community Centers of Excellence Program which includes the Impact Study to identify opportunities for quality improvements and comparative analysis of key performance indicators and metrics)

Programmatic Overview Survey

Early Detection:

*Do you have a LDCT screening program? (Your facility may offer this program or you may want to partner with independent imaging freestanding centers and navigate patients to your program and multidisciplinary team)

Which department will manage the LDCT screening program? (Usually imaging or broad oncology service line); this program could be split utilizing imaging for the scheduling and actual imaging but oncology for follow up

Are you going to offer or make every patient see a Nurse Practitioner or Physician's Assistant prior to screening make sure that they qualify and have shared decision-making

visit along with smoking cessation addressed? This will be a centralized model instead of a decentralized model where the PCP is responsible for the appropriate order.

How are Lrads 3 and 4 managed? (Opportunity to make sure patients do not fall through the cracks)

Does the facility provide physician aids for shared decision making? (This is something you can offer to aid your PCP referrals, can be branded to your facility)

*How engaged are your IT team from the EMR to the PACS team? (Being able to identify and track patients along with informing the entire healthcare team of the patient's status and identified needs are very important)

Are your imaging notification letters and follow up letters automated? (This may be expensive to start but is best for the team since very time intensive; when first starting a LDCT screening program, sometimes it can be managed by a logistical patient navigator, working under a RN navigator, then as automation occurs, the role could be transitioned into a follow up navigator and tumor conference coordinator)

*Do you currently offer an incidental finding management program? (This needs to occur wherever imaging occurs for best patient outcomes and risk liability-remember always consult the PCP for next steps or have a pre-approved physician automated referral process)

If yes, where does this occur-Emergency room, any outpatient department, all imaging including inpatient?

Do you currently offer a lung nodule follow up clinic?

Which specialists see the patients? Could it be coordinated virtually if more than one need to see the same patient in one day?

Do you have respiratory therapy available to do pulmonary function testing during the clinic time?

*Are lung biopsies performed at your facility? (Biopsies can be performed by pulmonologists trained to perform interventional procedures, radiologist and/or surgeons-truly depends on skill set of the providers but need to occur for both initial tissue diagnosis and potential progression of disease.

Which Equipment is Utilized for Biopsies/Risk Stratification:

Ebus

Navigational bronchoscopies (Super D/Covidien/Medtronic, Veran, Auris, Intuitive ION, or other newer devices)

Is a pathologist or cytotech in the room at time of tissue retrieval? (This will help by securing adequate tissue obtained and using ROSE)

Are you utilizing a blood-based testing (liquid biopsy), nasal or sputum testing?

Treatment- (questions your facility needs to determine if needed for a comprehensive lung program)

Do you have dedicated thoracic surgeons? If not, who performs surgery? You may need to have a planned outmigration pathway to recapture patient if leaves your facility.

Do you offer SBRT? If not, who performs SBRT? You may need to have a planned outmigration pathway to recapture patients if they leave your facility.

Do you have lung specific tumor conferences? How often?

Who facilitates your tumor conferences? (This may encourage your specialists the opportunity to lead and attend whether that be a pulmonologist, radiologist or thoracic surgeon-sometimes these early diagnosticians do not attend general tumor conferences)

What determines tumor conference case presentation? Are they mainly retrospective, in the diagnostic phase, reoccurring or metastatic patients?

Supportive Services Overview- (do you currently have, need to develop, have local or national partners to refer out?)

Lung Specific Educational Materials (The GO2 Foundation for Lung Cancer has a handbook available for patients and care partners called Navigating Lung Cancer 360 degrees of Hope. It can be downloaded via the website or get copies for hospital distribution)

Smoking cessation program

Pulmonary rehabilitation

Oncology rehabilitation

Inpatient palliative care

Outpatient palliative care

Oncology social workers

Oncology financial navigation/counselor team

Survivorship program

Lung support groups The GO2 Foundation for Lung Cancer has an in person as well as real time "You tube" participation monthly for patients and care partners to join called Bring Hope Home Living Room. Experts are featured and questions can be submitted for discussion. Lungevity also has support options. Many of the biomarker specific patients have their own support groups.

General support groups

Survivorship program

Nutrition/Dietitian consults

Genetic counselor

Hospice

*Needed as the basics for a successful lung program

Physician Overview Survey	**Notes**	**Readiness Level 1-5 (1-starting from scratch to 5-ready to go)**
*Engaged respected physician	To help with policies/procedures and have your back when other physicians push back, many meetings may be needed from this crucial team member	
Emergency Room Physicians	Will be good to engage with them with incidental findings (quality initiative)	
Hospitalists	Engage for inpatients (quality initiative)	
Proceduralist (range of capabilities)	This should be a mix of radiologist, pulmonologist and thoracic surgeon to obtain tissue for diagnosis.	
Radiologist	Are they champions for early diagnosis (screening and IPNs) plus extra tumor conferences/case discussions-could possibly add a conference to discuss IPNs/Lrads 3 and 4; are they comfortable performing FNAs	
Pulmonologist	They need to be involved to help with risk stratification and management of nodules; obtain tissue; will need to attend extra meetings/conferences	
Thoracic Surgeon	This is good to have their leadership and commitment to attend extra meetings	
Pathologist	Need to attend extra meetings/conferences including possible additional molecular tumor board; dedication for ROSE (rapid onsite evaluation) or providing cytotech during tissue retrieval	

Medical Oncologist	May need to attend extra tumor board/leadership meetings	
Radiation Oncologist	May need to attend extra tumor board/leadership meetings	
Employed verses Independent Physicians	This will help determine how to structure referrals (if all are employed, may be able to agree on standardized patient flow; otherwise may need to let the PCP determine who next physician to oversee the patient care will need to be; by letting the PCP determine either by calling their office or by written preferences, it helps protect the navigator)	
Facility Overview Survey		
*Engagement of Administrative Team	They need to see the vision and strategy for the entire continuum of care lung program providing resources needed to make it come to fruition	
*Dedicated lung navigator	Recommend at least a dedicated clinical navigator to start a program and can add ancillary staff as the program grows	
Program navigation	If starting from beginning, should focus on screening, detection, treatment, or survivorship first. Pick one area. Would be hard to create comprehensive program all at the same time.	

*Do you have a thoracic or lung program leadership/steering committee?	This is very important as this group could report to the cancer committee who reports to the CMO so policies and procedures can be approved; also monitors quality reports and measures for the continuum of lung cancer care	
Monitoring of lung specific quality data	Commission on cancer is beginning to add surveillance data and other lung cancer specific measures in addition to the ACR requiring data and follow up for the LDCT screening; The GO2 Foundation for Lung Cancer offers a Care Continuum Community Centers of Excellence Program which includes the yealy Study to identify opportunities for quality improvements and comparative analysis of key performance indicators and metrics	
Do you have dedicated lung nodule review discussion, lung tumor board discussion and/or general tumor board discussion?	How often do you hold these discussions? Some will start with combined lung tumor board and then as their program grows, have nodule review discussion in addition to tumor board discussion.	
Who facilitates your lung discussions/tumor boards?	This may encourage your specialists the opportunity to lead and attend whether that be a pulmonologist, radiologist or thoracic surgeon-sometimes these early diagnosticians do not attend general tumor conferences	

What determines lung discussions/tumor board case presentation?	All Lrads 3/4 and/or IPNs? Are they mainly retrospective, in the diagnostic phase, reoccurring or metastatic patients?	
Programmatic Overview Survey Early Detection		
Do you have a Low Dose CT (LDCT) screening program?	Your facility may offer this program or you may want to partner with independent imaging freestanding centers and navigate patients to your program and multidisciplinary team	
Which department will manage the LDCT screening program?	Usually imaging, pulmonary or oncology service line. This could be split utilizing imaging for scheduling and actual imaging but then oncology for follow up.	
Will you offer or have every patient see a Nurse Practitioner or Physician's Assistant prior to screening making sure they qualify and have shared decision making visit along with smoking cessation addressed?	This will be a centralized model instead of a decentralized model where the PCP is responsible for the appropriate order.	
How are Lrads 3 and 4 managed? (opportunity to make sure patients do not fall through the cracks)	Opportunity to make sure patients do not fall through the cracks.	

Does the facility provide physician aids for shared decision making?	This is something you can offer to aid your PCP referrals, can be branded to your facility	
How will you market your program?	Do you have physician liaisons? Grand rounds? Lunch and learns? Community outreach?	
*How engaged are your IT team both from EMR and PACS team?	Being able to identify and track patients along with informing the entire healthcare team of the patient's status and identified needs are very important)	
Are your imaging letters and follow up letters automated?	This may be expensive to start but is best for the team since very time intensive; when first starting a LDCT screening program, sometimes it can be managed by a logistical patient navigator, working under a RN navigator, then as automation occurs, the role could be transitioned into a follow up navigator and tumor conference coordinator	
*Do you currently offer an incidental finding management program?	This needs to occur wherever imaging occurs for best patient outcomes and risk liability-remember always consult the PCP for next steps or have a pre-approved physician automated referral process	
If yes, where does this occur?	This needs to occur wherever imaging occurs for best patient outcomes and risk liability-remember always consult the PCP for next steps or have a pre-approved physician automated referral process.	

Do you currently offer a lung nodule follow up clinic?	Which specialists see patients? Could it be coordinated virtually if more than one need to see the same patient in one day? Do you have respiratory therapy available to do pulmonary function tests during clinic time?	
*Are lung biopsies performed at your facility?	Biopsies can be performed by pulmonologists trained to perform interventional procedures, radiologists and/or surgeons-truly depends on skill set of the providers but need to occur for both initial tissue diagnosis and potential progression of disease.	
Diagnostic		
Will you offer risk stratification?	This could be blood based, sputum or nasal swab.	
Do you have EBUS?	This wil help with staging?	
Navigational bronchoscopy and biopsy equipment available	Common devices are: Super D/Covidien/Medtronics, Veran, Auris Monarch, Intuitive ION, Body Vision and other newer devices/techniques	
Are pathologists or cytotechs in the room at the time of tissue retrieval?	By using ROSE (rapid onsite evaluation), this will help by securing sufficient tissue	
Are you utilizing blood based tissue (liquid biopsy) testing?		
Do you have a standardize reflex testing for biomarkers?		
Do you offer PET or refer out?		

Treatment		
Do you have a dedicated thoracic surgeon?	If not, who performs surgery? You may need to have a planned outmigration pathway to recapture patient if leaves your facility.	
Do you offer VATS and RATS?		
Do you offer SBRT (stereotactic body radiation therapy)?	If not, who performs SBRT? You may need to have a planned outmigration pathway to recapture patients if they leave your facility.	
Do you have dedicated medical oncologists that specialize in lung cancer?		
Do you have access to clinical trials?		
Support Services	**Can be offered onsite, referred out to a community partner or referred to a national organization**	
Smoking cessation program		
Pulmonary rehabilitation		
Oncology rehabiliation		
Inpatient palliative care		
Outpatient palliative care		
Oncology social workers		
Nutritional/Dietitian		
Genetic Counselor		

Oncology financial navigator/counselors		
Survivorship program		
Lung cancer support group		
Hospice		