Before the First Visit:
A Triage-Forward Outpatient Cancer Diagnostic Pathway

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Issues Addressed / Background

The Problem: Patients with suspected malignancy are often admitted for urgent, but not emergent, diagnostic workups, placing great strain on inpatient resources and delaying definitive care. Can some of these workups be managed outpatient in a timely manner with the right infrastructure?

The Solution: The UCSD Suspicion of Cancer (SoC) clinic was developed as a triage-first outpatient pathway, using an **inverted model** (see central flowchart) to initiate workup prior to the first visit and reduce delays in diagnosis.

Objective: To evaluate early operational outcomes following SoC clinic launch in December 2025.

Description of the Project

Target Population

Patients with findings suspicious for malignancy without a confirmed site-specific diagnosis

Referral Sources

Emergency department (ED) providers, inpatient teams, and specialty oncology clinics

Referral Order Set –Kept Simple

1. Are findings suspicious for cancer?
2. Is there a known primary site?

CT C/A/P

Mandatory CT chest/abdomen/pelvis ordered for all ED-placed referrals at time of referral.

1–2 Business Days

Target for first patient contact after referral received.

Expedited Pathways

Outpatient biopsy and imaging pathways coordinated before clinic visit.

Access Supervisor

Dedicated new patient access supervisor with expertise in scheduling, insurance verification, and records retrieval.

Clinic Capacity: ~2 SoC slots per week during initial phase

Results

65 Total Patients Referred

46% Diverted Without SoC Visit

25% Completed SoC Appointments

December 2025 – March 2026 (4 months)

Patient Disposition (n=65)

Disposition	n	%
Diverted to disease-specific team or PCP	30	46%
Completed SoC appointment	16	25%
Insurance denial	5	8%
Patient refusal or no-show	5	8%
Pending or closed for other reasons	9	14%

KEY FINDING

46%

of referred patients were diverted to disease-specific teams or primary care without requiring an SoC clinic visit

Triaging Actions Enabling Diversion

Physician-led triage facilitated direct routing through:

- Ordering additional imaging or diagnostic testing
- Placing expedited interventional radiology biopsy referrals
- Correcting misdirected referrals
- Direct communication with patients and families

Impact:

These actions enabled rapid patient contact by SoC staff within days of referral and initiation of outpatient workup prior to any clinic visit, **reducing delays compared to the traditional consultation-first model.**

Model Comparison

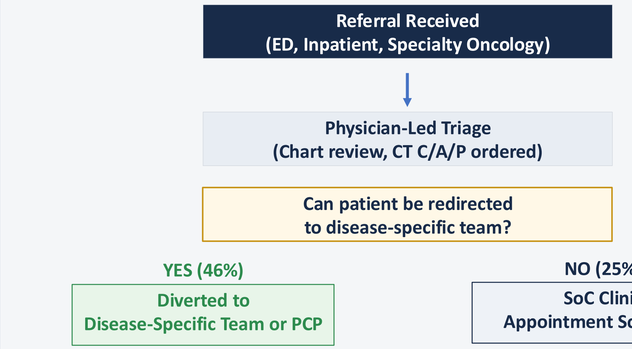
Conventional Model (Consult-First)

Referral placed
↓
Patient scheduled and seen
↓
Diagnostic testing ordered
↓
Results reviewed
↓
Redirected if needed

SoC Model (Triage-First)

Referral placed
↓
Physician triage at referral
↓
Diagnostic testing initiated immediately
↓
46% diverted directly to appropriate care
↓
Only complex cases seen

SoC Clinic Workflow



Referral Outcomes

Recommendations / Next Steps

1. Establish Disease-Team Liaisons

Designated oncologists to accept early referrals based on tirage data, allowing patients to bypass SoC when a likely diagnosis is identified.

2. Improve Patient Follow-Through

Implement proactive outreach after initial contact to support completion of pre-visit testing and reduce insurance denials and no-shows (15% of referrals)

3. Expand Referral Sources

Include primary care providers in addition to ED, inpatient, and oncology teams

4. Track Additional Metrics

Time from referral to imaging completion, time to diagnosis, and longitudinal tracking of whether the 2-slot-per-week capacity remains appropriate as referral volume grows.

Limitations:

- *Early operational data from a single academic center over 4 months.*
- *Limited sample size precludes comparison of time-to-diagnosis against conventional pathways.*
- *Insurance denial and no-show rates may reflect systemic barriers rather than clinic design issues.*