TL7 – Nurse leaders, with clinical nurse input, use trended data to acquire necessary resources to support the care delivery system(s).

Provide one example, with supporting evidence, where a nurse leader, with clinical nurse input, used trended data to acquire necessary resources to support the care delivery system(s).

Example 1: Emily Couric Clinical Cancer Center: Care Coordinator Expansion

The oncology patients served at the Emily Couric Clinical Cancer Center (ECCCC) have complex care needs and require a coordinated approach to care delivery to optimize their outcomes. Their care often spans multiple specialties located within the Emily Couric building, as well as throughout the health system, and requires many diagnostics, treatments and appointments. Navigating the course of care is emotionally and physically challenging for patients and their loved ones.

The professional nursing care coordinators of the ECCCC provide integral patient support within the framework of the care delivery system. They perform assessments to evaluate patients and their support systems, contribute substantially to the plan of care and participate in the implementation of that plan. Patient education is a prominent aspect of the care coordinator role and continues throughout the continuum of care. Evaluation of the patient's response to care, coping and ongoing needs direct the interventions carried out in collaboration with the interprofessional team.

As a Center of Excellence, growth of cancer programs, physician faculty, research and care system supports are part of the organization's clinical direction. In 2013, Nurse Leaders Jody Reyes, MSBA, BSN, RN, OCN, Administrator for the ECCCC, and Veronica Brill, MSN, RN, Director for ECCCC Clinical Operations, began planning for a significant expansion of services. Planned expansion included the addition of 34 half-day clinic sessions to accommodate the volume of patients that would be brought to the Center, with eight new hematology/oncology physicians, an additional neurosurgeon and an additional thoracic surgeon. This expansion necessitated an allocation to add nursing care coordinator positions.

Figure 1 shows the actual and projected increase in patient visits for which Reyes and Brill needed to plan.

TL7 Figure 1. Cancer Center Volume (Patient Visits), FY12-FY14

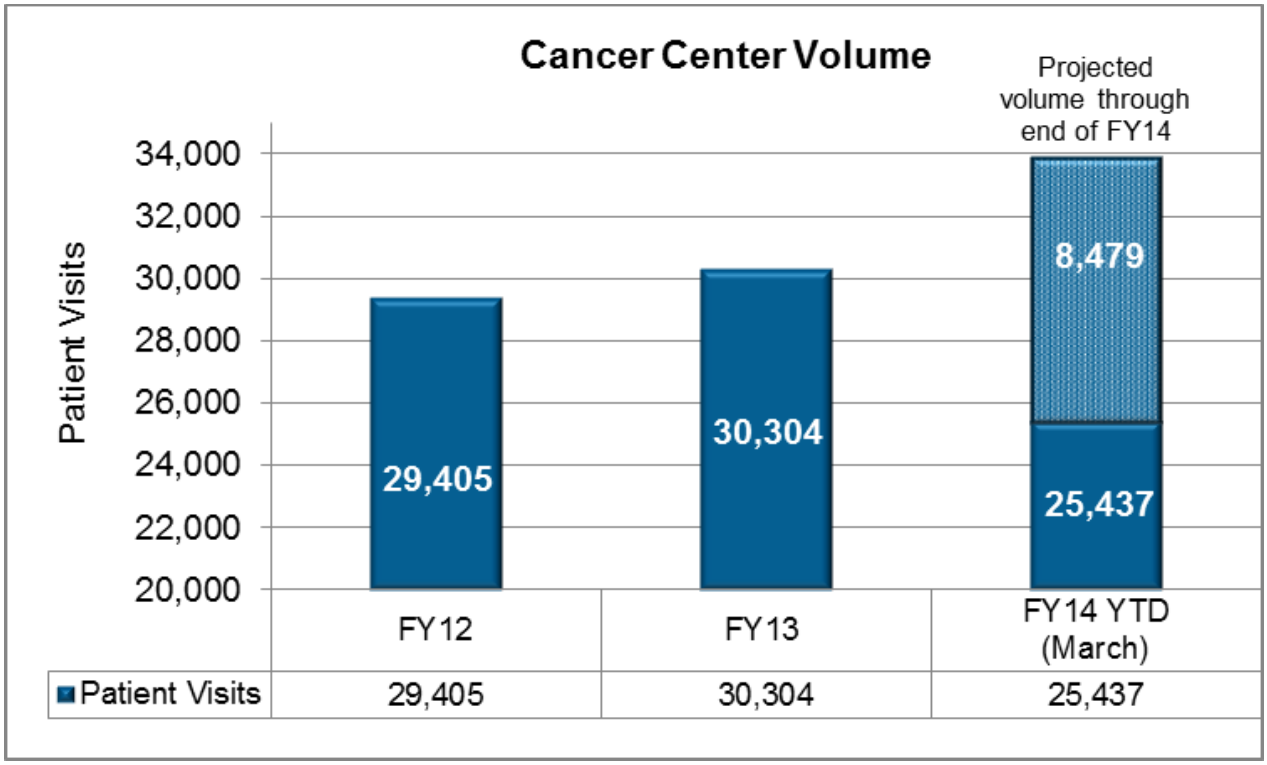

Exhibit TL7.a (Cancer Center Performance Report Brill page 5) is the performance report with the FY12 and FY13 data reflected in Figure 1.

In addition to the raw numbers of care coordinators that would be required, Reyes and Brill also acknowledged the potential care fragmentation for patients receiving treatment from more than one physician service. As described in OO8, the PNSO has adopted Relationship-Based Care (RBC) as its care delivery system. Reyes, Brill, and their team wanted to incorporate the principles of nursing's RBC model as they adapted their local interprofessional care delivery structures to a disease-specific population model. They hypothesized that a "disease-specific population" model of care delivery would provide a practice environment where nursing staff could foster therapeutic relationships with their patients/families, and they could have access to and connect with the correct resources to help patients on their survivorship journey. They engaged the current nursing care coordinators to participate in a comprehensive evaluation and redesign of the local care delivery model.

Participants:

TL7 Table 1. Participants, Cancer Center Care Coordinator Redesign

Name	Discipline	Title	Department
Jody Reyes	Nursing	Administrator	ECCCC
Veronica Brill	Nursing	Director, Cancer Center Clinical Operations	ECCCC
David Schneider	Nursing	RN Care Coordinator, Clinician IIII	ECCCC
Peggy Scott	Nursing	RN Care Coordinator, Clinician III	ECCCC
Melissa Otoya	Nursing	RN Care Coordinator, Clinician III	ECCCC
April Lauter	Nursing	RN Care Coordinator, Clinician III	ECCCC
Adrienne Banavage	Nursing	Nursing Education Coordinator II	ECCCC
Kelly Near	Nursing / Library Science	Nursing Public Health and Hospital Liaison Librarian	Health Sciences Library

Brill was not new to the organization, but she joined the ECCCC team as a nurse leader in February 2013. The process of facilitating this redesign with the care coordinators was one of her first leadership tasks. She allocated time for care coordinators to plan for the redesign as a group and for individuals to engage in specific follow-up activities. These reflective processes showed great respect for the RBC principles of healthy relationships with self and colleagues as a foundation for redesigning their care delivery relationships with patients and families.

The process began by asking the team to identify how they saw the state of the cancer center today and how they dreamed it should look a year from now. Each care coordinator was encouraged to participate and write down their personal thoughts/comments on an index card. The results of this March 8, 2013, exercise are captured in Exhibit TL7.b: State of the Cancer Center Team Exercise. This provided Brill with an assessment of their engagement, work frustrations and ideas for improvement and was used to set the goals of the cancer center care coordinator staff for the next year.

Next, the group of care coordinators evaluated the available evidence on care coordinator roles. Melissa Otoya, MSN, RN, CNL, Assistant Nurse Manager, and David Schneider, BSN, RN, OCN, RN Care Coordinator-Clinician IV, assisted by Kelly Near, MLS, MSN, RN, WHNP-BC, Nursing Public Health and Hospital Liaison Librarian, conducted an exhaustive literature review on care coordinator and nurse navigator role

descriptions and successful program models. The group also contacted cancer centers across the country to gather information on their care delivery models and typical care coordinator case loads and to find out what worked and what words of wisdom they could offer.

Using the information gathered, the group created a care coordinator job description. The end result included a comprehensive, RBC-anchored description of the care coordinator's essential duties and responsibilities (Exhibit TL7.c: Job Description, RN Care Coordinator-Clinician III). The group completed the draft and shared the job description with care coordinators and leaders throughout the organization, and it was adopted with very minor edits as the job description for all care coordinators.

With an evidence-based job description in hand, the team began focusing its efforts on breathing life into this fundamental document by ensuring care coordinators are aligned with similar patient populations. Previously, nursing coordinators were assigned to physicians as opposed to patient populations, and referred to themselves as "the care coordinator for Dr. X." With this new model, the need for nursing support is focused on the clinical complexity and care requirements of patient populations instead. Exhibit TL7.d is an example of the resources allocated per disease-specific team, which is used to continually evaluate data to ensure appropriate care coordinator positions (Exhibit TL7.d: Care Coordinator Need Assessment December 2013, May 2014).

An example of the ways in which disease-specific care coordination benefits patients can be found in the population of patients with head and neck cancer. The needs of this population are challenging, as the care needs are often complex and often include multiple social factors that make care coordination difficult. At the present time, there is a multidisciplinary team looking at how to streamline care between the surgery, radiation therapy and medical oncology teams. The care coordinators involved with these three services come together to review and ensure continuity of education material across the continuum, as well as to understand what each specialty has to offer the patient and to create a mechanism that makes communication among all care providers easily accessible and standardized.

Keeping the patient as the focus of the planning has guided decisions and priorities. The allocations described here are only a portion of the changes undertaken to improve the care delivery for cancer patients. Clinic configurations are being revised so that similar populations are being seen in the same location. This better organizes the resources around the patient and promotes communication between teams. The GI oncologists and surgeons are now in the same location, and efforts are underway to expand this model. Social work has also adopted the disease-specific assignment model, further synergizing the focus on the patient. Structures and processes are under constant evaluation to ensure the best possible care delivery to the patients served in the ECCCC.

Nurse leaders Brill and Reyes advocated for the resources they need to support the upward trend of patient visits. In total, $555,734 was allocated for the additional care coordinator positions. Exhibit TL7.e: RN Care Coordinator Decision Pack is the approved budget documentation submitted by Jody showing the total allocation for labor. They took the opportunity to engage their clinical nurses in a comprehensive redesign of the care delivery system that ultimately better supports their patients.