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Unit Staffing Collaborative: Cancer Services, Gynecology/Oncology

February 4, 2021

Revised: April 5, 2021

Note: One slide deck per HCS USC, calling out differences between clinics as appropriate

VERMONT FEDERATION OF NURSES & HEALTH PROFESSIONALS

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Unit/ Clinic USC Members

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- **Carolyn Sweet, RN**
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- Julie Hart, RN
- **Jennifer Provost**

- **Bold = Active member of this subgroup**

Components of USC Project Plan Per Article 20B

- Unit profile
- Minimum staffing levels
- Analysis of time spent by nurses on nursing and non-nursing activities
- Analysis and recommendation of acuity process and/or tool
- Analysis and determination for Circulating RN(s) to enable Circulating RN(s) to facilitate meal/break coverage and assist in transfers/discharges in all critical, procedural and acute care units
- Staffing effectiveness data (see Article 20), including unit specific quality data and NDNQI RN satisfaction and Practice Environment results
- Unit-specific quality data, including unit-based improvement initiatives
- Staffing plan (grid) that includes patient care staffing of RNs and ancillary staff where appropriate
- Staffing data, including the unit budget
- Financial impact of the proposal
- Metrics to be used to measure the effectiveness of the USC Project

Timeline

- The USC Project plan must be completed and submitted to the Chief Nursing Officer of the Hospital and President the VFNHP within three (3) months of completion of project **(Inpatient: 11/20/2020; Ambulatory: 12/1/2020).** The manager will make reasonable time available for the committee to work on the written plan. Staffing plans developed under this Article 20B shall require approval by both the Chief Nursing Officer of the Hospital and President of the VFNHP. A decision on the memorandum of agreement shall be made within three (3) months of the submission of the final report **(2/22/21)**. A failure to reject the plan or provide specific reasons for the rejection by either party within three (3) months of submission shall be considered acceptance. Where a final USC Project plan is rejected in good faith by either party, the USC committee shall reconvene and submit a new final report within three (3) months. Either party may initiate mediation following the rejection of a report.

Unit Profile

- Gyn/Onc: referral-based practice located in Women's Healthcare in the Ambulatory Care Center on level 4
- The clinic provides services to outpatients M-F from 8am-5pm.
- The clinic provides comprehensive care to women with both surgical and medical oncologic needs pertaining to gynecologic cancers and complex surgical management of gynecologic conditions
- The ambulatory clinic works in collaboration with hematology/oncology infusion center, OR and Radiation Oncology to coordinate care for cancer patients. Additionally, blood draws, port access and flush, staple removal, foley catheter insertion and removal, as well as pre-operative and chemotherapy teaching/education
- There are approximately 1,500 Provider visits annually and 400 RN visits
- Age range: adolescence and up

Meeting Dates

- 9/1- Kick off meeting
- 9/10- Primary/Nurse Navigator and Infusion
- 9/18- Rad/Onc
- 9/24- Primary/Nurse Navigator and Infusion
- **9/25- Gyn/Onc**
- 10/2- Rad/Onc
- 10/8- Primary/Nurse Navigator and Infusion
- **10/9- Gyn/Onc**

Meeting Dates

- 10/16 - Rad/Onc
- 10/22 - Primary/Navigator and Infusion
- 12/17 - Primary/Navigator and Infusion
- 12/17 - Infusion
- **12/18 - Gyn/Onc**
- 12/18 - Rad/Onc
- **1/8/21- Gyn/Onc**
- **1/15/21- Gyn/Onc**
- **1/22/21- Gyn/Onc**
- **1/29/21- Gyn/Onc**

- **Bold= Dates reflective of this subgroup**

Minimum Staffing Levels

- What are your core RN staffing levels?
  - 1 RN and a Care Coordinator (RN)
  - There are no LPNs or MAs specifically assigned to gyn oncology
- Speak to what the minimum number of RNs needed, address LPNs if applicable
  - 1RN needed to maintain the minimum standard of care (short term basis)
  - Ideally 2 RN FTEs are needed to adequately cover clinic/patient needs on a daily basis

  Current Nursing Tasks include:
  - Phone triage
  - Chemotherapy and preop education
  - Central line maintenance and labs
  - Placing orders for imaging, labs, medications, referrals
  - Scheduling of imaging, follow up, medical clearance, referrals
  - FMLA / disability paperwork completion
  - Post op staple removal, wound care, foley catheter removal/insertion
  - Coordination of care across multiple medical services, and psychosocial services
  - Prior authorization initiation for imaging, medication, genetic/somatic tissue testing
  - Triage of referrals including request of slides, imaging, additional records as applicable
  - Consider infusions and procedures if applicable N/A
  - Regardless the number of arrived visit volume (phone volume can be inversely proportional to visit volume)
- Address tactics to flex staffing up and down (i.e. sister sites, floating, per diems, resource pool)
  - Utilization of per diem
  - Exploration of an oncology resource pool? Rad Onc, Primary, Gyn Onc, Miller 5 etc.

Time Spent on Nursing vs Non-Nursing Duties

- What is the *approximate* time per week spent on non-nursing functions?
  - 50% of time spent (for each FTE):
    - The equivalent of 1.0 clerical FTE's
  - Pre-visit planning
    - Gathering image results, lab results, pre-op clearance, tracking down records and slides
  - Scheduling
    - Imaging (outside facilities and UVM)
    - Outgoing referrals (pre-op testing/clearance appts)
    - Follow up appointments
    - Chemotherapy
    - PCP/Cardiology clearance appointments for surgery
  - Initiation of Prior Auth for imaging being done at outside facilities
  - New referrals
    - Records request/imaging request/pathology slide requests
  - Order entry
    - Completing all but PA order entry, for each appointment
- Is there a recommendation on who could do the work? (goal is to identify options, not solve/implement)
  - Dedicated gyn onc PSS? Bandwidth to do so is problematic
  - Consistent MA/LPN
  - Call center to take phone calls?
  - Intake/coordinator?
  - Network
  - Reconcile order entry w/ current policy. Current practice is not in alignment with Medical group policy.
  - Epic Optimization (centralizing work outside of clinics)

Recommendation for Acuity Process

- This is a narrative
  - What non-phone work drives more acute staffing needs?
  - How does volume of nursing procedures affect acuity?
    - Patient acuity (stable, good performance status, asymptomatic vs symptomatic, poor or worsening performance status)
    - # of procedures, tests, appts needed by patient
    - Barriers to pt care (travel, financial, emotional distress). Decreased timely access to care including imaging, biopsies
    - Frequent "touches" or contacts through email or calls to pt to address questions and needs
    - Down a provider, yet same volume of patients thus impacting access to appts and surgery
  - Does in basket volume drive more acute staffing needs?
    - High volume of in basket messages (from both providers and patients) resulting in increased coordination of care needs
  - Document acuity process, what is considered/discussed
    - Ideal state: get to a place where we can look ahead in the schedule for indicators of acuity to potentially flex staffing up
- What are the “work triggers” which cause a change in practice?
  - Clinical practice changes
    - Higher volume of in-basket messages
    - Increased volume of patients
    - Higher patient acuity
    - Addition of new providers (Hiring 3rd attending MD to join practice)
    - Community provider no longer in network with BCBS; patients transfering care to UVMMC
    - Non-clinical roles of providers impacting access to patient care and availability to nursing staff
      - On call but in OR, or off site
      - Meetings for administrative roles impacts getting ahold of them with questions and other patient needs
      - Covering inpatient service but need to see someone in the outpatient setting
      - Workflow of how providers route patients through clinic (not always going to check out, go to RN's instead). Should be communicating via Epic to check out person who can move this forward
  - What requires more nursing support
    - New providers
      - Hiring 3rd Provider
    - Triage of incoming referrals with need for benign, non gyn oncology level of care
    - Higher patient acuity and increased barriers to care
    - Current patients are staying in the practice longer, effecting volume and need for extended coordination of care across time
    - Increased coordination of care outside of UVM

Analysis for Nurse Circulator

- For critical, procedural, acute care units – N/A for ambulatory

Staffing Data including Unit Budget

- Total Budgeted RNs in 2305 for FY19: 2.82 (1.82 RN, 1.0 LPN)
- Current budget: 1.82 RN's, LPN FTE moved to different cost center as it is not dedicated support for GynOnc

AMS Benchmark Staffing Grid

University Of Vermont Medical Center
Cost Center# 12012305
Gynecology Oncology
Workload Standard Development Summary Table

Volume Indicator: Completed Provider Visits
Annualized Volume: 1,563

AMS Benchmark Paid Hours Per Visit Range: 1.37 – 1.89
AMS Benchmark Worked Hours Per Visit Range: 1.18 – 1.64
AMS Benchmark Required Paid FTEs: 1.03 – 1.42

Hours/Visit			Paid FTEs		
Current Pattern Paid	FY'21 Target Paid	Paid/ Worked Ratio	Current Pattern	FY'21 Target Pattern	Variance Cur to Tar
3.01	2.47	1.16	2.32	1.86	0.46

Staffing Summary
Gynecology Oncology
1,563 Completed Provider Visits

Skill	Actual Paid FTEs	Current Pattern FTEs	Target Pattern FTEs	Variance Current - Target Pattern
RN	1.26	2.32	1.86	0.46
Grand Total	**1.26**	**2.32**	**1.86**	**0.46**

AMS Benchmark Staffing Grid

University of Vermont Medical Center
Current Staffing Pattern
Gyn Oncology
Cost Center: 12012305

Skill	Description	Shift Length (hours)	Number of Staff: Mon	Tue	Wed	Thur	Fri	Sat	Sun	Total Weekly Shifts	Total Weekly Req Hrs w/o repl	Req FTEs w/o replace	Shift Replace Ratio	Total Paid Hours	Total Paid FTEs	Hours per Indicator: Worked	Paid
		A								B	C=AxB		D	E=CxD	F=E/40		
RN																	
RN	6a - 5p	8.0	2.0	2.0	2.0	2.0	2.0			10.0	80.0	2.0	1.100	88	2.2	2.0615	3.0874
			Pattern Total							10.0	80.0	2.0	1.100	88	2.2	2.0615	3.0874

Completed Provider Visits: 1,363
Average per Day: 5

University of Vermont Medical Center
Example of a Target Staffing Pattern
Gyn Oncology
Cost Center: 12012305

Skill	Description	Shift Length (hours)	Number of Staff: Mon	Tue	Wed	Thur	Fri	Sat	Sun	Total Weekly Shifts	Total Weekly Req Hrs w/o repl	Req FTEs w/o replace	Shift Replace Ratio	Total Paid Hours	Total Paid FTEs	Hours per Indicator: Worked	Paid
		A								B	C=AxB		D	E=CxD	F=E/40		
RN																	
RN	6a - 5p	8.0	2.0	1.0	1.0	2.0	2.0			8.0	64.0	1.6	1.100	74	1.8	2.1282	2.4939
			Pattern Total							8.0	64.0	1.6	1.100	74	1.8	2.1282	2.4939

Completed Provider Visits: 1,363
Average per Day: 5

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Current Staffing Pattern/Schedule

- Year to date actual at job code level is 1.95 FTE
  - RNs, LPNs for clinics who have LPNs
  - How is this different from budget and if different, why?
    - Variance to budget is unfavorable by 0.13 FTE (1.95 actual, 1.82 budget)
  - How is this different from AMS benchmark staffing grid and if different, why?
    - AMS actuals were pulled when 1.0 LPN was in this cost center. This has since changed, as this position was not dedicated to GynOnc
    - The AMS benchmark suggests that 1.03-1.42 FTEs can support the volumes. The AMS target pattern is 1.86 paid FTE's (which is 1.6 FTE's worked) and also over their recommended FTEs (1.42). This is likely not accounting for the degree of coordination, clerical work, and out of scope provider support that is asked of RNs currently occupying this role.
- How do you staff M-F (weekends if applicable)?
  - How many RN FTEs are needed per day?
  - 2 RNs (1.8 FTE full time) in clinic M-F, 8-5pm (w/ 30 min lunch)
  - Per diem coverage (0.2 FTE) on Thursday
- What is your current staffing pattern?
  - Same as above, 2 RNs, M-F, 8-5:00pm (w/30 min lunch)
- How will scheduled and unscheduled CTO and unproductive time will be covered?
  - 1 per diem on staff, but with sporadic availability. No depth beyond this RN.

Proposed Staffing Pattern/Schedule

- Narrative
  - The Gyn/Onc team is supported by onsite clerical staff to assist with daily visit activities (i.e. rooming and check in/out)
  - Currently, the Gyn/Onc team is not supported by PSS within the clinic to assist with scheduling, record retrieval (imaging and pathology slides), prior authorization initiation, and other clerical duties.
    - See slide 9 for more examples
  - Current Gyn/Onc RNs support MD order entry nearly 100%, ideally with education and support this practice should shift to align with current medical group policy
- Please add proposed RN staffing and staffing pattern (LPNs if applicable)
  - Continue with 2.0 FTE RN's (current staffing)
  - Increased clerical support with a dedicated PSS per current Medical Group clinic workflow
- Address differences from current staffing pattern/schedule and AMS benchmark (if applicable)
  - The difference between the current staffing pattern and AMS benchmark is rooted in the lack of clerical support and degree of coordination and out of scope work being performed by RNs in this role
  - Additionally we believe the comprehensive care provided across the medical and surgical continuum that is unique to Gyn Oncology at UVMMC may not be reflected in the AMS benchmark. Many Gyn Oncology units practice solely from a surgical management perspective, referring patients for medical oncology/chemotherapy management, thus skewing the paid hours per indicator benchmark.

Financial Impact of the Proposal

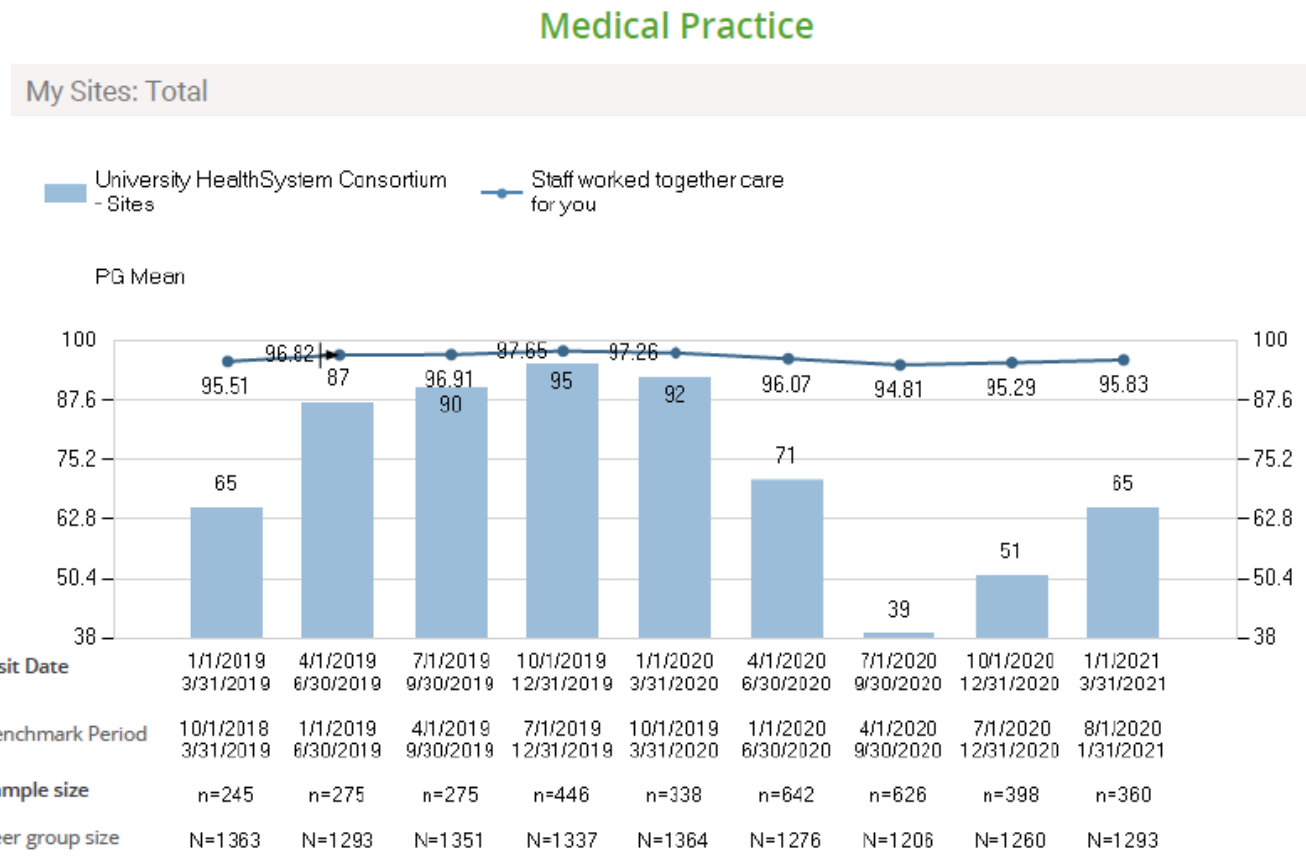
- Cost of additional RN/LPN
  - 1.0 FTE PSS to support Gyn/Onc team
    - $43,427 salary & fringe

Metrics to Measure the Effectiveness of the USC Project Plan

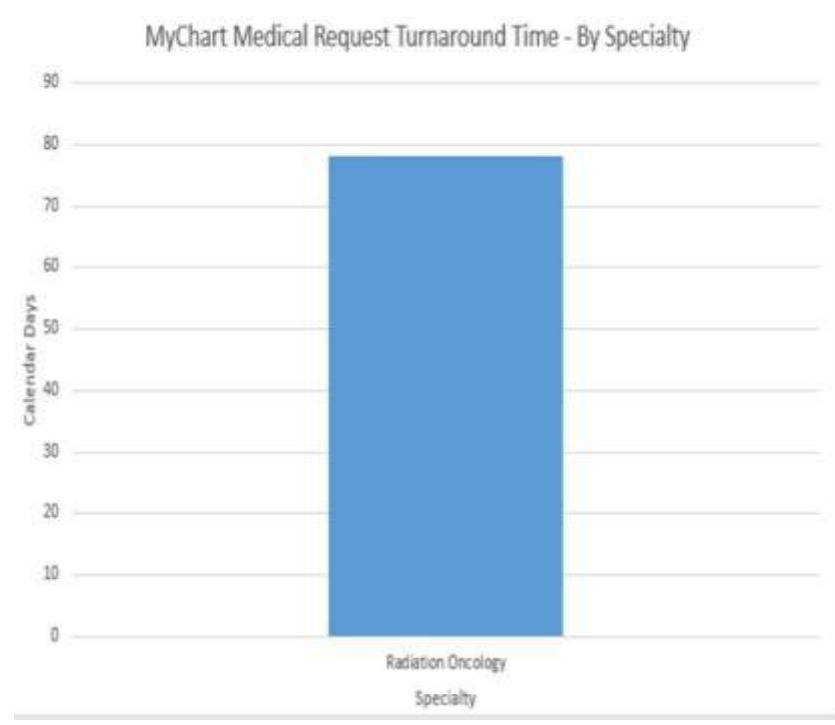
- How will you know staffing levels are effective?
  - Returning calls w/in 24-48 hours
  - Decrease in # PA initiations
  - Decrease in # of minutes spent gathering information for visits (i.e. images, etc.)
  - Decrease in order entry to support MDs
- How will you know changes are effective?
- Suggestions to consider monitoring:
  - Press Ganey metric specific to nursing
  - NDNQI metric
  - Utilization of premium pay/OT
  - Utilization of per diems
  - Utilization of resource pool
- Have the items you identified in the USC (i.e. non-nursing functions) been addressed
  - Yes
- This assessment will be ongoing beyond initial recommendations

Baseline Data

Press Ganey



MyChart Response Time



NDNQI

Unit - Survey DESC	Measure Short Desc	Year	Srvy Unit Mean	RNSrvy_PGUnitMean
Cancer Health Care Service	Adq staff to get work done	2020	2.22	2.63

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Highlighted Changes

- The current structure of Gyn/Onc does not contain the clerical support that is structured throughout the Medical Group. Our 1.8 RN FTE are left facilitating this clerical work and thus making the current staffing pattern unsustainable. This is impacting the current RNs ability to provide coordination of care to a complex and acute patient population in a timely and efficient manner. We are requesting a 1.0 FTE dedicated for clerical support (PSS) to the Gyn/Onc team. This clerical support would better enable the current RN staffing pattern to work to the highest level of their licensing, thereby better addressing patient barriers to care, acuity and needs. Proposed timeline to integrate PSS support for gyn onc within 1-3 months (Priority #1)

Highlighted Changes

- Tasks being performed by this requested 1.0 clerical FTE are as follows:
  - Entry of incoming referrals
  - Pre visit gathering of records for referrals including office visit notes, oncology treatment records, imaging reports and digital images (either on disc or pushed digitally from outside facility), Pathology reports and slides for UVM MC review, pertinent lab/tumor marker results
  - Scheduling
    - New pt consults once referrals triaged and appropriate records received
    - Follow up and surveillance visits for providers after clinic visits
    - Imaging at outside facilities and timely imaging scheduling at UVM
    - Preop appts for testing prior to surgery including H&P w/ PCP, labs and EKG at outside facilities, cardiology clearance and pulmonary clearance as needed. Follow up to ensuring receipt of results of outside reports once appts/testing have occurred, then scanning into EPIC and routing to MD for review.
    - Chemotherapy scheduling –this includes coordination of provider visit in gyn onc and infusion visit in cancer center
    - Post op follow up and staple/catheter removal as directed at time of pt discharge
    - Follow up for inpatient consults
  - Prior Authorization for imaging studies being done at outside facilities
    - It is yet to be seen how the centralization of prior auth will impact external PAs, but considering the volume of other clerical tasks, it is unlikely to impact the need for a 1.0 FTE.

Highlighted Changes

- Faxing or electronic transmission of orders to outside facilities.
- Ensuring transmission/communication of consult notes back to referring providers
- Coordination of monthly outreach clinic at RRMC
- Coordination of outgoing referrals
- The impact of shifting this work to a dedicated PSS would enable us focus on nursing functions, This includes:
  - Improved support and availability to our providers in clinic
  - More timely response to patient calls and my chart messages
  - Oversight of coordination of care and communication of plans and results to patients.
  - Ability of Nurse Navigator for GynOnc to focus on new patient intake via timely outreach and coordination of services. This will better meet the psychosocial needs of our patient population and the needs of referring providers.

Highlighted Changes

- Current order entry work being done by gyn onc nursing team to support MDs should be brought into alignment with current medical group policy. We would like to initiate this effective immediately. We anticipate this process may require additional training and support for MDs and would aim for full integration of this process within 1-3 months' time. (Priority #2)
- We believe our proposed changes provide a cost effective approach that would also have positive impacts on nurse retention, nurse satisfaction as well as patient satisfaction and outcomes.
- There is potential for opportunity in a shared resource, especially as further integration of cancer services is explored. The most likely source of this collaboration is cc1465 (Hematology/Oncology). This is due to similarities in clerical work performed and the proposed vision in consolidating cancer care.

Time line and Deliverables

- Check in/progress update - schedule call with P. Gagne and D. Snell by **October 15, 2020**
- Final plans submission deadline:
  - **INPATIENT UNITS: November 20, 2020**
  - **AMBULATORY CLINICS: February 15, 2021**

- Submit to: CNO and President VFNHP
  - Scan as 1 document and email to Peg.Gagne@uvmhealth.org and debs@vfnhp.org

Follow Up Items Submitted on 3/8/21

- Please see the following slides regarding our financial data and metrics to measure success.
- The centralization of Prior Auth could impact the need for a full time PSS. This will depend on the final workflow.
- Adherence to order entry would greatly improve our RN ability to coordinate care.
  - Much of this initiative is rooted in significant workflow changes for the providers. Epic education will certainly be needed. This could also impact provider ability to maintain volumes. The task of meeting the Order Entry policy will be a challenge in this division.

Project Plan Approval

May 3, 2021

Dear Women's USC Teams:

Thank you very much for your engagement and efforts in the Unit Staffing Collaborative (USC) project. We are pleased to let you know that your project plans with the addition of a PSS 1.0 FTE has been approved for FY 22. This will be a shared resource across the four areas. We are unable to approve the additional 1.5 FTE of support staff requested for your areas at this time, given the AMS benchmarking data and the potential impact of shifting support functions (prior authorization) to other groups.

Service	Staffing Addition	FTE
MFM	PSS	1.0
REI		
OB/GYN		
GYN Onc		

If you have any questions about the USC project approvals, please let us know.

Going forward, your USC team is responsible for the implementation and ongoing monitoring of the effectiveness and progress of your staffing plan, review of any Concern Forms and submission of proposed changes/ reports to the Staffing Committee (see Article 20B).

Regards,
Peg and Deb

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Screenshot of Finance Document due on 3/7

Area	FY21 Budget		AMS Recommendation		Difference Between FY21 Budget & AMS		Proposed		Difference Between FY21 Budget & Proposed		Difference between AMS & Proposed		Summary Comments
	FTE's	Salaries	FTE's	Salaries	FTE's	Salaries	FTE's	Salaries	FTE's	Salaries	FTE's	Salaries	
y RN, cc1465	13.4	$1,172,264	8.8	$770,716	(4.6)	($401,548)	13.4	$1,172,264	0.0	$0	4.6	$401,548	These are the primary RN FTEs from Hematology/O total is inclusive of RNs from cost center 1467 (Hem (Stem Cell). There are also positions here that have which is reflected in our actuals.
y PSS, cc1465	8.8	$344,481	8.8	$344,481	0.0	$0	9.8	$383,627	1.0	$39,146	1.0	$39,146	These are the PSS FTEs from Hematology/Oncology no change in regards to the AMS benchmark.
y Total	22.2	$1,516,745	17.6	$1,115,197	(4.6)	($401,548)	23.2	$1,555,891	1.0	$39,146	5.6	$440,694	Total FTE financials for affected staff in the proposa
n RN, cc 1465	13.2	$1,154,762	16.1	$1,405,836	2.9	$251,074	15.2	$1,329,726	2.0	$174,964	(0.9)	($76,110)	These are the RN FTEs from the infusion center in Hematology/Oncology
y & Infusion RN (cc)	26.6	$2,327,026	24.9	$2,176,552	(1.7)	($150,474)	28.6	$2,501,990	2.0	$174,964	3.7	$325,438	This is a roll up of both primary and infusion FTEs. A distinct entities with minimal overlap, the FTEs com cost center
y & Infusion Total 1465, 1467, 2306)	35.4	$2,671,507	33.7	$2,521,033	(1.7)	($150,474)	38.4	$2,885,617	3.0	$214,110	4.7	$364,584	Total FTE financials for affected staff in the proposa
	4.1	$326,877	4.6	$368,334	0.5	$41,458	4.1	$326,877	0.0	$0	(0.5)	($41,458)	These are the RN FTEs for Radiation Oncology
	0.5	$22,058	1.15	$44,491	0.7	$22,433	1.0	$38,688	0.5	$16,630	(0.2)	($5,803)	These are the MA FTEs from radiation oncology
ftected Staff	4.6	$348,935	5.8	$412,825	1.2	$63,891	5.1	$365,565	0.5	$16,630	(0.7)	($47,261)	Total FTE financials for affected staff in the proposa
	1.82	$173,002	1.86	$176,804	0.04	$3,802	1.80	$171,101	(0.02)	($1,901)	(0.06)	($5,703)	These are the RN FTEs for GynOnc
	0.00	$0	0.00	$0	0.00	$0	1.00	$39,146	1.00	$39,146	1.00	$39,146	This is a PSS FTE represented by the same avg. cost FTE (no current gyn/onc PSS, so no base data around
fected Staff	1.80	$173,002	1.90	$176,804	0.04	$3,802	2.80	$210,246	0.98	$37,244	0.90	$33,442	Total FTE financials for affected staff in the proposa
Navigation	5.0	$531,336	6.7	$710,928	1.7	$179,592	6.0	$637,603	1.0	$106,267	(0.7)	($73,324)	These are the RN FTEs for our Nurse Navigators. An can be found in our slidedeck. Generally, only 4 FTE center 2309 with the 5th in cost center 2250, surgica are navigators and no AMS benchmarking was provi so they were combined.
r	3.6	$140,774	3.6	$140,774	0.0	$0	4.6	$179,878	1.0	$39,104	1.0	$39,104	This is a PSS FTE represented by the same avg. cost FTE (no current gyn/onc PSS, so no base data around
	0.0	$0	0.0	$0	0.0	$0	0.5	$43,732	0.5	$43,732	0.5	$43,732	This is a FTE request for primary nursing support in s Reasoning can be found in slide deck.
otal (cc2309)	8.6	$672,110	10.3	$851,702	1.7	$179,592	11.1	$861,214	2.5	$189,103	0.8	$9,512	Total FTE financials for affected staff in the proposa
ices RN	37.5	$3,358,241	38.1	$3,432,618	0.5	$74,377	41.0	$3,681,303	3.5	$323,062	3.0	$248,685	Total FTE financials for RNs in all the Cancer Service
ices Support	12.9	$507,313	13.6	$529,747	0.7	$22,433	16.4	$641,339	3.5	$134,025	2.9	$111,592	Total FTE financials for affected support staff in all t Services
ices	50.4	$3,865,554	51.6	$3,962,365	1.2	$96,811	57.4	$4,322,641	7.0	$457,088	5.8	$360,277	Total FTE financials for affected staff in all the Canc