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Unit Staffing Collaborative: Cancer Services Nurse Navigation

February 15, 2021

Revised: April 5, 2021

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

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Unit/ Clinic USC Members

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***BOLD indicates active members of this group**

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: 2/15/2021).** 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 **(3/31/2021)**. 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

- This department reflects the four clinical program coordinators who perform the Nurse Navigator functions for Hematology, Medical Oncology, and Surgical Oncology patients.
- The nurse navigators primarily support three groups of oncology patients:
  - Hematology Oncology- Infusion Room
  - Hematology Oncology- Clinic
  - Surgical Oncology
- The nurse navigator team works from 8am-5pm, Monday through Friday

Meeting Dates

- 9/1- Kick off meeting
- 9/16/2021
- 10/22/2021
- 2/9/2021
- 2/10/2021
- 2/11/2021
- 2/12/2021

Minimum Staffing Levels

- What are your core RN staffing levels?
  - Current: 3 Nurse Navigators. 4 would be indicative of "Core" (w/2 Intake Coordinators for support)
- Speak to what the minimum number of RNs needed, address LPNs if applicable
  - 2 Nurse Navigators could safely manage clinical intake of cancer patients.
    - Short term basis only; this is not sustainable as there would be components of the job description that could not be completed
    - This would require robust clerical support
    - This would likely require a far greater lift on internal and community providers
    - This would considerably delay imaging, provider visits, and time to treatment
    - This would result in significantly less patient centered care
  - 4-5+ Nurse Navigators ideally (all disease sites should be navigated), current workload of some Nurse Navigators is not sustainable long term
- Navigator Roles/Responsibilities:
  - Triage all new cancer patient referrals, determine need for additional workup/staging/tests and appropriate specialty consults
  - Patient education re: diagnosis, workup, consults, treatment, etc...
  - Place the vast majority of orders for tests/procedures
  - Schedule tests/procedures, communicate to patient
  - Place the majority of referrals for consults w/surgery/med onc/rad onc/GI/pulmonary/etc...
  - Place the majority of referrals to supportive services (SW, dietician, counseling, etc.)
  - Telephone triage/in-basket messages from staff/my chart messages from patients
  - Communication to interdisciplinary team including MD's, RN's, schedulers, etc. (within UVM and outside UVM)
  - Coordination/tracking of patient care at other sites as part of overall treatment plan
  - Coordinate/send patient referrals for second opinions at other cancer centers (i.e., DFCI, MSKCC, etc.)
  - Miscellaneous tasks given to NN (committee participation, projects, tumor board data to Cancer Committee, etc.)
  - Triaging of new referrals (non-cancer) in other clinics to ensure appropriate workup scheduling (i.e., review referrals to GI clinic to determine need for clinic consult vs procedure, may require speaking with patient to explain referral, plan and answer questions)
  - Coordination of Multi-disciplinary Clinics requires RN presence in clinic (3-4 hrs.), scheduling of patient appts with surgery, medical and radiation oncology, ensuring treatment recs/plans scheduled and initiated, etc.
  - Tumor board
    - Soliciting cases for review, finalizing TB list and distributing list to attendees, confirming outside imaging and path slides are at UVM for review, communicating TB recs to pt/clinic staff/PCP, etc., ensure TB recs get scheduled, f/u on results of any rec tests/procedures, take attendance, document needed data for Cancer Committee meetings in excel
    - For new Tumor Board/epic process-place Tumor Board order in epic, schedule patients in epic, arrive pts in epic, complete Tumor Board documentation in epic and route to appropriate MD for co-sign)
  - As referrals for NPV's and from Tumor Board increase, the workload for the Nurse Navigator increases
- Address tactics to flex staffing up and down (i.e. sister sites, floating, per diems, resource pool)
  - Currently, only 1 per diem available to provide coverage. These are salaried positions, so volume increase and acute needs are generally absorbed by working more hours

Time Spent on Nursing vs Non-Nursing Duties

- What is the *approximate* time per week spent on non-nursing functions?
  - This can vary by day, week, and disease site
  - Approximately 6-10 hours per navigator, per week
  - What non-nursing functions are consistently assigned to RNs?
    - Entering orders for MD's, outgoing referrals, coordinating appointments
- Is there a recommendation on who could do the work? (goal is to identify options, not solve/implement)
  - Currently, intake coordinators facilitate most of the clerical duties. This person supports 3 Nurse Navigators. Clerical work that this person does not have bandwidth for falls to the Nurse Navigators.
  - Support in the form of additional intake coordinators would be ideal
  - Tumor registrars could assist with tumor board preparation
  - Pre-cert support would create bandwidth for current intake coordinators to absorb more clerical duties.
- What activities do not require RNs or prevent RNs from doing core RN work (i.e. RNs can perform rooming function, but does it keep RNs from staffing triage calls)
  - Scheduling tests/procedures, requesting/faxing records, requesting outside imaging/path slides, entering orders for MD's, outgoing referrals,
- Discuss what is needed to have RNs working to top of license
  - Less disease sites per Nurse Navigator
  - Additional Intake coordinator support for each nurse navigator
  - Consistent utilization of Epic for internal communication, and adherence to order entry policy by inte

Recommendation for Acuity Process

- What non-phone work drives more acute staffing needs?
  - How does volume of nursing procedures affect acuity?
  - New cancer referrals have varying acuity dictating level of time and support needed from the Nurse Navigator; # of tests/procedures/appts needed, patient distress level/need for supportive services referrals, patient health status (stable/asymptomatic/good performance status vs very symptomatic/poor and declining performing status, # of identified and removed barriers to care, patient need for frequent calls/emails for questions and support
- Does in basket volume drive more acute staffing needs?
  - Requires a lot of touches
    - High volumes of in-basket messages and increased coordination across the community creates more acute needs
  - High resource utilizers
  - Volume/aging messages
- Document acuity process, what is considered/discussed

- What are the "work triggers" which cause a change in practice?
  - Clinical practice changes (which create more work and effort by Nurse Navigators to find efficient/timely work arounds for patient scheduling and care)
    - Increasing poor and limited access to care at UVMMC and affiliate sites including tests/biopsy/scans/provider NPV consult/appointments, etc.
    - No secondary reads for outside imaging by radiology-outside imaging reports are often incorrect and are relied on by the Nurse Navigators to guide workup/staging. This creates an increased volume of patients to be discussed at tumor boards so we can get radiology interpretation
  - What requires more nursing support
    - Expansion of scope of service
    - New providers
    - Increased volume of new patients
    - Higher acuity of new patients
    - Current patients staying "active" with the Nurse Navigator for extended time (esophageal cancer needing tri-modality care with chemoradiation and surgery, Nurse Navigator stays involved for the duration of treatment and into surveillance, ~6 months plus)
    - Increasing # of non-cancer patients referred to the Nurse Navigator for triage/coordination of care by other clinics
    - Increasing # of primary nurses/schedulers/providers requesting Nurse Navigator support for existing patients

Analysis for Nurse Circulator

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

Staffing Data including Unit Budget

- FY21 Budgeted RN FTEs
  - Budgeted RN FTEs from cost center 2309 (cancer center admin) is 4.1
  - Budgeted RN FTEs from cost center 2250 (surg/onc) is 1.0
  - Total Budgeted RN FTEs for nurse navigation is 5.1

AMS Benchmark Staffing Grid

University of Vermont Medical Center

Current & Example of a Target Staffing Pattern

Cancer Center Admin

Cost Center: 12012309

Completed Provider Visits	42,692
Average per Day	171

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	SVH Replace Ratio	Total Paid Hours	Total Paid FTEs	Hours per Indicator Worked	Paid
		A								B	C=AxB		D	E=CxD	F=E/40		
		Clin. Program Coord															
Clin. Program Coord.		8.0	3.6	3.6	3.6	3.6	3.6			17.9	142.7	3.57	1.121	160	4.0	0.1738	0.1948
					Pattern Total					17.9	142.7	3.6	1.121	160	4.00	**0.174**	**0.195**

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AMS Benchmark Staffing Grid

University of Vermont Medical Center
Cost Center# 12012309
Cancer Center Administration
Workload Standard Development Summary Table

Volume Indicator: Completed Provider Visits
Annualized Volume: 42,692

AMS Benchmark Paid Hours Per Visit Range: 0.19 – 0.25
AMS Benchmark Worked Hours Per Visit Range: 0.17 – 0.22
AMS Benchmark Required Paid FTEs: 3.98 – 5.08

Hours/Visit			Paid FTEs		
Current Pattern Paid	FY'21 Target Paid	Paid/ Worked Ratio	Current Pattern	FY'21 Target Pattern	Variance Cur to Tar
0.19	0.19	1.121	4.0	4.0	0.0

AMS Benchmark Staffing Grid

UVMMC
Cc 12012300 Cancer Center Admin
Labor Target Analysis

Major Work Category	Benchmark Indicator	Actual Volume FY 2019	Benchmark Paid Hours per Indicator Low		High	Benchmark Required FTEs Low		High	Comment
Nurse Navigator Functions									
Care Coordination									
Hem - Onc - Infusion Room	Completed Provider Visits	15,583							
Hem - Onc - Clinic	Completed Provider Visits	20,946							
Surgical Oncology	Completed Provider Visits	6,183							
Additional Clinic Staff Subtotal	**Completed Provider Visits**	**42,692**	0.12	-	0.25	3.08	-	5.08	
Variable Subtotal	**Completed Provider Visits**	**42,692**	0.12	-	0.25	3.08	-	5.08	
Additional Fixed Workload Functions		-							
Other	# Weeks	52	0.00	-	0.00	0.00	-	0.00	
Fixed Subtotal	**Completed Provider Visits**	**42,692**	0.00	-	0.00	0.00	-	0.00	
Total Paid Hour Benchmark	**Completed Provider Visits**	**42,692**	0.12	-	0.25	3.08	-	5.08	
Total Worked Hour Benchmark	**Completed Provider Visits**	**42,692**	0.17	-	0.22	3.55	-	4.53	

AMS Benchmark Staffing Grid

Staffing Summary

Cancer Center Administration

42,692 Completed Provider Visits

Skill	Actual Paid FTEs	Current Pattern FTEs	Target Pattern FTEs	Variance Current - Target Pattern
RN	4.02	4.0	4.0	0.00
Grand Total	**4.02**	**4.0**	**4.0**	**0.00**

Discrepancies With AMS Benchmark

- Context:
  - AMS benchmark was obtained using total volume of patients between hematology/oncology (4.1 budgeted Nurse Navigators) and surgical oncology (1.0 budgeted Nurse Navigators)
    - 42,692 Total visits
  - The paid hours per indicator is 0.19-0.25. Running this benchmark against the total visits resulted in AMS proposing a staffing pattern of 4.0 RNs
    - This benchmark states that 4.0 RN FTE's navigated 42,692 new patients in FY19
  - The correct indicator for this clinic should have been NEW PATIENT VISITS
    - 3797 across both surgical oncology and medical oncology
    - 2859 across only medical oncology
  - Running the paid hours per indicator against the new patient volumes results in significantly less FTEs, and a benchmark that is significantly lower.
    - This new benchmark would imply that a 0.3 RN could support intake of all cancer patients (3797 patients)

Discrepancies With AMS Benchmark

- Discussion with AMS regarding discrepancy
  - A meeting was held with AMS to discuss the variance, the correct indicator, and next steps.
  - When exploring the question of why the work defined within the navigator role was weighted in a way that did not reflect reality, it was shared with us that the worked and paid hours per indicator were adjusted to better fit actual staffing. In other words, they communicated that the worked hours per indicator was chosen to generate 4 FTEs at the end.
  - This was discussed in great length, as it was this committee's understanding that this benchmark, which was their proprietary information, would not change, but remain a constant based on the work being performed. It is the indicator (visit volumes) that would act as the variable and affect the final staffing benchmarks.
  - AMS was not willing to provide further explanation as to how they arrived at the benchmark
  - Upon learning this, our unit decided to obtain an accurate benchmark based on other, more objective information AMS was able to provide.

Discrepancies With AMS Benchmark

- Process:
  - Cancer Services was split into 5 separate groups: Infusion, Primary (triage), Rad/Onc, Gyn/Onc, and Nurse Navigators.
    - Each group has a distinctly different job description.
    - Primary nursing is mostly triage and has a specific benchmark (0.75-1.00 worked hours/indicator)
    - Gyn Onc is both triage and navigation, and has a specific benchmark (1.37-1.89 worked hours/indicator)
    - Thus, we can assume if these benchmarks were structured similarly to a pay grade (min., midpoint, max.), the Nurse Navigation benchmark would be the max (2.00-2.78 worked hours/indicator)
  - For the purposes of this project, we can assume that there are 3 nurse navigators in 2309. The 4th supports navigation and primary in surgical oncology, so reflective of the midpoint benchmark (1.37-1.89)
  - Thus, when using the indicator of non-surgical oncology new patient visits (2859) and the benchmark worked hours/indicator above, the correct benchmarked FTEs we are using for cost center 2309 is:
    - 2.75-3.82 Medical Oncology

Discrepancies With AMS Benchmark

- Process:
  - Surgical oncology primary support is built into the nurse navigator's roles, but only for surgical oncology. This is why cost center 2250 was included in the navigator USC but was noted as unique. Adding primary RN support into cc2250 would better delineate the work and provide a cleaner staffing structure within our Cancer Service Line.
  - When using the indicator for surgical oncology (total visits) and the midpoint benchmark of 1.37-1.89, the correct benchmarked FTEs is:
    - 2.86 – 3.94 Surgical Oncology
  - Total Navigator FTEs between both units is:
    - 5.61 - 7.76

Current Staffing Pattern/Schedule

- Year to date actual at job code level
  - 5.1 Actual from cost center 2309 (med/onc) and cost center 2250 (surg. Onc).
  - How is this different from budget and if different, why?
    - There is no variance to budget between these cost centers YTD (5.1 to 5.1)
  - How is this different from AMS benchmark staffing grid and if different, why?
    - The AMS staffing grid provided reflects 4 FTEs in 2309. This is even to budget. No benchmark provided for 2250.
    - Our adjusted AMS benchmarks (slide 18) imply that between 5.61 and 7.76 FTEs should support, or 6.69 if we use the midpoint.
    - This variance (5.1 actual to 6.69) is rooted in the non-nursing tasks as well as the robust volumes and disease sites that our clinicians currently support.
- How do you staff M-F (weekends if applicable)?
  - Each of our navigators are 8-5, Monday-Friday
- What is your current staffing pattern?
  - 5 total exempt FTEs spread through week as stated above
- How will scheduled and unscheduled CTO and unproductive time will be covered?
  - We currently are supported by 1 per diem, but this sustainability is difficult due to the need for expertise and coverage across all disease sites

Proposed Staffing Pattern/Schedule

- Please add proposed RN staffing and staffing pattern (LPNs if applicable)
  - 4 Med/Onc Nurse Navigators, 2 Surg/Onc, 0.5 Primary RN for Surg/Onc (cc2250)
    - 8-5pm, Monday – Friday
    - Spread disease sites to create sustainability
- Address differences from current staffing pattern/schedule and AMS benchmark (if applicable)
  - 2.0 Navigators and 0.5 Primary RN in Surg. Onc. would be 0.36 FTE favorable variance to the adjusted AMS benchmark (see slide 18).
  - 4 Nurse Navigators in MedOnc would be 0.18 FTE over the high end of our adjusted AMS benchmark (see slide 18)
    - We believe this variance is rooted in the broad coordination of care for new cancer patients that is being performed across the region. This geographic difference may not be captured in the benchmark.
    - We also believe the benchmark is not reflective of the volume of orders placed, clerical work performed, and tumor board support that is currently required in this role.
    - Current staffing is outdated. Care for cancer patients today has become much more acute and extended. Patient's stay on treatments for far longer than they used to, requiring the nurse navigators to follow more patients over a longer period of time. Entry into the 'cancer world' is much sooner because of screenings. These are patients that are followed by the nurse navigators.

Financial Impact of the Proposal

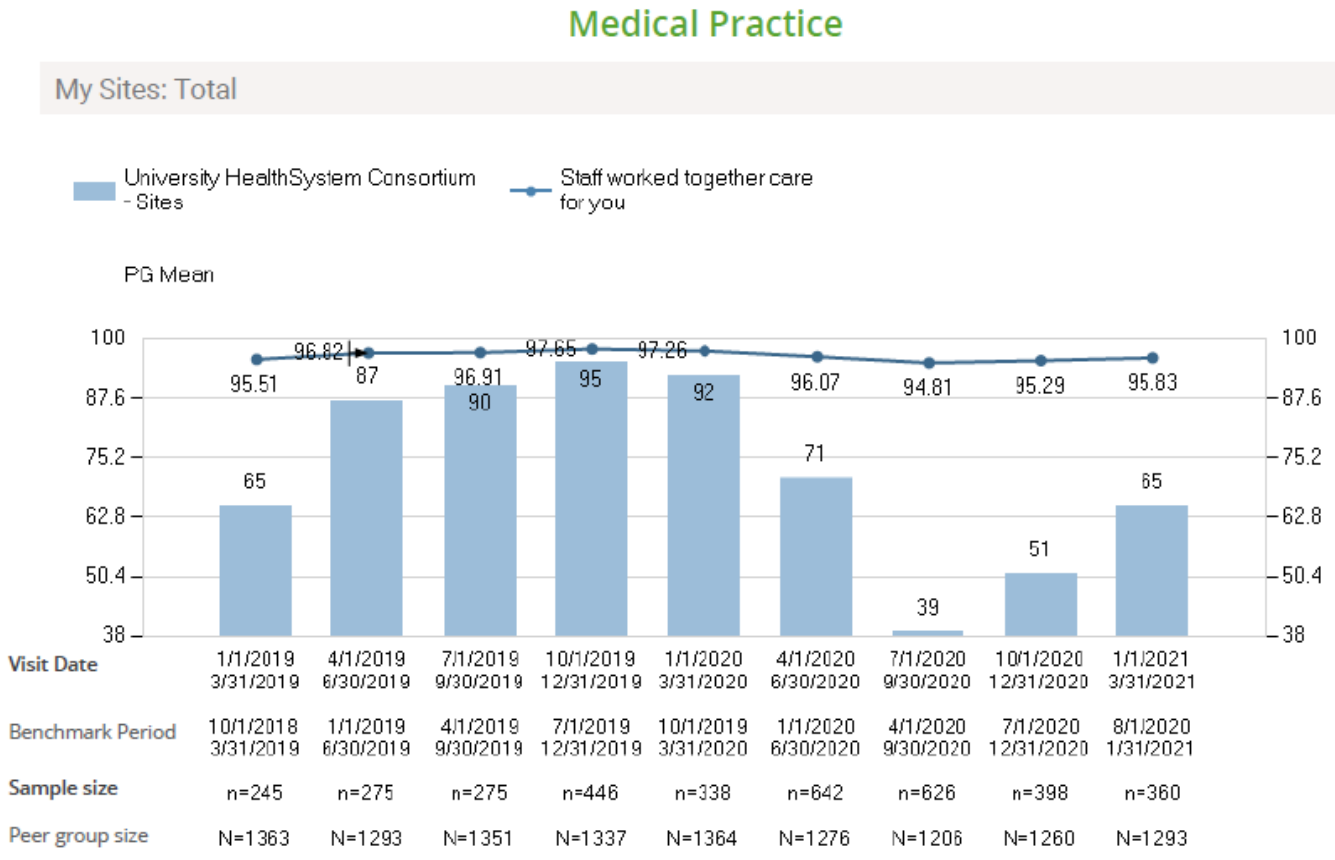
- Cost of additional RN/LPN (if applicable)
  - Nurse Navigator (1.0 FTE)
    - $143,247 (salary + fringe)
  - Intake Coordinator (1.0 FTE)
    - $53,039 (salary + fringe)
  - Primary RN (0.5 FTE)
    - Midpoint of $38.33 x 2080 hours = $79,726
    - $79,726 + Fringe (29.44%) = $103,197
  - Total = $299,483

Metrics to Measure the Effectiveness of the USC Project Plan

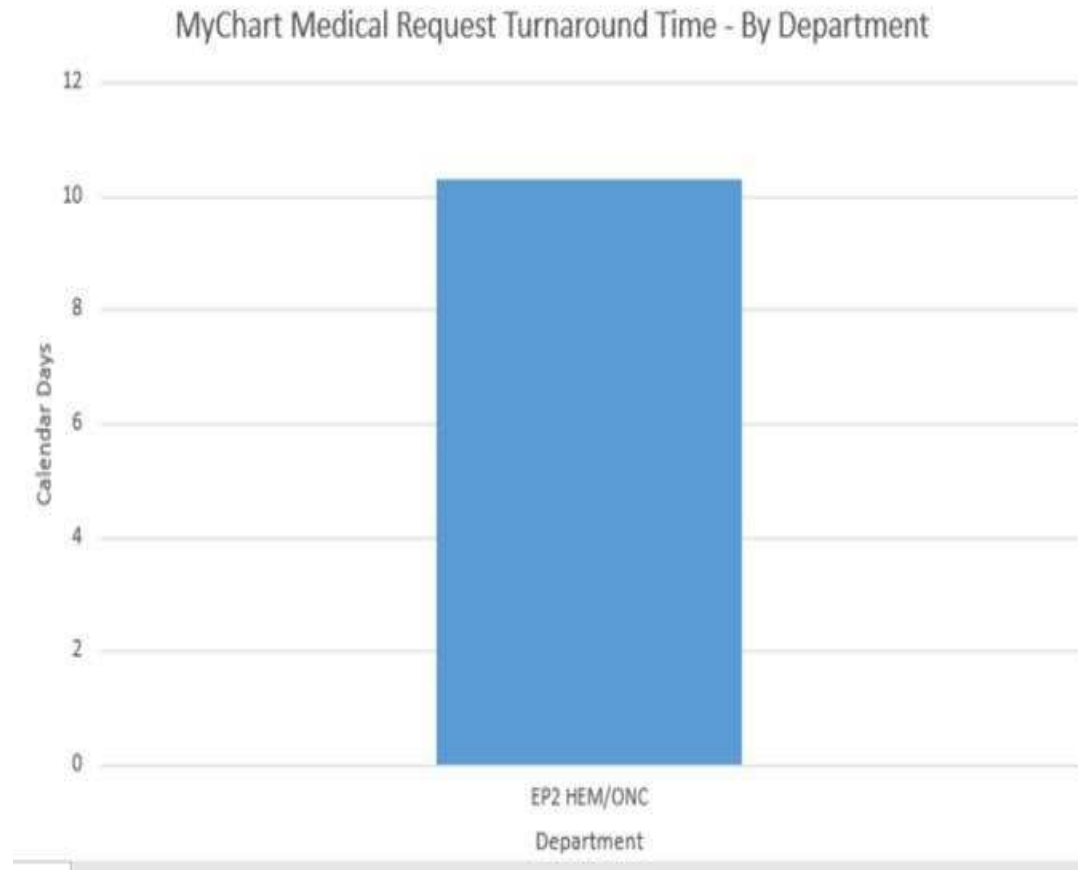
- How will you know staffing levels are effective?
  - Nurse Navigators are exempt employees but can begin manually tracking hours to gauge impacts on work/life balance
- How will you know changes are effective?
  - We have requested data on delays in care that can be used as a baseline for some of these staffing recommendations.
  - We can measure the volume of referrals and orders placed by navigators
- 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
  - This is a work in progress. Epic education for providers and clerical support would be helpful in addressing these non-nursing functions.
- 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

- To maintain safe and sustainable staffing within the nurse navigator role, we are requesting the following changes:
  - 1.0 incremental nurse navigator FTE (Priority #1)
    - This addition will allow better clinical focus on specific disease sites, improve work life balance, and allow our nurses to provide the highest degree of patient centered care while working at the top of their scope
- The proposed disease sites for a new navigator would be GU and Head and Neck cancers. This would reallocate volumes across the navigator team in a much more equitable way, both in terms of objective new patient volumes and in complexity of workup.

Highlighted Changes

- 1.0 incremental intake coordinator (Priority #2)
  - This is a current role. The additional clerical support will ensure our nurse navigators are working at the top of their scope, and are able to offload the coordination of care, tumor board prep and other clerical needs. This is a significant volume of work that is currently managed between our 5 navigators and easily equates to 8 hours/navigator (40 hours of support, 1.0 FTE).
  - By providing clerical depth and removing non-nursing tasks, timeliness of record retrieval and the coordination and provide more timely access to records.
- 0.5 incremental primary RN to support the primary duties of surgical oncology (Priority #3)
  - This would allow our navigators to delineate from the current model and separate navigation from primary. Adding this incremental 0.5 would still keep us below the bottom end of the adjusted benchmark for surgical oncology.

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

- AMS Benchmark Data for 2250
  - This is the cost center for surgical oncology and data was not provided to myself or our surgical team on benchmarks. Because the workflow for surgical oncology matches that of gynecology/oncology, we chose to utilize those benchmarks and use surgical oncology volumes as the indicator.
  - **Please refer to slide 18 and 19 for specific information (in red).**
    - **This will help clarify why the AMS benchmark was incorrect for Nurse Navigation and why this group created a new benchmark using existing AMS data**
- Discussion on new benchmarks
  - It was brought to the attention that we would be exploring alternative methods unless an explanation could be obtained regarding why the constant within the benchmark (worked hours per indicator) was altered. AMS did not provide an accurate alternative or reasoning behind why their determination was that navigation should take more time than triage but the worked hours/indicator was chosen to match current staffing. We chose to use our best representation of an objective measure that was provided by AMS by comparing like services to like services. We did not intend on double counting any triage work, only using like benchmarks across like services.
- Proposed timeline for implementation of highlighted asks would be October of 2021.

National Data To Support Request

- http://www.jons-online.com/issues/2019/october-2019-vol-10-no-10/2569-national-aonn-initiative-in-collaboration-with-astellas-unlocking-navigation-acuity
- While we were not able to obtain benchmarking data that could cleanly replace the invalid AMS benchmarking, the link above may provide some objective, evidence-based reasoning for the need in oncology navigation.
- Some of the key takeaways are summarized in the following slides:
  - A gap exists in the availability of a standardized and validated evidence-based acuity tool in patient navigation to aid in the optimal allotment of navigation services and resources. The Academy of Oncology Nurse & Patient Navigators (AONN+) announced a collaboration with Astellas US, LLC, in response to this identified gap in navigation at the AONN+ 9th Annual Navigation & Survivorship Conference in 2018. The aim of the project is to develop, standardize, validate, and implement an evidence-based navigation-specific acuity tool that will characterize the intensity of the navigation workload, aid in the allocation of navigation resources, and measure the effectiveness of navigation on patient outcomes.

National Data To Support Request

- Navigation services are rarely reimbursable, so there has been debate about whether such services are fiscally prudent. There has been a call for a measurable way to validate the benefit of navigation services. Oncology administrators and leaders want to be able to measure the return on investment for navigation programs. A major step to addressing this concern was made with the introduction of standardized navigation metrics from AONN+ in 2017. These 35 evidence-based navigation metrics allow all models of navigation programs to measure their success and sustainability.[2]
- Although standardized metrics help us measure the outcomes of navigation, a gap exists for best practices to optimize the utilization of navigation resources. The diversity of practice settings and types of navigators along with the need for a tool to be used across the cancer care continuum present unique challenges. A number of practices and professionals have sought to develop navigation acuity tools as a means to assist with allocation of resources, caseload management, and workflow.

National Data To Support Request

- In 2018, AONN+ identified a gap regarding the lack of an available navigation-specific acuity tool and recognized the opportunity to develop a validated evidence-based tool to measure the intensity of navigation services. The tool will be designed for use across the cancer care continuum with the intent to be used in all care settings and navigation roles to build sustainable navigation programs. When finalized, the acuity tool is expected to help oncology navigators characterize the intensity of the patient navigation workload, aid in the allocation of resources, and measure the effectiveness of navigation on patient outcomes. The acuity tool may support and enhance the effectiveness of oncology navigators through patient-centric evidence-based methods that may have the potential to decrease the overall cost of care.
- Literature review supports the success of patient acuity classification in determining staffing needs, improving patient care, and controlling healthcare costs. Yet, the quest to establish a valid and reliable evidence-based acuity tool for oncology patient navigation continues.

Project Plan Approval

May 3, 2021

Dear Cancer Services USC Teams (Nurse Navigation, Primary Nursing, Infusion Nursing):

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 following FTEs have been approved for FY 22. For the Nurse Navigation USC, the addition of 0.5 Primary Nursing and shared 1.0 support staff with the Primary Nursing group is approved which should impact overall nurse navigator workload – the additional 1.0 FTE Nurse Navigator is not approved. If there is an urgent need for FTE additions prior to FY 22 (10/1/2021), please follow the position review/ approval process with your leadership team:

Service	Staffing Addition	FTE
Surg Onc/ Navigation	RN, Primary Nursing	0.5
Radiarion Oncology	MA	0.5
Infusions	RN	2.4
Primary/ Navigation	Support Staff (PSS or Intake Coordinator)	1.0

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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