Title: Improve needs assessment for the newly diagnosed brain tumor patient across their continuum of care

Why? The term “cancer survivor” refers to individuals who have been diagnosed with cancer and also includes the people in their lives who are affected by the diagnosis. These individuals manage numerous physical, psychological, social, spiritual, and financial issues throughout the diagnosis, treatment processes as well as, the remaining years of their lives. Poor coordination of care and communication of needs leads to tremendous distress in the patients, their caregivers and the medical team. Lack of validated assessment tools, approved education materials and inefficient, non-standardized processes have led to tremendous waste in our outpatient clinic.

Slide 2
Where we started:

Process mapping- SIPOC, VSM
Voice of the customer-patient satisfaction surveys
Identifying the Critical to Quality Measures (CTQC)-customer feedback
Lead time from diagnosis (first clinic visit) to treatment 21 days
No standard work or standard coordination of care
Staff working above or below their scope of practice
No standard assessment tools
Increased distress in patients due to
- Trauma of the diagnosis
- Insufficient time to adjust
- Toxic therapies and treatments
- Not enough information or understanding of their diagnosis and prognosis
- Loss of control
Tremendous overtime and overburdened staff due to rework in patient care management
Data collection and identifying what data we didn’t have

Slide 3
Through brainstorming we worked as a team to better identify the cause and effect of the problems. First priority became the patient education materials.
Slide 4
5S of patient education areas and materials eliminated significant outdated, unapproved resources that were located in multiple locations.

Slide 5
Results: Standardized and centralized patient education resources reduced time spent searching, steps taken to different locations throughout the hospital and staff frustration when resources were not available or didn’t exist.

Slide 6
Big win with the patient education materials led to work on the after visit summary and development of the nurse practitioner clinic.

We had worked on stabilizing and standardizing the current process of administering the patient after visit summary with the goal being 100% of patients would receive their plan of care at their 1st clinic visit by August 2012. We are up to 95% as of 11/17/12. Before the process was stabilized, a patient’s care plan may not have been complete due to the work involved in having to find the patient’s diagnosis, health history, treatment schedule and plan of care in multiple locations throughout the electronic medical record. This process was full of wasted time and added to staff frustration which resulted in much variability and inconsistent use of the patient after visit summary. We worked with IT and nursing informatics to streamline this process into a dot phrase.

Slide 7
1. Established nurse practitioner clinic (billing for NP services came as a bonus)
2. Standardized patient flow to nurse practitioner clinic
3. Patient lead time from diagnosis to treatment reduced from 21 days to 14 days
4. Standardized after visit summary
5. Current rate of distributing after visit summary up to 95% as of 11/17/2012
6. Standardized and centralized patient education resources
7. Standardized administration of the supportive screen assessment and referral process for identified patient distresses

Slide 8
1. Lack of dedicated time for working with the team
2. Team support
3. Leadership change
4. System constraints-IHIS, space, resources
5. Process ownership- who will do the work? How will the work be sustained?
6. Limited data and tools- poor, delayed or no use of metrics as a baseline for understanding VOC or productivity. Working with the quality department to obtain the needed data as well as, working with the team to track work in real time (tracking patient education manual use and resources for example).
7. Neuro-oncology treatment team all under different managers
8. Culture change
**Slide 9**

**Key Learning**

1. **Available resources—billing for NP clinic**
2. Better understanding of the process through VSM, root cause analysis, measuring results and developing standards
   a. **role definition—better coordination of care through delegation**
   b. **patient assessment—one person cannot accomplish all the patient care needs**
   c. **care management—better coordination of care by identifying what resources are available for ongoing care needs and standardizing the process for assessment and referral (social work, rehab, mental health, pain management, primary care)**
3. **Communication**
4. **Patient Education manuals**
5. **After Visit Summary**
6. **Continuity of care with discharge planning**
7. **Bi-monthly team meetings**
8. Team now requesting work on other processes

**Work in Process**

1. Work with IT to administer distress screening on tablets
2. Write patient education materials as needed
3. Write standard work for patient care pathways
4. Operations council meetings
5. Continue bi-monthly team meetings for monitoring progress and data
6. Centralized call center for scheduling

**Slide 10**

Treatment Team