HSCT in 2020
System Capacity Initiative

Outpatient Transplant Care Team

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September 16, 2010

Financial Disclosure – None

System Capacity Challenge

- Cost Containment – 1993
- Inpatient Bed Capacity – 2000 ->

Solution Identified

- Establish an outpatient care delivery model to safely provide acute care previously delivered in the inpatient setting

Implementation of Solution

- Stakeholders engaged
  - Medical Directors
  - Administration

- Resources needed
  - Change of ambulatory care guidelines
  - Increase medical and expert nursing staff
  - Mandatory adult caregiver policy
  - Mandatory 30-minute travel time to center
  - 24/7 triage and access to care
  - Expand and integrate patient/caregiver education program

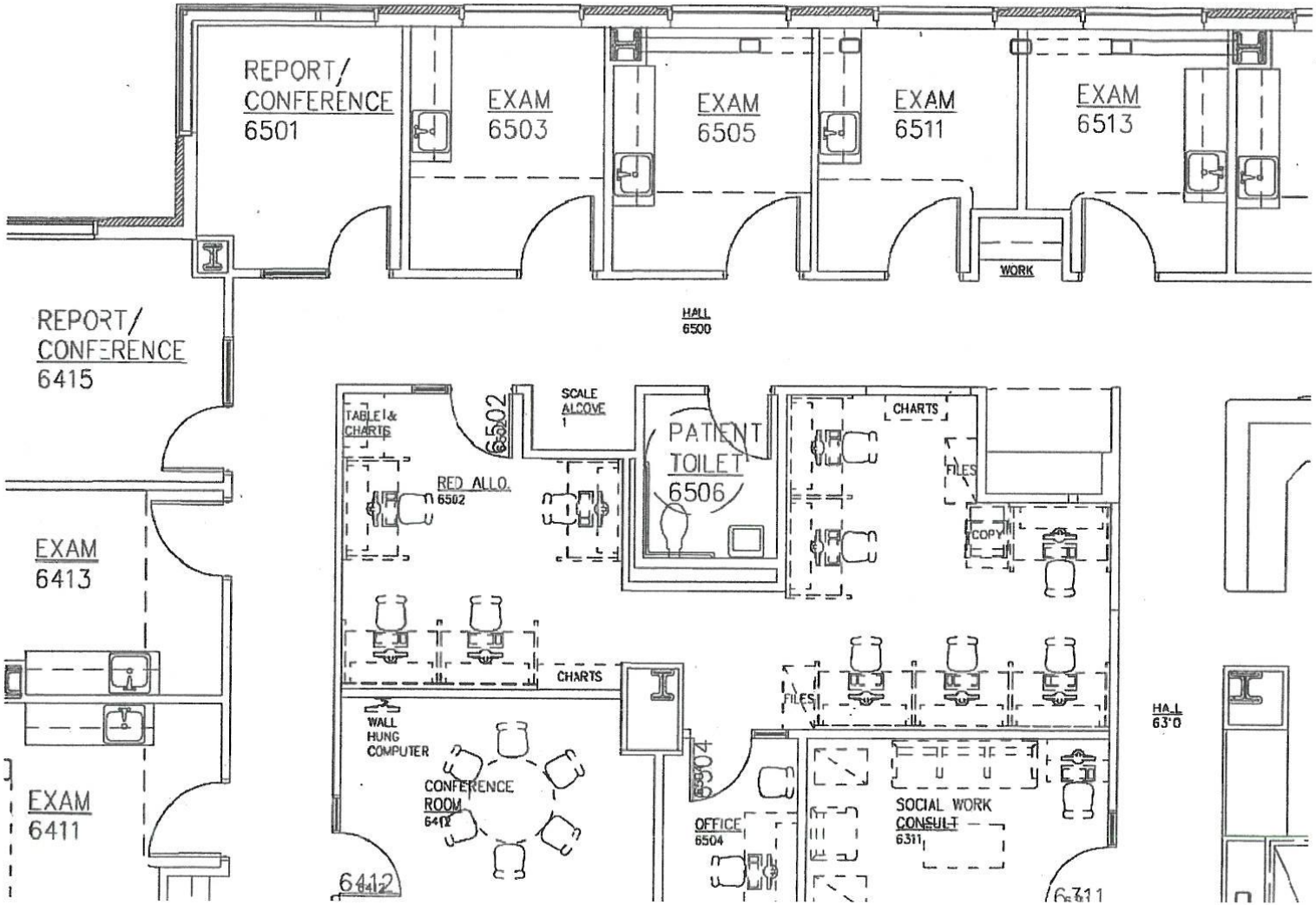
Implementation of Solution

- Obstacles experienced
  - Short timeline to implement
  - Resistance of staff to new model
- Steps taken to overcome
  - Nursing staff excited to meet new challenge while keeping patient safety top priority
  - Patient feedback supported a continuity model of care

Example of Outpatient Team Structure

Attending Physician		
Blue Team	**Lime Team**	**Yellow Team**
Primary Provider	Primary Provider	Primary Provider
RN	RN	RN
Scheduler	Scheduler	Scheduler
Clinical Pharmacist		
Clinical Dietician		
Social Worker		

Clinic Team Space



Impact on System Capacity

- Inpatient census dropped from 75 to 50 (includes closure of "step-down" unit)

- Outpatient census rose from 80 to 110

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Midlevel Provider Orientation

William Levy PA-C
Assistant Medical Director Adult Blood and Marrow Transplant Service
Director Midlevel Provider Service
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September 16, 2010

Background

- Midlevel Providers added to transplant service in 1984. No formal training or orientation existed
- Need became evident with first set of providers but more so as new providers added to staff
- Orientation/education evolved over the years

FHCRC utilization

- FHCRC currently does >500 transplants yearly
- Transplant pt care based on PA/NP workforce
- Approximately 40 midlevels in all aspects of adult and pediatric care in both inpatient and outpatient settings as well as consulting services and intake office

Principles

- Up front investment in education/orientation pays off with increased retention and minimizes attrition
- Acceptance that longer orientation is costly in terms of 'nonproductive' salary
- Everyone (MDs,APPs,nsg) has a role to play and a responsibility to participate

Schedule

Month 1: inpatient observational rotation
Month 2: outpatient observational allo rotation
Month 3: 2 weeks ID consult service
2 weeks pulm/critical care service
Month 4: outpatient auto rotation
Month 5: inpatient provider with limited # of patients teamed with experienced provider
Month 6: inpatient provider full patient load teamed with experienced provider

No call or other 'extra' responsibilities during month 5 and 6

Materials

- FHCRC/SCCA Blood and Marrow Transplant Service Orientation and Survival Guide
- FHCRC/SCCA Selected Clinical Guidelines
- FHCRC Hematopoietic Stem Cell Transplantation DVD collection
- FYI on line protocol catalog
- Standard Practice on line catalog
- Midlevel teaching rounds, grand rounds, patient care conference, fellows rounds

System Capacity Challenge

- Recognition of value of intensive and extensive orientation regardless of program size
- Funding

Solution Identified

- Buy in by center administrations and medical services to commit resources and mandate participation

Implementation of Solution

- Stakeholders engaged
  - Agreement among the participants of this conference as to need
- Resources needed
  - $$$
  - Shared resources among centers

Impact on System Capacity

- Increase staff retention
- Increase staff recruitment
- Potential educational/programmatic material for fellows
- Potential material for structuring BMT fellowship programs

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Autologous Stem Cell Transplant in Puerto Rico

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Cancer Center

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Financial Disclosure – None

System Capacity Challenge

- Lack of formally trained doctors, nurses and other personnel
- Insufficient physical facilities for transplant at the hospital
- No insurance contract
- No stem cell lab available at the hospital

Solution identified

- Formal training as a BMT physician at Moffitt Cancer Center
- Courses to the nurses and hospital personnel
- Insurance contracts
- Contract with American Red Cross for stem cell collection and processing

Implementation of solution

- Stakeholders engaged
  - HIMA Caguas hospital
  - American Red Cross
  - IRB of Universidad Central del Caribe School of Medicine
- Resources needed
  - Stem cell transplant unit(6 beds)
  - SCT staff
  - Insurance contracts

Implementation of solution

- Obstacles experienced
  - Hospital executives were unaware of such procedures
  - The hospital did not have the facility
  - No stem cell lab within the hospital
  - Personnel experience with BMT patients

Implementation of solution

- Steps taken to overcome
  - Formal presentation to the hospital executives about what entails a bone marrow transplantation and the needs of a unit in PR and the Caribbean
  - Start working with the hospital to create a close unit with 6 rooms with all the needs for the patient and a caregiver
  - Start doing contracts with health insurance companies
  - Contract with American Red Cross for stem cell collection and processing

Impact on System Capacity

- It is a benefit for patients in PR to have access to Stem Cell Transplant Unit on our own island and in the Caribbean
- Economic benefit for the patients and institution
- Specialized nurses
- Now there is a better understanding of BMT and has paved the way for future autologous transplants – and why not allogeneic?