ACHIEVING EXCELLENCE IN HEALTHCARE: NURSE STAFFING STANDARDS

PRESENTED BY:

- Sherry B. Perkins, PhD, RN, FAAN
- Matthew D. McHugh, PhD, JD, MPH, RN, FAAN
- Nancy Blake, PhD, RN, NEA-BC, FACHE, FAONL, FAAN

NURSE STAFFING TASK FORCE

Project ECHO®

Session Etiquette

FROM DATA TO ACTION

We have the data.

We want change.

It's time for action.

Series Host

Nicole Anselme

MBA, MSN, RN, CCRN, SCRN, GERO-BC

Senior Policy Advisor
Nursing Programs
American Nurses Association

Series Overview

1 **Sept. 14, 2023**

Creating a Healthy & Supportive Nurse Work Environment: Key Steps

2 **Sept. 21, 2023**

Transforming Cost into Value: Recognizing Nurses' Unique Contribution

3 **Sept. 28, 2023**

Innovative Care Delivery in Nursing: A Paradigm Shift in Healthcare

4 **Oct. 05, 2023**

Maximizing Nursing Efficiency: The Future of Regulatory Innovation

5 **Oct. 19, 2023**

Achieving Excellence in Healthcare: Nurse Staffing Standards

Speaker Introductions

Sherry B. Perkins
PhD, RN, FAAN

President, Luminis Health Anne Arundel Medical Center
Chief of Hospital Integration, Luminis Health

Sherry B. Perkins, PhD, RN, FAAN, NEA-BC is President of Luminis Health Anne Arundel Medical Center and Chief of Hospital Integration at Luminis Health, one of the busiest hospitals in Maryland with excellence in behavioral health, cancer, emergency, obstetrics, orthopedic, and surgical specialties. She oversees business operations at the system's Medical Center (LHAAMC), behavioral health facility, alcohol and substance use facility. Dr. Perkins served as the Chief Nursing Officer and Chief Operating Officer for Luminis Health Anne Arundel Medical Center from 2006 until 2016 and led the system to top decile results and Magnet recognition.

Speaker Introductions

Matthew D. McHugh
PhD, JD, MPH, RN, FAAN

Professor and Independence Chair for Nursing, University of Pennsylvania School of Nursing
Senior Fellow, Leonard Davis Institute of Health Economics at Penn.

Matthew D. McHugh, PhD, JD, MPH, RN, FAAN is Professor and Independence Chair for Nursing at the University of Pennsylvania School of Nursing, and Senior Fellow at the Leonard Davis Institute of Health Economics at Penn. Dr. McHugh is the Director of the Center for Health Outcomes and Policy Research (CHOPR) at Penn Nursing where he conducts highly visible studies that draw on his expertise in nursing, law, public health, and health services research to evaluate how nursing can be a force for quality, equity, and innovation in health services. A fundamental goal of Dr. McHugh's program of research is to bring evidence to bear upon the health system, law, and policy reforms needed to facilitate effective nursing practice and achieve the best patient outcomes, health equity, clinician well-being, and important national and international health policy goals. He is an elected member of the National Academy of Medicine, Fellow in the American Academy of Nursing, Faculty

Speaker Introductions

Nancy Blake

PhD, RN, NEA-BC, FACHE, FAONL, FAAN

Chief Nursing Officer, Los Angeles General Medical Center

Dr. Nancy Blake is the Chief Nursing Officer at Los Angeles General Medical Center. She was the Chief Nursing Officer at Harbor-UCLA Medical Center from March of 2019 until June of 2021. Prior to that she was the director of critical care services at Children's Hospital Los Angeles (CHLA) for over 30 years where she helped CHLA achieve Magnet designation. Nancy has been an active member of ANA, SPN, ACNL, AONL and AACN, where she was a national board member from 2003-2006. She is a national speaker on pediatric disaster preparedness, staffing and healthy work environments.

Nancy has numerous publications on Healthy Work Environments in healthcare. She is an Associate Adjunct Professor at UCLA School of Nursing and was named the Distinguished Alumni Member for 2021

SESSION OBJECTIVES:

- By the end of this session, participants will:
  - Describe the **evidence base for establishing staffing standards**.
  - Identify ways to advocate for the adoption of **enforceable policies that support staffing standards**
  - Discuss **strategies for implementing staffing standards** in their own work environment

How did we get here?

NURSE STAFFING TASK FORCE

Project ECHO®

When do you remember learning about staffing challenges in the US?

PubMed®

Advanced

Save Email

Hospitals. 1982 Feb 1;56(3):53-6.

The nurse shortage: how can we turn the exodus around?

S G Kernaghan

PMID: 7054094

Abstract

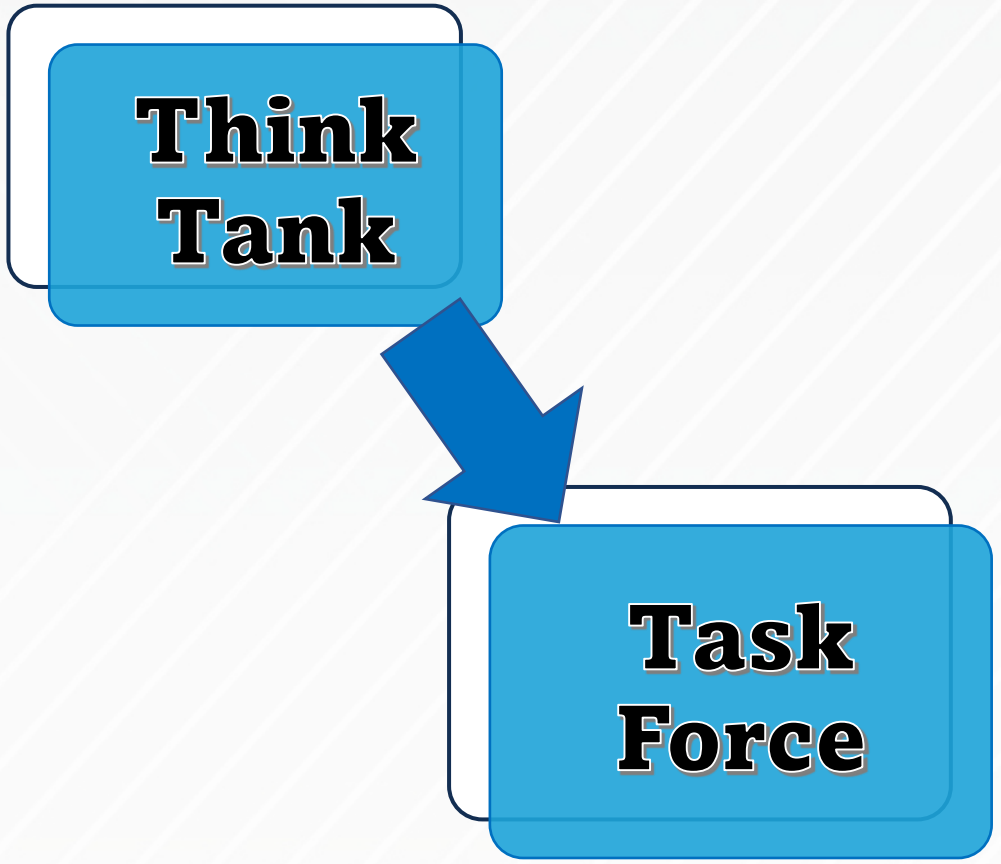
The nurse shortage can be seen as a symptom of the problems caused by the unwillingness of most hospital power groups to share their control of both resources and decision making. Nurses will continue to leave hospital work if hospitals persist in ignoring nurses' pleas for a share of the rewards and power that should be commensurate with the enormous contributions they make to patient care.

On a scale of 1 to 5:

(1 = Not aware; 5 = Know 'em by heart)

What is your awareness of the recommendations of the National Nurse Staffing Task Force?

National Level



Nurse Staffing Think Tank	Nurse Staffing Task Force
Implementable in 12-18 months Asked: **What can we do right now?**	Long term, sustainable solutions Asked: **How to address ongoing challenges?**
Process included voting and affirming Practical consensus "*Move forward on all*"	Iterative process with discussions and surveys Inclusive of diverse expertise "*Yes, and*"
Every 2 weeks for 3 months, 26-page document	Every 3 weeks for 9 months, 19-page document
Some policy implications, mostly focuses on organizational changes	Some organizational change, a greater focus on policy, regulation and payment structures
Identifies accountable entities and action steps to implement each recommendation	Identifies partners and options for actions; need to consider context and select among actions

Reform the Work Environment

Value the Unique Contributions of Nurse

Innovate the Models for Care Delivery

Improve Regulatory Efficiency

Establish Staffing Standards that Ensure Quality Care

Definition Of Appropriate Nurse Staffing

Appropriate staffing is a dynamic process that aligns the number of nurses, their workload, expertise, and resources with patient needs to achieve quality patient outcomes within a healthy work environment.

Establish Staffing Standards that Ensure Quality Care

- Support Think Tank Recommendation for **specialty nurse organizations** to develop **staffing standards for populations they serve**
- Advocate for state and/or federal regulations and legislation that **advances meeting minimum staffing standards**
- Propose that **CMS establish enforceable policies that support minimum staffing standards**
- Propose that **The Joint Commission enhance standards to support appropriate staffing**

On a scale of 1 to 5:

(1 = Poor; 5 = Excellent)

How do you rate your ability to consistently address staffing in a meaningful way?

Nurse Staffing:

Evidence & Standards

NURSE STAFFING TASK FORCE

Project ECHO®

Is there evidence of a need for public policy intervention to implement staffing standards?

2019 – Range Of Average Patient to Nurse Ratios On Medical-Surgical Units

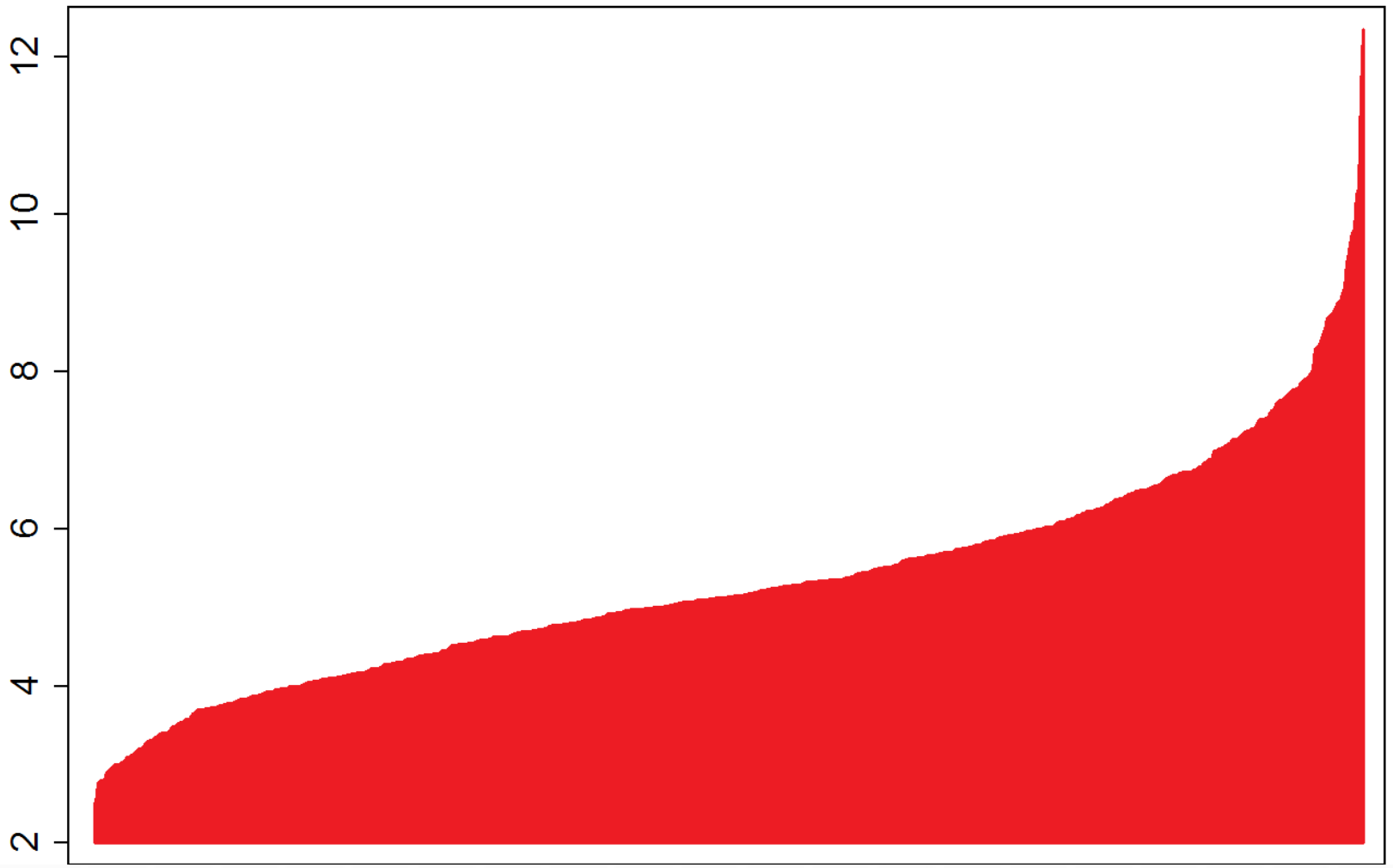
3.5 – 10
patients per nurse

Patients per Nurse By Hospital, US

Aiken, McHugh, et al,
***Medical Care*, 2011**

Over 600 hospitals

Mean: 5.3 patients per nurse
Range: 3 – 12



Evidence-Based Safe Nurse Staffing

- Concludes there is **strong, actionable evidence of association** of nurse **staffing and outcomes**
  - Lower **mortality**
  - Fewer readmissions
  - Shorter length of stay
  - Fewer ICU Admissions
  - Fewer healthcare associated infections
  - Fewer falls with injuries and pressure ulcers
  - Greater **patient satisfaction**
  - Greater **nurse job satisfaction**, less **burnout**, greater **intent to stay**

A Call to Action

ICN encouraged nurses and their national associations to support implementation of safe nurse staffing systems

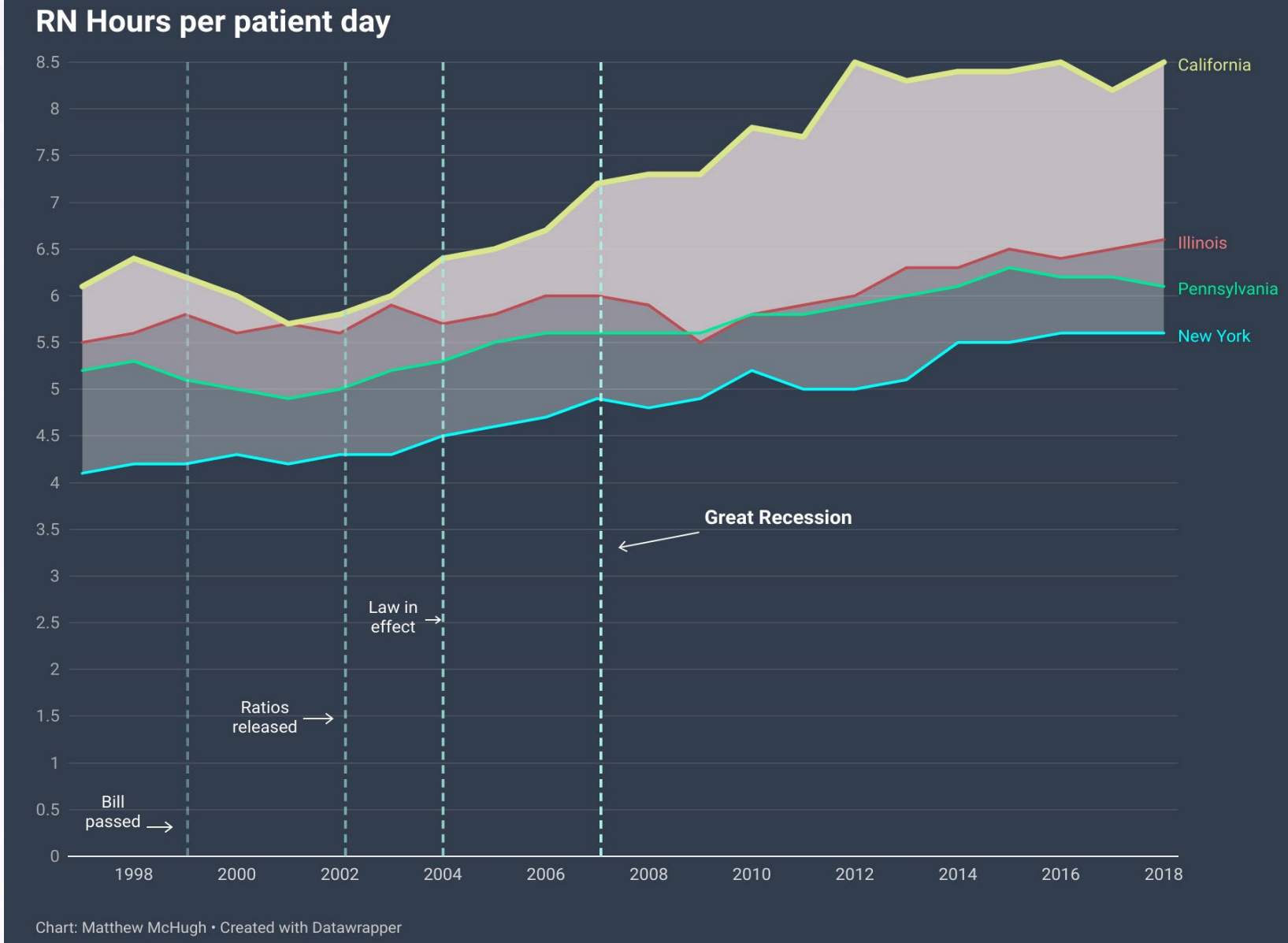
Nurse Staffing Policy Interventions Are Becoming More Common

- **Victoria, AU** in 2000
- **California, US**, passed 1999; implementation starts 2004, but roll-out through 2006.
- **MA** – 2014 (only ICU)

- **Last 5 years:**
  - Wales, UK
  - Scotland, UK
  - Ireland
  - Queensland, AU
- **Oregon** - 2023
- **NY** - 2023 (only ICU)
- Other jurisdictions considering: More **US states**, **Korea**, **Chile**

Did California policy lead to improved staffing?

YES



What if other US states implemented ratios like California?

Aiken, McHugh et al. *Health Services Research*, 2010

- **Pennsylvania** and **New Jersey** nurses care for **1-2 more patients** than nurses in California
- If Pennsylvania and New Jersey staffed at California levels:
  - odds of death after general surgery estimated to be **reduced by 10 to 13% annually**

But research challenges to study CA have resulted in contentious stakeholder debate on whether ratios worked

1. Lack of good **baseline measures**
2. Lack of **comparison groups**
3. Varying **quality of outcomes data, staffing data,** and **data sources**
4. Limited time horizon (mostly only go to 2008)

What is the evidence for arguments against staffing standards?

PAID FOR BY THE AMERICAN HOSPITAL ASSOCIATION

Hospital Workforce Shortage Crisis Demands Immediate Action

For two long years, the dedicated women and men of America's hospitals and health systems have experienced firsthand the overwhelming impact of COVID-19.

The pandemic has been frustrating, exhausting, and heartbreaking, and few have felt these emotions stronger and longer than those on the front lines of delivering care.

While there is always room to build on our efforts, the hospital field has worked hard to prioritize the safety, protection and well-being of our caregivers and other essential workers.

Rick Pollack
President and CEO
American Hospital Association

The health care field entered the COVID-19 pandemic with long-term challenges related to the workforce.

- In 2017, more than half of nurses were age 50 and older, and almost 30% were age 60 and older.
- Federal data shows that we are expecting to lose 500,000 nurses by the end of this year, many through retirement, bringing the overall shortage of nurses to 1.1 million.

However, due to significant shortages of faculty, classroom space and clinical training sites, nursing schools actually had to turn away more than 80,000 qualified applicants in 2019. Hospital employment overall is down 95,600 from pre pandemic levels, according to the consulting firm Altarum.

Because our workforce is our most precious resource, hospitals and health systems are committed to supporting them today, preparing them for tomorrow and building a pipeline for the future.

That's why our field has created programs and developed resources to promote caregiver well-being and resiliency. Examples include helping to pay back student loans, providing childcare and transportation, offering tuition reimbursement and training benefits, providing referral and retention bonuses, and supporting programs that address mental and physical health.

Hospitals are also developing new team-based care models that allow health care workers from various disciplines and specialties to provide customized, patient-centered care. This allows them to manage medical and social needs across all settings to improve care and enhance professional satisfaction.

At the same time, many hospitals are facing serious financial pressures, including rapidly increasing costs for hiring and retaining staff. Through November 2021, labor expenses increased 12% compared to pre-pandemic levels, according to the consulting firm Kaufman Hall. And, when looked at through the lens of expenses per adjusted discharges, meaning labor costs per patient, the increase was a staggering 19.5%.

Persistent staff shortages caused by the pandemic have forced hospitals to increase their use of contract workers to fill nursing, technician and other essential positions. Unfortunately, some staffing agencies are exploiting the severe workforce shortages by charging uniformly high rates and retaining up to 40% or more of those amounts for themselves.

The conduct of some of these staffing agencies could suggest widespread coordination and other abuses, which is why the AHA and congressional lawmakers have asked federal agencies to investigate possible collusion and price gouging.

Meanwhile, while some suggest there should be rigid nurse-to-patient ratios, we strongly believe that nurses need to be empowered with flexibility to determine appropriate staffing for the needs of their patients. A one-size-approach does not fit all when it comes to safe staffing, and strict, inflexible approaches will exacerbate the workforce shortage crisis.

Our workforce challenges are a national emergency that demand immediate attention from all levels of government and workable solutions.

These include:

- Lifting the cap on Medicare-funded physician residencies;
- Boosting support for nursing schools and faculty;
- Providing scholarships and loan forgiveness;
- And, expediting visas for all highly trained foreign health care workers.

In addition, we must support state efforts to expand scope of practice laws to allow health care professionals to practice at the top of their license. We also need to stop health insurers' burdensome bureaucratic practices that take caregivers away from the bedside.

The people who work in hospitals and health systems are truly the heart of health care. We must support them and stay focused on keeping our patients and communities safe and healthy.

American Hospital Association™
Advancing Health in America

"Meanwhile, while some suggest there should be rigid nurse-to- patient ratios, we strongly believe that nurses need to be empowered with flexibility to determine appropriate staffing for the needs of their patients. A one-size-approach does not fit all when it comes to safe staffing, and strict, inflexible approaches will exacerbate the workforce shortage crisis."

"Meanwhile, while some suggest there should be rigid nurse-to- patient ratios…"

Who are the "some" suggesting that there is a policy need?

- Nurses
  - The top reasons cited for leaving hospital employers is poor staffing
- ½ of physicians rated nurse staffing among top 3 priorities to reduce their own burnout.

(Aiken et al, 2023, *JAMA Health Forum*)

Nurses and physicians agree on most/least important interventions for improving work environment/reducing burnout

MOST important

- Improve staffing (nurse and physician)
- Management that listens and responds to clinician concerns
- Reduce documentation/EHR burden, bureaucracy, and red tape
- Allow for more time to spend with patients
- Uninterrupted breaks
- Work-Life balance

"... We strongly believe that nurses need to be empowered with flexibility to determine appropriate staffing for the needs of their patients."

Yes!

But how are nurses empowered with flexibility now?

How are nurses empowered with flexibility?

- Staffing committees?
  - They don't work to improve staffing
- Nurses report little control over assignments
  - So much so we need Safe Harbor policies

- Managers may have flexibility with what they are given
  - **Decisions about overall staffing = a function of central budget**
  - Lack of a direct line to revenue
  - In the US = results in cuts to nursing as a go-to strategy
    - Evidence from intro of DRGs, recessions, COVID, consolidation, private equity acquisition, and consultant playbooks.

(Han, Pittman, Barnow, 2021 Medical Care).

"A one-size-approach does not fit all when it comes to safe staffing"

Has this ever been advocated for?

NO.

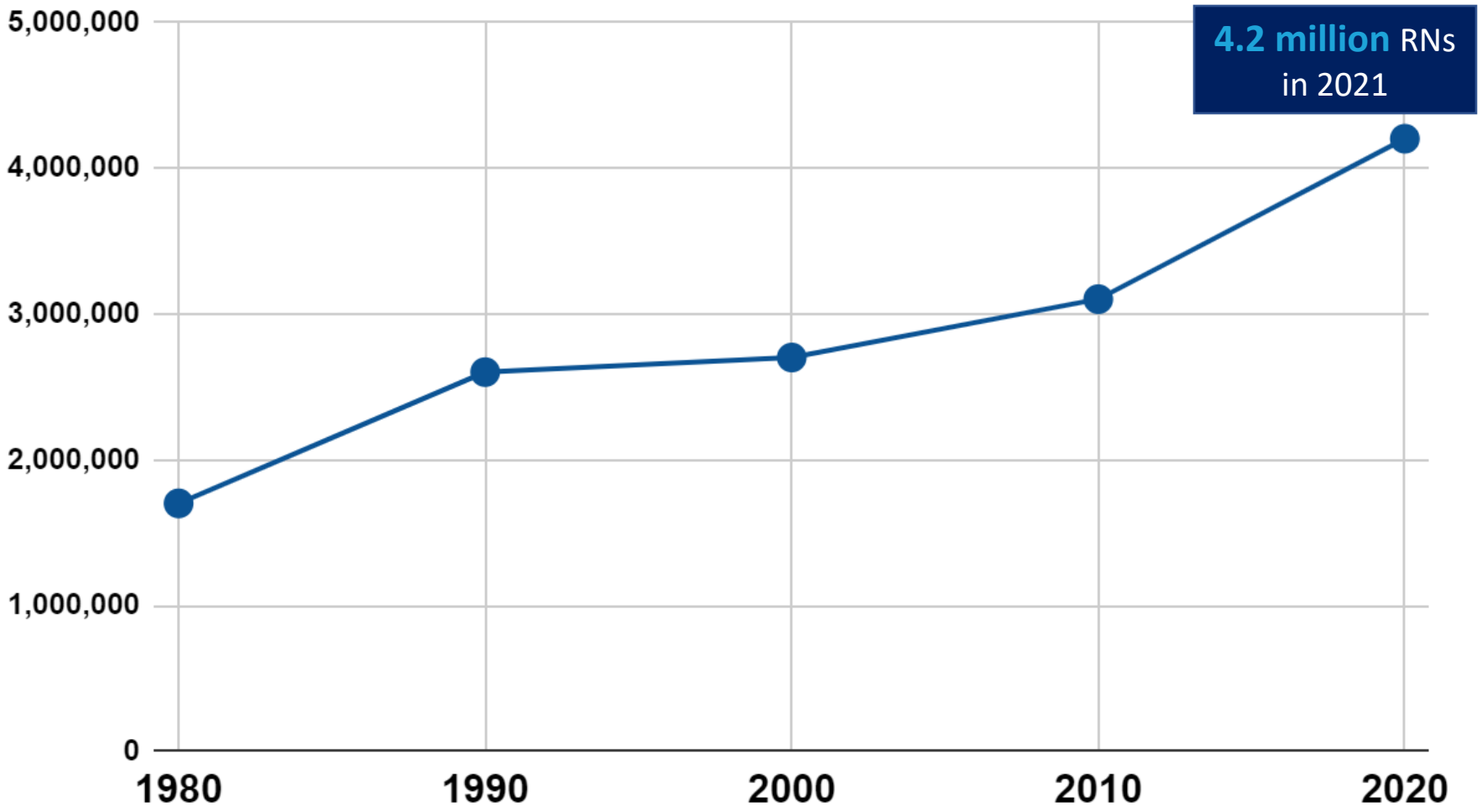
“A one-size-approach does not fit all when it comes to safe staffing”

- If this were the case California staffing levels would level off at the regulatory threshold
- Instead over time California **hospitals staffing levels got better and better** relative to other US hospitals
- Minimum ratios are **specific to unit/patient types** which accounts for broad **acuity differences**
  - E.g., ratio of **1:5 in medical-surgical** vs. **1:2 in critical care ICU** settings

- All enacted and proposed legislation establish a **minimum staffing standard** adjusting upward per acuity requirements
- **CALIFORNIA** – “These ratios shall constitute the **minimum** number of registered and licensed nurses that shall be allocated. Additional staff shall be assigned in accordance with a documented patient classification system for determining nursing care requirements, including the severity of the illness, the need for specialized equipment and technology, the complexity of clinical judgment needed to design, implement, and evaluate the patient care plan and the ability for self-care, and the licensure of the personnel required for care.”

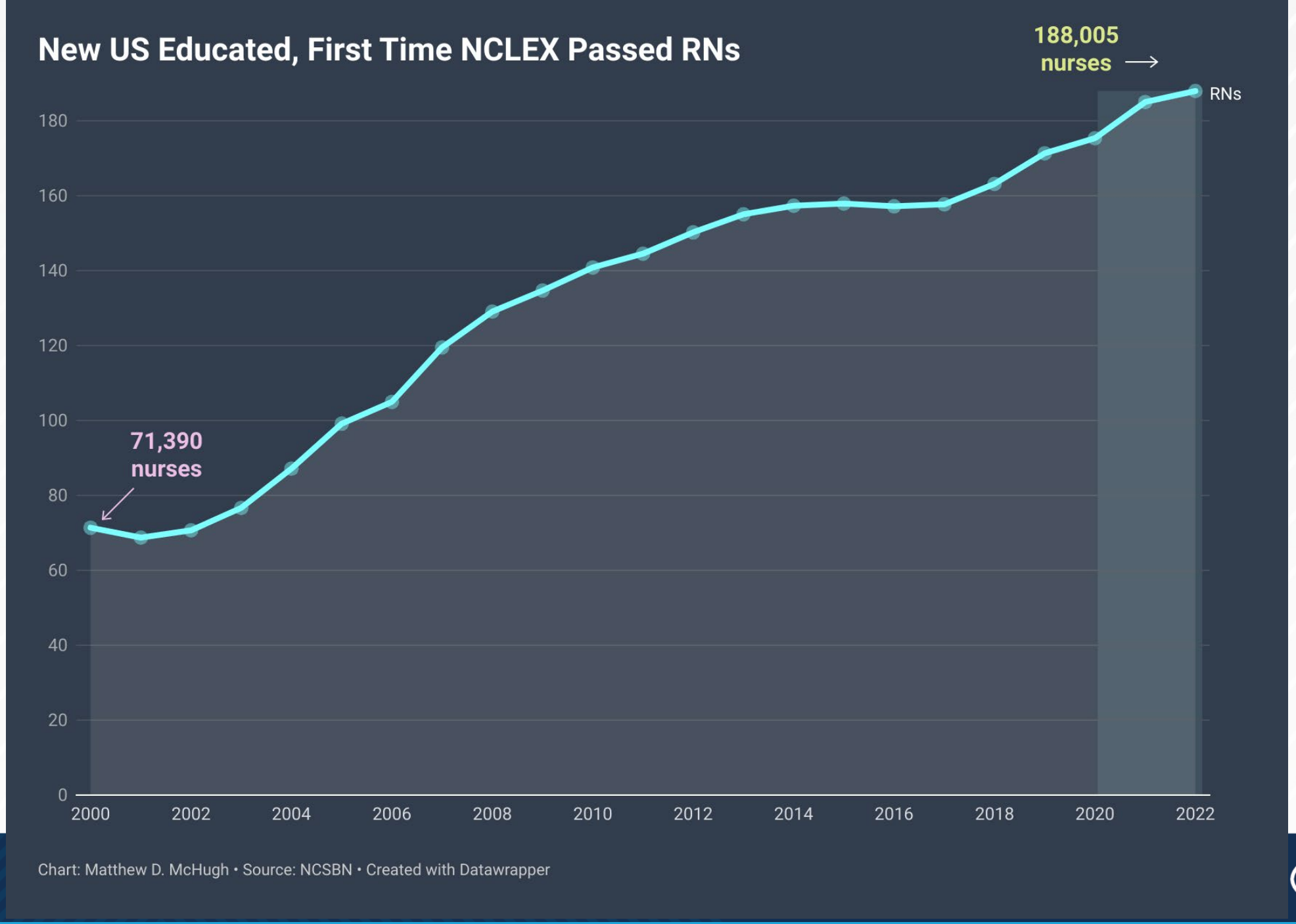
“...strict, inflexible approaches will exacerbate the workforce shortage crisis.”

Number of Registered Nurses in the US by Decade



1.7million in 1980 to 4.2 million now.

Nearly as many additional new nurses in the past decade alone (2010-2020 - 1.1 million growth) vs. all three decades before combined (1980-2010 - 1.4 million growth)


New US Educated, First Time NCLEX Passed RNs
188,005 nurses
RNs
71,390 nurses
180
160
140
120
100
80
60
40
20
0
2000
2002
2004
2006
2008
2010
2012
2014
2016
2018
2020
2022
Chart: Matthew D. McHugh • Source: NCSBN • Created with Datawrapper

Safety-net and critical access hospitals will be forced to close

- No evidence from **California**
- Safety-net hospitals saw **greatest staffing improvements** (McHugh, *Milbank Quarterly*).

Do minimum standards inhibit "innovation"?

- How?
  - Most **innovation** could be **complements *or* substitutes**
- The **difference** matters
- **Starting point:** Is there **evidence** that the innovation is (+)
- **Examples:**
  - **Team nursing**
    - **Past experience** linked with worse outcomes
    - **Reduced skill mix** linked with worse outcomes
    - **Unspecified models of 'other' interdisciplinary providers** (who?) or family?
  - **Virtual nurses, robot helpers, artificial intelligence**
    - Little evidence one way or the other

“Ratios” is not a policy monolith.

Policy design matters – lots of flexibility

NURSE STAFFING TASK FORCE

Project ECHO®

Queensland—Policy Experiment

- July 2016, Queensland Health **implemented nurse-to-patient ratios** in 27 public hospitals
- Ratios specify an average of **1:4 on morning/afternoon** and **1:7 on night shifts** in acute adult medical-surgical wards
- Prospective external evaluation with data collection and linked patient outcomes before and after implementation

Were the better outcomes attributable to the improvements in staffing following ratios implementation?

Yes

Were the better outcomes attributable to the improvements in staffing following ratios implementation?

Reductions of 1 patient per adult acute Med/Surg nurse were associated with significantly lower odds of:

Rating quality of care less than excellent	↓ 21%
Giving a failing grade on hospital safety	↓ 35%
Giving a failing grade on infection prevention	↓ 12%
Rating the hospital less than 9 or 10/10	↓ 8%
Not recommending hospital to family/friends	↓ 12%
Inadequate time to complete necessary care	↓ 16%
Inadequate time to detect patient changes	↓ 13%
Job dissatisfaction	↓ 8%
Burnout	↓ 7%

Data Source: RN4CAST-Australia survey data

Public benefits of nurse staffing improvements in QLD: first 2 years

145
Deaths avoided

255
Readmissions avoided
Estimated costs avoided **~ $1.2-2.4 million** (AUD)

29,222
Hospital days avoided
Estimated costs avoided **~ $54-81 million** (AUD)

McHugh et al. (2021). *The Lancet*

Leadership & Frontline Staff Working Together to Develop Enforceable Policies that Support Staffing Standards

NURSE STAFFING TASK FORCE

Project ECHO®

One California Public Hospital System's approach to developing policies with frontline nurses and leadership collaboration

Developing 1:1 Criteria for ICU patient

- Minimum ratios for ICU in **California** are **1:2** or **12-hours of care**
- ICU staff nurses **approached the CNO** to discuss **1:1** or **24 hours of care criteria**
- Guidelines were set forth for the **staff to develop criteria** based on their experience
- Several meetings and negotiations took place over 2 months to fine-tune the policy
- **1:1 criteria were developed** and the CNO brought them to the system CNOs for 4 hospitals; feedback was brought back to the committee
- Final criteria were **brought to the system leadership including the CEOs** and were approved in 2021

Intensive Care Unit (ICU) 1:1 Staffing Guidelines Proposal

- Routine **patient acuity and 1:1 guidelines will be assessed every 6 hours** by the primary nurse and charge nurse to **establish and ensure the need for 1:1 nurse to patient ratio**
- The **patient's acuity** that accurately reflects the patient's current condition shall be **entered in the acuity classification system** (i.e., Evalysis) **AND reassessed every 6 hours** or when reevaluation is due as indicated in Sections 1 and 2 below.
- All **efforts will be made to provide timely 1:1 patient care** as staffing permits
- Once a patient meets 1:1 guidelines, the **charge nurse will notify the following**:
  - Nurse manager on weekdays
  - Nursing supervisor on weekends, off-shift and holiday
- A patient will be considered **1:1** if he/she **fulfills 1 or more criteria** under **Section 1**
- A patient will be considered **1:1** if he/she **fulfills 2 or more criteria** under **section 2**

Developing 1:1 Criteria for ICU patient

Section 1
Patient must have at least **one** of the following:

1. **<u>Organ Donation or Donation After Cardiac Death (DCD)</u>**

Identified by One Legacy for organ donation and DCD

NOTE: Keep the patient 1:1 throughout ICU stay from initiation to completion of organ/tissue donation

1. **Post-op open heart surgery**

*NOTE: Keep the patient 1:1 for the first **8 hours** post-op and re-evaluate every 6 hours thereafter*

1. **Extracorporeal Membrane Oxygenation (ECMO)**

Patient is intubated on mechanical ventilation
Unstable oxygen saturation <90% with FiO2 100%, PEEP >20
Hemodynamic compromise requiring vasoactive medications and fluid replacements including blood products
Use of sedatives and paralyzing agents that requires multiple dose changes to reach goal
Monitoring for bleeding due to full anticoagulation that prevents clot formation in ECMO circuit

*NOTE: Keep the patient 1:1 for the first **8 hours** of ECMO therapy and re-evaluate every 6 hours thereafter*
Requires 2:1 staffing if utilizing ECMO-trained RN performing the role of the perfusionist responsible for the operation and troubleshooting of the device

Developing 1:1 Criteria for ICU Patient

Section 2 Patient must have at least **two criteria (criteria 1 AND any of criteria 2-11)**
1. **Hemodynamic instability requiring 2 or more vasoactive medications (excluding non-titratable vasopressin)** Unstable defined as: fluctuating or unpredictable heart rate, blood pressure, or oxygen saturation Vasoactive medications include but not limited to norepinephrine, epinephrine, dopamine, nicardipine, nitroprusside, dobutamine (please see policy for full list of medications) Active titration of vasoactive medications Anticipation for addition of vasoactive medications *NOTE: This criterion must be paired with another criteria (criteria 2-11)*
2. **Intra-aortic balloon pump (IABP), Impella or heart assistive device** Fluctuating or unpredictable heart rate, blood pressure, or oxygen saturation

We simultaneously re-evaluated the budget to ensure:

- **20%** of the patients would be at **24 hours of care** or **1:1** (based on historical need)
- Budgeted for a **"break nurse"** based on the number of nurses to be relieved to ensure they took their breaks according to California labor law
  - two 15-minute breaks and one 30-minute meal period per 8 hours of work
- Budget for a **charge nurse that was free from a patient assignment** as much as possible
- Reviewing the **span of control for the manager** and **assistant manager** so they can **focus on issues with the work environment** and **support the staff**
  - even more important post-pandemic due to the larger number of new graduates in the workforce

Even more collaboration between management and direct-care nurses is needed to develop new staffing models to create healthy work environments

Unintended Consequences of California's Nurse Ratio Legislation

NURSE STAFFING TASK FORCE

Project ECHO®

History of California Nurse Ratios

- In **1999**, California passed comprehensive legislation **mandating patient-to-nurse ratios** for its hospitals.
- Legislature asked **California Department of Health** to develop the ratios
- There shall be **no more than 50% Licensed Vocational Nurses** (or Psych Techs in Psychiatric areas)

- Ratios took effect **January 1, 2004** and were modified in **2008**

ICU	1:2	
Stepdown	1:4	Changed in 2008 to 1:3
Telemetry	1:5	Changed in 2008 to 1:4
Med Surg	1:6	Changed in 2008 to 1:5
Psych	1:6	
Pediatrics	1:4	
Specialty units	1:4	
ED – Trauma 1:1; Critical Care 1:2; Others 1:4		
L & D	1:2	

Unintended Consequences of the Ratios

- "**At all times**"
- Nurses used to go on breaks together
- They usually finished their work and then went on break
  - New staffing process required someone to be available for breaks and they would care of the patient while the assigned nurse went on break
- **Time and motion studies** to develop the ratios were done by research assistants, **not nurses**
- While direct care nurses **liked the ratios** and having **more licensed nurses**
- They didn't like the **"at all times"** provision in the ratios
  - The person who developed the specific ratios visited our hospital; received feedback from the staff

Additional Requirement in California

- Must have a **Patient Classification System** that determines the **individual needs of the patient** based on the **registered nurses' assessment**
- **Reliability** and **validity** of the classification system must be done **annually**
- This review of the patient classification system must be reviewed by a **committee** made up of at least **50% staff nurses**

Think Tank Recommendations Based on Today's Discussion

- Establish **empowered professional governance committees** that include **direct-care nurses** and have **authority to create and sustain flexible staffing approaches**
- Advocate for state and/or federal regulation and legislation that **advances meeting minimum staffing standards**
- Advocate for the development and utilization of approaches that **quantify nursing impact on organizational performance and outcomes**

Breakout Groups

NURSE STAFFING TASK FORCE

Project ECHO®

Discussion Questions

- Pick one of the **three existing policy interventions currently used at the state level** for promoting staffing standards – **public reporting, required committees, and mandated ratios.** How is this policy **effective**? What are the **unintended consequences** of this policy? How could we build **a more effective policy**?
- In one of our Task Force discussions, some members felt that the imperative of **establishing staffing standards** conflicted with the imperative to **innovate care delivery**. How do you see these **two imperatives interacting**?
- What are **actionable steps nurse leaders and hospital executives** can take to **advance and implement** these recommendations forward at the:
  - Individual level
  - Institutional level – Unit level
  - Policy level – Associations, etc.

Session Wrap-Up

- You will earn **1.5 CNE credits** for today's session
- Please **scan the QR code** or follow the **link placed in the chat** to claim your CNE credits

NURSE STAFFING TASK FORCE

Project ECHO®

Thank You To Our Task Force Presenters

1

Dr. Linda Cassidy
Dr. Sarah Delgado

+ Reform the Workplace Environment – Creating a Healthy & Supportive Nurse Work Environment

3

Dr. Katie Boston-Leary
Dr. Kiersten Henry

+ Innovate the Models for Care Delivery – Innovative Care Delivery in Nursing: A Paradigm Shift in Healthcare

5

Dr. Sherry Perkins
Dr. Matthew McHugh

+ Establish Staffing Models to Ensure Quality Care – Achieving Excellence in Healthcare: Nurse Staffing Standards

Dr. Nancy Blake
Guest Presenter

2

+ Value the Unique Contributions of Nurses – Transforming Cost into Value: Recognizing Nurses' Unique Contribution

Dr. Vicki Good, Dr. Lesly Kelly

4

+ Improve Regulatory Efficiency – Maximizing Nursing Efficiency: The Future of Regulatory Innovation

Zina Gontscharow, Brian Sims, Michelle Buck

NURSE STAFFING TASK FORCE

Project ECHO

FROM

DATA TO ACTION

The Nurse Staffing Task Force
Project ECHO®

Tackling the Nurse Staffing Crisis

Thank you for joining us!

Think Tank Recommendations

Task Force Recommendations

NURSE STAFFING TASK FORCE

Project ECHO®