**Nurse Staffing Think Tank (NSTT)**

**Meeting Six (6) Minutes**

**Respectfully Submitted by Melissa Jones, PhD**

**March 22, 2022**

**Think Tank Members Present**: Janet Ahlstrom, Carol Boston, Amber Clayton, Vanessa Dawkins, Vicki Good, Melinda Hancock, April Hansen, Helen Haskell, Kiersten Henry, Sherry Perkins, Larry Punteney, Rosanne Raso, Sarah Wells

**Absent Think Tank Members**: Danielle Bowie, Natalia Cineas, Pam Cipriano, Peggy Lee, Ryan Miller, David Tam

**Facilitator:** Regina Black Lennox

**Nurse Staffing Core Team**: Connie Barden, Katie Boston-Leary, Linda Cassidy, Wendy Cross, Sarah Delgado, Kendra McMillan, Cheryl Peterson

**Nurse Staffing Partners attending**: Patricia McGaffigan, Todd Nelson

**Absent Nurse Staffing Partners**: Robyn Begley

**Guest Leaders for Celebration:** Ernest Grant (ANA), Debbie Hatmaker (ANA), Kate Judge (ANF), Beth Wathen (AACN), Matt Fenwick (AONL)

**Reminder of Think Tank Goal:** Deliver written evidence-based recommendations on actionable short-term solutions to mitigate the nurse staffing crisis. This guidance will inform the work of the National Nurse Staffing Task Force. The Think Tank met from January 11, 2022, through March 22, 2022 (6 Meetings, 2 hours each)

**I.** **Welcome –** *Regina Black Lennox* - Tonight, this group will review and validate the priority topics and recommendations. Refine as needed – hopefully minor refinements. Once we have reached practical consensus, we can celebrate together.

**II. Reaching Practical Consensus –** *Katie Boston-Leary* - Shared PowerPoint on practical consensus.

* The goal is to achieve agreement.
* This exercise is not about the little details and what’s missing, this is to look for things that members can’t live with and uncover things that are missing.
* This is not the last opportunity for feedback to refine the document. The Core Team will always be available for further concerns.
* Will move forward if there are no red flags and practical consensus and validation are achieved.
* A section on DEI has been added using the expertise of Katie Boston-Leary and an outside expert.

**III. Staffing Recommendations Cross Walk** – Core Team members provided a rough draft of the

“Nurse Staffing Think Tank: Priority Topics and Recommendations.” The discussion focused on the

1) Recommended Action 2) Measurable Outcomes and 3) Action Steps/Implementation sections for each recommendation. See **Appendix** on page 7for draft used in the discussion.

**IV. Refine and Validate Recommendations**– *Core Team members and Think Tank members*

*Healthy Work Environments (HWE):*

HWE had three recommendations, but the first recommendation has two sub-sets that encompass the work (so it looks like only two recommendations).

Comments and Discussion:

* The higher levels of HWE can’t be achieved until basic safety is taken care of. The one thing the framework hasn’t called out is the physical safety element. It was an assumption but it is now time to specifically call out physical and psychological safety for our workforce.
* Patient advocate noted concern about asking for specific legislation to protect healthcare workers. Violence is widespread – not just against healthcare workers. Worried that the underlying issues are so often medical and that to blame the patient is to put a band-aid over it. More advocacy is needed for care of mentally ill patients. The blame is frequently on people who have mental illness.
* In the 2018 AACN HWE survey, 83% of respondents had been involved in an episode of workplace violence (physical or verbal). It showed this is definitely an area of focus. The onus should be placed on organizations and institutions to ensure the safety of their healthcare workers. Not necessarily who is at fault, but how to prevent incidents happening so our healthcare workers can practice in a safe environment.
* Question: Are there accepted standards on safe staffing? They have not been defined – more nursing equals better outcomes but a certain ratio or care limit has not yet been defined in the evidence.

**Practical consensus reached**

*Diversity, Equity, and Inclusion*

This was mentioned during an initial meeting as something to prioritize. It is part of a healthy work environment, but stands out as an important item. Recommendations are to increase diversity, build a diverse nursing workforce, provide psychological safety to attract/retain a diverse workforce, and establish a nursing diversity dashboard. Heeded the call about being bold. Dashboard will allow for clear indication of progress. Document is set up to move group in the right direction and see measurable and meaningful change as it relates to diversity in nursing and, in particular, and nursing leadership.

Comments and Discussion:

* The recommendations do not address equity and inclusion as much as they addresses diversity.
* Need to be careful of some of these metrics as they may not be attainable in certain parts of the country. Diversity doesn’t exist in some areas. Speed in which people of color move up the corporate ladder – diversity is bigger than just color. Make sure we’re looking at equity and inclusion along with the diversity piece.
* Diversity is not just related to BIPOC hiring. LGBTQ and gender diversity is also needed.
* Not sure how to implement action step that directs all current and upcoming vacancies to be diverse hires.
* It’s also about sexual orientation – or women in C-suite jobs.
* Ableism also needs to be addressed. Nurses who use a wheelchair often have trouble getting into bedside nursing. There is sometimes unnecessary exclusion for people with different ADA needs.

Amendments will be made based on what was heard in comments.

**Practical consensus reached**

*Work Schedule Flexibility*

Centered on leveraging what we have now – a form of a float pool. How can we expand our staff who are designated as float pool staff to support nurses assigned to their designated units? Biggest things to focus on is flexibility in scheduling, shifts, and roles. Use nurses who are cross-trained to go where most needed.

Comments and Discussion:

* There is a need to address the potential and actual use of virtuality as well. This present document contemplates a total presence and in-person nursing. There is work that can be done in a virtual mode (e.g., case management and discharge planning). This is an existing option and may be expanded. Call it a “flexible environment.”
* Question: In the ICU we’ve talked about tele-ICU – a very prescribed structure. Are there two separate areas – telemedicine *and* virtual work?
* This is also included in the last section of the Models of Care – a crossover.
* Is it possible to look at regular employees’ scheduling to see how employers can modify that? It’s not just about a float pool. What can we do for those employees who have a schedule that isn’t working out? Is there flexibility in the scheduling process to help retain/acquire those nurses?
* This needs to be stated explicitly. Also allowances for flexibility in shift length (4, 6, 8, 10, and 12-hour shifts).

The recommendations covered flexibility of work, hours, and roles – might help to drive the types of shifts to best suit a particular organization.

**Practical consensus reached**

*Stress Injury Continuum*

recommended action of addressing burnout, moral distress and compassion fatigue. Want nurse wellness to be a value stream for all organizations. Hoping through the regular check-ins and support services, there is the ability identify those having high moral distress, we can help support them and prevent regression from getting worse. Second recommendation talks about well-being of nurses. Onus to ensure this should be on organization not on individual.

Comments and Discussion:

* In some systems there is a focus on physician well-being, nurse well-being and APP well-being. While our lens is nurses, we should also consider the interdisciplinary team.
* We do want this to be an interdisciplinary concern.
* Can this be taken to an HR level? Is this fundamental to care? To providing a safe environment? Maybe collaborate with SHRM or another HR group and not take it on single-handedly.
* Also discussed how to reach travel nurses. Needs to apply to everyone.
* There is a need to stop the culture that you should work without taking a break.

**Practical consensus reached**

*Innovative Care Delivery Models*

Proposing that we set up definitions for tribrid versus hybrid care delivery models. Make sure that there is a step process. Engaging a lot of stakeholders on what is developed. Building off the team model. Way to keep nurses at home institution and keep the talent in-house. Building in a way to measure success and look at outcomes.

Comments and Discussion:

* Thinks this is terrific and is pleased with the way it has turned out.
* More content is located in the broader document.
* Need a clearer definition around APRN roles to ensure that their contribution can be leveraged without diminishing scope of practice that was hard won. When roles are clearly defined, it’s easier to support a team staffing approach during a surge. “I’m comfortable in my role and I know I can step back when we’re out of this need.”

**Practical consensus reached**

*Total Compensation*

Attentive to generational needs. Reframing a narrative telling leaders that instead of looking at nursing as an expense item, reframe the conversation that appropriate nurse staffing is fundamental for optimizing payment for services. There is a direct impact. As the ratios rise, the documentation levels will change and this will impact the bottom line financially. How do we reward those at the bedside? Make sure it’s an optimal field to work and stay in.

Comments and Discussion:

* A task that we’ll be carrying forward to our finance friends.
* It is huge for us to have this really different philosophical approach and to get it supported by CFOs. It means a lot that we have your support in this.
* Confirm that the midnight census is mentioned because it is very important.

**Practical consensus reached**

**V. Next Steps** – *Linda Cassidy* - You all have exceeded any dreams we had for this work. We’ll now be moving on to the next phase, the Task Force. We needed a strong foundation to get the Task Force moving. You have accomplished that.

Task Force meetings begin on April 25 and will meet every three weeks for the next nine months. The purpose of the Task Force is to further evolve the work but also to provide another powerful forum for dialogue about the importance of staffing and its symbiotic relationship to a healthy work environment.

Hope this group takes some time to reflect on what a contribution this work is and how much we appreciate all you have put into it. You’ve energized us.

The Task Force will be more diverse – with experts from policy, regulatory, and healthcare organizations and those from other areas that touch acute and critical care nursing (nurse researchers). There will be a broad array and diverse membership, as well as a geographical diversity.

**VI. Celebration** – *Regina Black Lennox* - A true spirit of collaboration is the reason this final effort is what it is. You can celebrate that you were a part of it. Share takeaway ideas and feelings from this experience with others. Has it changed you? Are you excited? Do you have new hope for your profession? How will you communicate what you’ve done with others?

Final Comments from Think Tank members:

* Hope really *is* a strategy. Nurses can feel they’ve been struck down. This shows that all hope is not lost and there can be a happy, joyful, and impactful future for nurses—and this will help us get there.
* This is exciting. Nurses have been undervalued and undercompensated forever. Excited about the changes.
* To see that we’ve got such high-level groups engaged in change brought hope for the future. This is a pivotal change that the profession needs. This has forced us to get out of that rut.
* Learned a lot with regards to the industry. There are a lot of challenges here and hope that this work will make some change. We’re causing the effect here by the work we’re doing.
* COVID gave us many things, positive and negative, but it’s helped us raise the issues that we’ve had for many years to the forefront. Inspired that we’ve taken the opportunity to have these meetings and dialogue and to have this structure going forward. Inspired that we can and will impact change.
* Think about how creative we were over the last two years. This team reminds me that we can be creative and think differently. We should think differently. If we don’t do things like this, we will fall behind. Feels good to be part of something that’s moving things forward.
* Raise physical and psychological safety to a higher level – it’s not at a great place right now. Safety in the workplace involves everybody. If healthcare workers are safe, the patient is safe. This is the most optimistic thing since COVID.
* Will be a nurse for 40 years this spring, and just over 20 years ago, “To Err is Human” introduced patient safety language into our vernacular. This is the next big movement since then. It wasn’t okay until 20 years ago to talk about harm in hospitals. Vision meeting actual execution and driving real change.
* A blog about the Quadruple Aim reminded the member that our clinical workforce is fourth in importance. How did it fall behind the other three so far? Why isn’t it at the same level of importance and given the same national attention? Whether it’s resiliency or safety, what is notable about this group is all of us have been working on this individually. We have some cool stories and one-off ideas. But the power of the collective is inspirational.
* Used to think hope was not a strategy, it was a mindset change to realize it *is* a strategy. The other word that came to mind is trust. Not sure about the process at first, but learned to trust the process. Trusts the incredible colleagues that are represented here from every possible level and discipline and perspective and what we came up with. Read that the Quadruple Aim has been expanded to the Quintuple Aim – adding “equity.” All five of these elements are in our document.
* Feels hopeful and recharged as a bedside nurse. So many nurses have been lost over the last two years, and they’re not just leaving the department but the workforce. There is lack of faith that anyone cares anymore. That feeds into the feelings of betrayal. This work can be taken as evidence that people care – they want you here. You’re so important that we’ve formed this think tank.
* The phrase that came to mind was “collaborative self-advocacy.” We could rest on our 20 years as the most trusted profession and the fact that people need and respect us. That’s not supporting our workforce in the way that we need. Nursing doesn’t look to others to make it happen – has a history of self-advocacy. To the bedside point – to be able to tell the people at the bedside that there are people working on this issue at the national level gives hope. The grit, evidence, and work to drive this forward is phenomenal.

Moderator final words: The group was given the image of the moonshot at the beginning. This group has landed on the moon and has their flag up there. You did something very few groups can do, you reached consensus. That is rare and inspiring.

Nurse Staffing Partners and guest organizational leaders provided additional comments.

**VII. Adjournment** - Meeting adjourned at 8:00 ET

**APPENDIX**

**DRAFT: Nurse Staffing Think Tank: Priority Topics and Recommendations**

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| **Overview of Priority Topics and Recommendations** | **Healthy Work Environment** | * Elevate clinician psychological and physical safety to equal importance with patient safety through federal regulation * Specialty nursing organizations investigate evidence related to scope of practice and minimum safe staffing levels for the patients in their specialty | |
| **Diversity, Equity, and Inclusion (DEI)** | * Implement INCLUSIVE EXCELLENCE: A change focused iterative planning process whereby there is deliberate integration of diversity, equity and inclusion ideals into leadership practices, daily operations, strategic planning, decision making, resource allocation and priorities. | |
| **Work Schedule Flexibility** | * Build a Flexible Workforce with flexible scheduling, flexible shifts, and flexible roles | |
| **Stress Injury Continuum** | * Address burnout, moral distress, and compassion fatigue as barriers to nurse retention * Incorporate wellbeing of nurses as an organizational value. | |
| **Innovative Care Delivery Models** | * Implementation of Tribrid Care Delivery Models (combination of onsite care, IT integration and ambulatory access and virtual/remote) to deliver care with key processes in place to improve access, improve patient and staff experience and resource management with continuous measurement for improvement and adjustment for sustainability and support. | |
| **Total Compensation** | * Organization wide formalized and customizable total compensation program for all employees that is stratified based upon generational needs and inclusive of benefits such as PTO for self-care and wellness, wealth planning for all generations. | |
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| **Think Tank Participants:** | * **Janet Ahlstrom,** *University of Kansas Medical Center* * **Carol Boston-Fleischhauer,** *The Advisory Board* * **Danielle Bowie,** *Bon Secours Mercy Health* * **Natalia Cineas,** *New York City Health and Hospitals* * **Pamela Cipriano,** *University of Virginia, International Council of Nurses (ICN)* * **Amber Clayton,** *Society of Human Resource Management* * **Vanessa Dawkins,** *NYP Weill Cornell and NYP Westchester Behavioral Health* * **Vicki Good,** *Mercy Health Springfield Missouri* * **Melinda Hancock,** *Sentara Healthcare* | | * **April Hansen, *Aya*** *Healthcare Group* * **Helen Haskell,** *Founding member of NAQC* * **Kiersten Henry**, *MedStar Montgomery Medical Center* * **Peggy Lee,** *VA of Southern Nevada and Nevada Action Coalition* * **Ryan Miller,** *Christiana Care Health System* * **Sherry Perkins,** *Luminis Health Anne Arundel Medical Center* * **Larry Punteney,** *Avantas* * **Rosanne Raso,** *New York Presbyterian Weill Cornell* * **David Tam,** *Beebe Healthcare* * **Sarah Wells,** *Acute Care Nurse and Founder, New Thing Nurse*   *\*Special Contributor for DEI and Inclusive Excellence, Dr. Rumay Alexander* |

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| **Think Tank Purpose:** | American Nurses Association (ANA), American Association of Critical-Care Nurses (AACN), American Organization for Nursing Leadership (AONL), Healthcare Financial Management Association (HFMA), and the Institute for Healthcare Improvement (IHI) launched a nurse staffing think tank to find solutions to the nurse staffing crisis. The think tank brings together nurses, leaders, and other stakeholders. As a collective, the think tank worked over 3 months to develop actionable strategies set to implement within a year with measurable outcomes that will address the nurse staffing crisis. This work sets the foundational work for a nurse staffing task force scheduled to launch in April 2022 by   * Providing strategic advice on broad ideas and direction based upon data that identifies the root causes of the nursing shortage * Providing input on workforce trends, challenges and issues hindering progress toward feasible and practical staffing solutions * Providing strategic direction for broader goals, and * Identifying options for action and their associated outcome |

# **Healthy Work Environment**

**Operational Definition:** Safe, healing, humane, and respectful of the rights, responsibilities, needs and contributions of all people including patients, their families, nurses, and other health care professionals.

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| **Recommended Action** **Health Work Environment:** Elevate clinician psychological and physical safety to equal importance with patient safety through federal regulation | | |
|  | **Workplace Violence (physical safety)** | **Work environment (Psychological safety)** |
| **Definition** | Nurses' hazards: lifting and moving patients, handling sharps, chemical, radiation, or infectious exposures and violence, chronic stress from high stakes work, and workplace violence | Psychological safety: Able to be oneself without fear of negative consequences  Team has shared belief that interpersonal risk taking is safe Prevention of incivility, bullying, and workplace violence |
| **Who is this targeting?** | Clinician physical safety in work environment | Health care teams, health care leaders |
| **Scope of Impact** | Every U.S. acute, critical access, long-term care hospitals | National impact via federal regulation, institutional impact if adopted by leaders |
| **Accountable Entity** | Federal, health systems. Interdisciplinary team.  Professional nursing organizations for advocacy  health care leaders for institutional implementation | Centers for Medicare/Medicaid (CMS)  Health systems  Federal  Professional nursing organizations for advocacy  health care leaders for institutional implementation |
| **Timeline** | Within 12 months | **6 months** |
| **Measurable Outcome(s)** | Implementation of federal legislation and/or CMS regulation.  Decrease in physical violence against healthcare worker rates in the organization (and define exemptions like organic brain disease)  Decrease in workers’ compensation claims for violence | Every organization has a process for routinely measuring their work environment  Every organization has a process for acting on data about the work environment to move toward improvement  A CMS Condition of Participation that addresses the work environment is implemented  Data on work environment is routinely collected and drives needed changed |
| **Action Steps/ Steps Toward Implementation** | Federal legislation/CMS regulations to protect and give employees a bold voice against physical violence in the workplace. \*  \* *Exemptions will be specified around patients with illness-related delirium and other organic processes.*  Advocate for implementation of federal legislation to protect healthcare workers  Advocate for implementation of a standard or Condition of Participation by CMS requiring that hospitals protect healthcare workers | Discussion with Deputy of CMS  Advocate for clinician experience as a criterion in the Value Based Purchasing program (mirroring patient experience)  Advocate to create a CMS Condition of Participation (COP) that requires organizations to regularly assess/ measure the health of the work environment and demonstrate evidence of continual improvement. |
| **Supporting Evidence:** |  |  |

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| **Recommended Action Healthy Work Environment:** Specialty nursing organizations investigate evidence related to scope of practice and minimum safe staffing levels for the patients in their specialty. | | |
|  | Investigate minimum staffing levels for specific patient populations | Development of Staffing Standards  Sto address the needs of patients in their specialty population |
| **Definition** | Similar to the role professional organizations take in defining “Scope and standards of practice” for nurses, there is a role to define appropriate staffing. | Staffing standards are defined according to patient needs and existing evidence that correlates staffing levels and patient outcomes. |
| **Who is this targeting?** | Specialty nursing organizations, direct care nurses and nursing leaders | Specialty nursing organizations, direct care nurses and nursing leaders |
| **Scope of Impact** | National impact | National impact |
| **Accountable Entity** | Specialty nursing organization | Specialty nursing organization |
| **Timeline** | 6 months | **12 months** |
| **Measurable Outcome(s)** | Specialty organizations assess applicability and, if so, report that they have undertaken this work within six months | Specialty organizations define staffing standards for patients in their specialty. |
| **Action Steps/ Steps Toward Implementation** | Nursing specialty organizations investigate evidence related to scope of practice and minimum safe staffing levels for the specialty. | Organizations play a role in creating standards that delineate staffing requirements for optimal care. |
| **Supporting Evidence:** |  |  |

**Diversity, Equity, and Inclusion (DEI)**

**Operational Definition of Inclusive Excellence:** Nurse leaders have a responsibility to address structural racism, cultural racism, and discrimination based on identity (e.g., sexual orientation, gender), place (e.g., rural, urban), and circumstances (e.g., disability, mental health condition) within the nursing profession and to help build structures and systems at the societal level that address these issues to promote health equity.A change focused iterative planning process whereby there is deliberate integration of diversity, equity and inclusion ideals into leadership practices, daily operations, strategic planning, decision making, resource allocation and priorities. It also states that the work is about change and therefore requires constant, innovative ways to have a diverse workforce. This definition really shuts down the typical comments of lowering quality in order to achieve diversity (Williams, Berger, McClendon, 1985).

Building a diverse nursing workforce is a critical part of preparing nurses to address SDOH and health equity. While the nursing workforce has steadily grown more diverse, nursing schools need to continue and expand their efforts to recruit and support diverse students that reflect the populations they will serve. Diversity and Inclusion is evidentially linked to psychological safety. Psychological safety has an impact on retention.



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| **Recommended Action Diversity, Equity, and Inclusion (DEI):** Implement **INCLUSIVE EXCELLENCE**: A change focused iterative planning process whereby there is deliberate integration of diversity, equity and inclusion ideals into leadership practices, daily operations, strategic planning, decision making, resource allocation and priorities. | | | | |
|  | **Increase diversity in nursing leadership** | **Building a diverse nursing workforce** | **Provide psychological safety to attract/retain a diverse workforce** | **Establish a Nursing Diversity Dashboard** |
| **Definition** | A change focused iterative planning process whereby there is deliberate integration of diversity, equity and inclusion ideals into leadership practices, daily operations, strategic planning, decision making, resource allocation and priorities. | Diverse workforce is a critical part of preparing nurses to address SDOH and health equity | Psychological safety is linked to diversity, equity and inclusion. 4 Stages – inclusion safety, learner safety, contributor safety, challenger safety | Data that tracks demographics of workforce and measure alignment with the community/state/nation |
| **Who is this targeting?** | Nurse leaders | Direct care nursing staff | Health care workforce | Health care workforce- dashboards for nursing, nursing leadership and c-suite |
| **Scope of Impact** | Managers, directors, administrators, c-suite | Patients and nurses, schools of nursing, faculty | Health care teams | Health care team |
| **Accountable Entity** | Nursing Leadership, C-suite | Nursing Leadership, C-suite | Nursing Leadership, C-suite | Nursing Leadership, C-suite |
| **Timeline** | 1 year | **1 year** | 1 year | 6 months |
| **Measurable Outcome(s)** | Data dashboard of nursing leaders will show improvement in diversity within 1 year | Data dashboard of nursing workforce will show improvement in diversity in 1 year | Overall data dashboard shows improvement within 1 year | Data dashboard available within 6 months |
| **Action Steps/ Steps Toward Implementation** | Review leadership team  Direct all current and upcoming vacancies to be diverse hires (in accordance with labor laws and HR guidelines)  Monitor speed at which people of color move up the corporate ladder  review turnover data for BIPOC staff | Nursing schools recruit and support diverse students that reflect the populations they will serve  Embrace LPNs and ADNs as a strategy to diversify workforce and they must be treated and respected similar to RNs. Support and respect their desires to pursue advanced degrees  Institute diversity awards and publicize demographics of awardees for awards granted with award program. | Orientation sessions include commitment to diversity and zero tolerance for assaults on another's self-esteem  Add a DEI category to performance appraisals for annual goals for performance ranking tied to compensation | overall, nursing, nursing leadership, C-suite with yearly improvement (New hires, turnover (90 days, 6 months, 1 year), RN satisfaction).  Be transparent with data with meaningful dashboards on DEI metrics for staff and community with webpage visibility of your workforce demographics and activities- no more than one click away. |
| **Supporting Evidence:** | Morrison, V., Hauch, R. R., Perez, E., Bates, M., Sepe, P., & Dans, M. (2021). Diversity, equity, and inclusion in nursing: The Pathway to Excellence framework alignment. *Nursing Administration Quarterly*, *45*(4), 311-323. | Gerull, K. M., Enata, N., Welbeck, A. N., Aleem, A. W., & Klein, S. E. (2021). Striving for inclusive excellence in the recruitment of diverse surgical residents during COVID-19. *Academic Medicine*, *96*(2), 210-212. | Clark, T. R. (2020). The 4 stages of psychological safety: Defining the path to inclusion and innovation. Berrett-Koehler Publishers. | Williams, D. A., Berger, J. B., & McClendon, S. A. (2005). *Toward a model of inclusive excellence and change in postsecondary institutions* (p. 39). Washington, DC: Association of American Colleges and Universities. |

# **Work Schedule Flexibility**

**Operational Definition:** A staff scheduling approach that encompasses flexibility in work options, policies, and scheduling with nurses cross trained to various units, to support well-being during a shift and incorporates time for professional development and leadership engagement such as shared governance

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| **Recommended Action Work Schedule Flexibility:** Build a Flexible Workforce with flexible scheduling, flexible shifts, and flexible roles | | | | |
|  | **Site Float Pool** | **Multi-Hospital System Float Pool** | **Seasonal and Surge PRN to Full-time Float Pool** | **Interdisciplinary care team** |
| **Definition** | Single entity, on-site float i.e.: hospital, clinic, floating to multiple units within a specialty or as cross trained | Multi-site enterprise float pool where appropriate in a defined geographical region for daily or long-term placement | Expansion and contraction of workforce as needed to accommodate predictable seasonal fluctuations (seasonal trends, geography, demographic of patient population served)   1. Retired workforce picking up assignments based upon demand 2. Per diem/ part time workforce who picks up full time assignments to bump up FTE 3. .6 that works .3 during the summer and .9 FTE | Interdisciplinary team for shift-based tasks – resource nurse, ancillary staff, admissions, discharge, med pass nurse, break nurses, weekend coverage etc. Staff in this category follow non-traditional hours and shifts to support peak volume and tasks and can be hired into float or non-float departments. |
| **Who is this targeting?** | Group of clinicians who float by specialty within their scope of practice and competency and licensure | Group of clinicians who float by specialty within their scope of practice and competency and licensure. Highly skilled staff cross trained and oriented to multiple units. | Float  Group of clinicians who float by specialty within their scope of practice and competency and licensure. Highly skilled staff cross trained and oriented to multiple units.  Non-float  Group of clinicians assigned to a dedicated unit to practice within their scope of practice and competency and licensure. | Float  Group of clinicians who float by specialty within their scope of practice and competency and licensure. Highly skilled staff cross trained and oriented to multiple units.  Non-float  Group of clinicians assigned to a dedicated unit to practice within their scope of practice and competency and licensure.  Also includes ancillary staff. |
| **Scope of Impact** | **Patient care** – quality and safety  **Staff** – satisfaction  **Cost,**  **Management** | **Patient care** – quality and safety  **Staff** – satisfaction  **Cost,**  **Management** | **Patient care** – quality and safety  **Staff** – satisfaction  **Cost,**  **Management** | **Patient care** – quality and safety  **Staff** – satisfaction  **Cost,**  **Management** |
| **Accountable Entity** | Nursing, financial, HR, and hospital leadership | State boards of nursing to support compact licensure and multi-state practice, scope of practice, Nursing, finance, HR, and hospital leadership | State boards of nursing to support compact licensure and multi-state practice, scope of practice, Nursing, finance, HR, and hospital leadership | State boards of nursing to support compact licensure and multi-state practice, scope of practice, Nursing, finance, HR, and hospital leadership |
| **Timeline** | **3-6 months** – change management, hiring, training, deployment | **6-12 months**  change management, hiring, training, deployment | **3-6 months** – change management, hiring, training, deployment | **6-12 months**  change management, hiring, training, deployment |
| **Measurable Outcome(s)** | Frontline employee engagement, patient experience  Reduction of agency overtime, reduction in vacancy and turnover rates | Frontline employee engagement, patient experience  Reduction of agency overtime, reduction in vacancy and turnover rates | Frontline employee engagement, patient experience  Reduction of agency overtime, reduction in vacancy and turnover rates | Frontline employee engagement, patient experience  Reduction of agency overtime, reduction in vacancy and turnover rates |
| **Action Steps/ Steps Toward Implementation** | * Cost analysis to build program (review unit level spending to scope specialty to include premium and agency spend) * Understanding workflow trends and data to build flexible schedules that will allow for continuity of patient care * Build a job description * Pay structure/ total compensation and benefits * Set up organizational structure for management * Education structure (orientation, competency) * Upskilling and cross training workforce * Education and change management for the organization about new team to include organizational definition of flexible workforce and definition of internal contingency and float pool rules * Defining way to deploy for operational use. | * Cost analysis to build program (review unit level spending to scope specialty to include premium and agency spend) * Understanding workflow trends and data to build flexible schedules that will allow for continuity of patient care * Build a job description * Pay structure/ total compensation and benefits * Set up organizational structure for management * Education structure (orientation, competency) * Upskilling and cross training workforce * Education and change management for the organization about new team to include organizational definition of flexible workforce and definition of internal contingency and float pool rules * Defining way to deploy for operational use. | * Cost analysis to build program (review unit level spending to scope specialty to include premium and agency spend) * Understanding workflow trends and data to build flexible schedules that will allow for continuity of patient care * Seasonal trend and analysis for volume analysis to build team. * Build a job description * Pay structure/ total compensation and benefits * Set up organizational structure for management * Education structure (orientation, competency) * Upskilling and cross training workforce * Education and change management for the organization about new team to include organizational definition of flexible workforce and definition of internal contingency and float pool rules * Defining way to deploy for operational use. | * Quantitative and qualitative data analysis of shift-based needs to build unique roles such as break nurses, resource, preceptor pool etc. * Cost analysis to build program (review unit level spending to scope specialty to include premium and agency spend) * Understanding workflow trends and data to build flexible schedules that will allow for continuity of patient care * Seasonal trend and analysis for volume analysis to build team. * Build a job description * Pay structure/ total compensation and benefits * Set up organizational structure for management * Education structure (orientation, competency) * Upskilling and cross training workforce * Education and change management for the organization about new team to include organizational definition of flexible workforce and definition of internal contingency and float pool rules * Defining way to deploy for operational use. |
| **Supporting Evidence:** |  |  |  |  |

**Stress Injury Continuum**

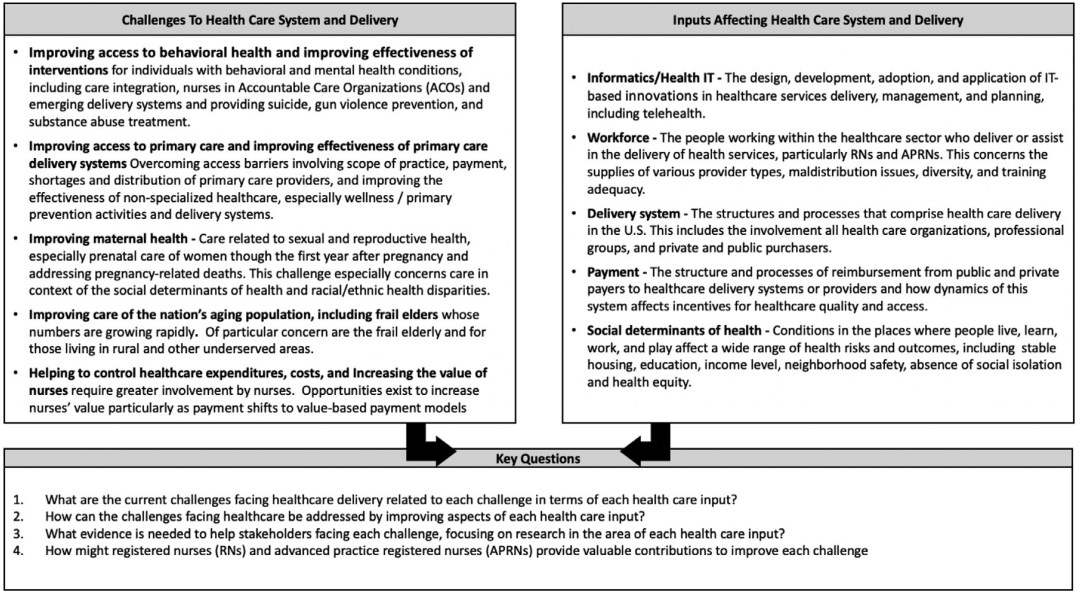
**Operational Definition:** Stress injury continuum is inclusive of burnout syndrome, compassion fatigue, moral distress, anxiety, depression and PTSD and other phenomena and refers to the range of negative consequences from stress exposure

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| **Recommended Action Stress Injury Continuum:** Address burnout, moral distress and compassion fatigue as barriers to nurse retention. | | | | |
|  | **Routine Assessment of Stress Injury** | **Provide Resources that include peer support and mental health services** | **Dedicated Team that collects and analyzes data** | **Data informs the development of further resources** |
| **Definition** | Routine use of a standardized tool to measure stress injury | Resources to support the breadth of impacts stress injury can have (different in different individuals) | Organizational leader or team or outside group (EAP) is accountability for assessing aggregate data from the assessment tool | A team that includes leaders and frontline staff uses data to inform further resource development. |
| **Who is this targeting?** | **The whole of the nursing workforce** | | **Employee Assistance Program or Chief Wellness Officer or wellness committee/team** | |
| **Scope of Impact** | Frontline nurses and frontline leaders  Impact includes bringing attention to individual and group wellbeing and raising awareness of resources | | Leaders, wellness team, EAP  Demonstrating impact of data on action could impact trust between clinicians and leaders | |
| **Accountable Entity** | Frontline staff (uptake)  Leadership (providing time and emphasizing importance of use) | Frontline staff (uptake)  Leadership (providing time and emphasizing importance of use) | Depending on organizational structure- a wellness team, wellness officer, human resources or EAP personnel | Depending on organizational structure- a wellness team, wellness officer, human resources or EAP personnel |
| **Timeline** | **3 months** | **3 months** | 3-6 months | 12months |
| **Measurable Outcome(s)** | METRICS that demonstrate impact of recommendation implementation  Changes in absenteeism among nurses/leaders  Changes in nurse retention and nurse turnover (that is attributable to stress injury)  Response to changes in data on stress injury severity- is action taken when the numbers rise?    Metrics that evaluate the process of implementing the recommendation   * Correlate the rate of screening to the use of services to see if they align * Track the use of screening tool (similar to hand hygiene) * Extrapolate from existing measures that institutions use to measure- engagement surveys, satisfaction surveys- to see if recommendation impacts these | | | |
| **Action Steps/ Steps Toward Implementation** | Identify (or develop or adapt) screening tool- consider a downloadable, very short, electronic tool ([sample tool](https://www.theschwartzcenter.org/media/Stress-First-Aid-Self-Care-Organizational-NCPTSD10.pdf))  Ensure anonymity in collecting aggregate data  Establish a structure for escalation – where to send people who screen as urgent.  Address ADA considerations  . | Catalog existing resources and identify gaps  Include clinical services such as ethics, palliative care, pastoral care that may offer support for wellbeing or may be expanded to do so  Provide a continuum of support that includes peer support and access to mental health care.  Identify common sources of distress and target root causes  Do not put the burden on the individual- it’s everyone contributing to the culture that supports wellbeing | When screen tool is codified as part of practice, aggregate data can be collected  Identify priority clinical areas or groups at high risk and consider further data collection | Include key stakeholders to participate in resource development based on data analysis.  Frontline staff with paid time to attend meetings and contribute to this work |
| **Supporting Evidence:** | ANA document on Moral Resilience  NAM Compendium | | | |

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| **Recommended Action Stress Injury Continuum:** **Organizations incorporate the wellbeing of nurses as an institutional value (aligns with NAM)** | | | | |
|  | **Recognition of the continuum of stress injury** | **Actions that promote well-being are imperative** | **Individuals and organizations share responsibility for team member wellbeing** |  |
| **Definition** | Stress injury can have a variety of impacts including burnout syndrome, compassion fatigue, moral distress and mental health disorders including depression, anxiety and PTSD | The normal state is to need time/help processing experiences in health care workforce | Institutional obligation to provide support with corollary individual responsibility to accept it. |  |
| **Who is this targeting?** | Direct care staff, hospital leaders | Direct care staff, hospital leaders | Direct care staff, hospital leaders |  |
| **Scope of Impact** | **All employees, greater impact on those without awareness of stress injury** | All employees of the organization | Increase organization-employee trust |  |
| **Accountable Entity** | Professional organizations, health care leaders | Professional organizations, health care leaders | Health care leaders, direct care staff |  |
| **Timeline** | 3 months | **3-6 months** | 6-12 months |  |
| **Measurable Outcome(s)** | Risk of stress injury included in orientation, evaluation, huddles/meetings and other standard procedures and interactions | Track use of resources with aim of increasing use | Adoption of wellbeing as a value is binary (yes/no)  Professional organizations/NAM collect data on number of hospitals taking this approach |  |
| **Action Steps/ Steps Toward Implementation** | Build the conversations about wellbeing into employee evaluations, staff meetings, unit/shift huddles and other communications (What are doing to stay well and how can I support that?)  Raise awareness of resources and risk for suicidality among nurses | Provide time off for mental health, the same as we do physical health.  Create safe spaces for mental health conversations within the clinical space/work time  Standardize breaks/end a culture that values working without a break. | National organizations- invest in “Wellness as a value” toolkit  Offer Modified duty/alternate work site to accommodate changes in mental health status/stress status  Support flexible staffing options to mitigate/prevent stress injury- a different schedule or an opportunity to engage differently (serving as an educator, a leader, cross training to another clinical space) |  |
| **Supporting Evidence:** |  |  |  |  |

# **Innovative Care Delivery Models**

**Operational Definition:** Care delivery models that combine hi-tech and hi-touch for high quality care with an inclusive and integrated approach for patient and nurse satisfaction, reduction of practice pain points and improved outcomes.



Cohen, C. C., Barnes, H., Buerhaus, P. I., Martsolf, G. R., Clarke, S. P., Donelan, K., & Tubbs-Cooley, H. L. (2021). Top priorities for the next decade of nursing health services research. Nursing outlook, 69(3), 265-275.

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| **Recommended Action:** A Tribrid Care Delivery Model offers a more holistic approach that has 3 components with onsite care delivery, IT integration of patient monitoring equipment and ambulatory access and virtual/remote) to deliver care. This approach will improve access, improve patient and staff experience and resource management with continuous measurement for improvement and adjustment for sustainability and support. | | | | |
|  | **Assess and analyze the practice landscape and identify the gaps and opportunities** | **Identify Resources and Critical Success Factors** | **Craft the Plan with support for nurses to lead and execute hybrid care models** | **Test and Implement** |
| **Definition** | Organizational needs assessment | Resource allocation and a shared definition of success | Inclusion of nurses in all sections of planning and identification of nurse champions for implementation | PDSA – Plan, Do, Study, Act |
| **Who is this targeting?** | Nursing Leadership collaborating with other key HCPs and nurses who provide direct patient care to lead and own execution. | Nursing Leadership collaborating with other key HCPs and nurses at the bedside to lead and own execution. | Nursing Leadership collaborating with other key HCPs and nurses at the bedside to lead and own execution. | Nursing Leadership collaborating with other key HCPs and nurses at the bedside to lead and own execution. |
| **Scope of Impact** | Patients, families, nurses & HCPs | Patients, families, nurses & HCPs | Patients, families, nurses & HCPs | Patients, families, nurses & HCPs |
| **Accountable Entity** | Nursing & Health system leadership with key focus of Total Cost of Care (TCC) and other key metrics for value based purchasing and accountable care. Requires C-suite and BOD support. | Nursing & Health system leadership with key focus of Total Cost of Care (TCC) and other key metrics for value based purchasing and accountable care. Requires C-suite and BOD support. | Nursing & Health system leadership with key focus of Total Cost of Care (TCC) and other key metrics for value based purchasing and accountable care. Requires C-suite and BOD support. | Nursing & Health system leadership with key focus of Total Cost of Care (TCC) and other key metrics for value based purchasing and accountable care. Requires C-suite and BOD support. |
| **Timeline** | 6-9 months | 3- 6 months | 3-6 months | 12 months |
| **Measurable Outcome(s)** | Transparent and comprehensive assessment report of the current state of care delivery models – Pre-pandemic and pandemic data (skill mix, NHPPD, nurse vacancies, nurse turnover, number of days to fill positions – particularly specialty areas (ED, ICU), core measures and other patient outcomes. Nurse sensitive indicators – Pressure ulcers, falls, Nosocomial infections. | **Measure and Publish Data on the impact of changes to care delivery model**  Track measures and nurse sensitive quality indicators that are measurable on a frequent basis – falls, core measures, restraint use, nosocomial infections, nurse satisfaction, surveys of patient safety and workforce safety culture, Nurse engagement, likelihood to leave/remain in practice. Provide gainsharing models for the entire team to financially benefit from improvements in metrics. | | |
| **Action Steps/ Steps Toward Implementation** | * Characterize trends with patient and workforce demographics, disease processes, nature, social determinants of health and type of care and support to be provided along with resources to provide care (human, supply and technological solutions) and volume * Ensure meaningful engagement of nurses at all levels, other care team members and pt/family representative in the assessment process      * Review baseline data with patient outcomes (morbidity, mortality, NDNQI, pt satisfaction and engagement), surveys of safety culture, nurse satisfaction/engagement and efficiency, workforce safety and wellbeing?      * Review models of care – primary, functional, team, etc.      * Obtain feedback from patient advisors on existing model and patient and family centered considerations with new models.      * Assess competencies and capabilities of the existing team in preparation for change.      * Utilize appreciative Inquiry – list what resources are working well (human, supplies, equipment, technology), in addition to barriers and challenges.      * Design future state – determine what could be added/modified/ stopped to improve care delivery      * Research and select model/s of care suitable for implementation and understand cost implications and unintended consequences. * Engage support from patient and family advisors      * Obtain buy in and support from human resources, finance and other members of the C-suite.      * Review and improve EHR documentation systems on a regular basis to reduce documentation burden on nurses. | * Recruit talent and human resources needed to execute the plan – scribes for admission assessment documentation, LPNs for administering medications as appropriate, documentation during assessments * Obtain, recruit and onboard resources (equipment, materials, etc.) to reduce nurses’ workload and improve responsiveness to patients’ needs – nurse transcription services, device integration with regularly used equipment, virtual health, early warning system (EWS), surveillance systems and Artificial Intelligence (AI). * Review and improve EHR documentation systems on a regular basis to support new care models and reduce documentation burden on nurses. * Build teams and support services to improve workflows on all shifts with code teams, IV therapy teams, pharmacy support, supply management, etc. | * Consider alternative and appropriate use of personnel with all care delivery agents (RNs, scribes, LPNs, MAs, EMTs, paramedics, APRNs, PCTs) to incorporate as members of the care delivery team and support and augment care (Include clinician and non-clinicians).      * Co-design model with active engagement of patient/family advisors.      * Consider a remote or virtual nursing care delivery model to augment in person care delivery along with ambulatory opportunities for surveillance from the home setting.      * Review scopes of practice from licensing boards and revise competencies as needed to adjust to the new plan. Craft new job descriptions as needed      * Determine how the revised model compares to existing models, including anticipated cost considerations      * Formalize, define, communicate and educate all stakeholders and set a launch date/month/year      * Determine metrics that will be used to evaluate models and establish plans for regular review for effectiveness and evolution      * Identify and list improvement opportunities expected with the new model. Consider combining and hybrid-ing models. Conduct failure, models, effectiveness analysis (FMEA) to assist with selection process.      * Support development of necessary skills for nurses in delegation, conflict resolution, leading teams, etc. * Hire APRNs to lead care delivery teams in the acute care setting | * Use go-live infrastructure similar to EHR implementation go- lives (mini-command center, check ins, response for problem solving). * Conduct rapid cycle testing of new models, beginning with small tests of change and using Plan, Do, Study, Act (PDSA) and build in critical success factors for continuous assessment and measurement. * Post and publish the new plan and utilize it for orientation and onboarding for core, float, and temporary nurses and nursing support staff. * Engage masters’ and doctoral nursing students and interprofessional teams on staff and through clinical affiliations to conduct studies and publish research on CDMs. Offer grants to students to conduct research on CDM effectiveness for internal use and publication. * Revisit list of improvements and pain points removed or mitigated. * Celebrate milestones and wins! |
| **Supporting Evidence:** | Komariah, M., Maulana, S., Platini, H., & Pahria, T. (2021). A Scoping Review of Telenursing’s Potential as a Nursing Care Delivery Model in Lung Cancer During the COVID-19 Pandemic. *Journal of multidisciplinary healthcare*, *14*, 3083. | Dillard-Wright, J., & Shields-Haas, V. (2021). Nursing with the people: Reimagining futures for nursing. *Advances in Nursing Science*, *44*(3), 195-209. | Parreira, P., Santos-Costa, P., Neri, M., Marques, A., Queirós, P., & Salgueiro-Oliveira, A. (2021). Work methods for nursing care delivery. *International Journal of Environmental Research and Public Health*, *18*(4), 2088. | Cohen, C. C., Barnes, H., Buerhaus, P. I., Martsolf, G. R., Clarke, S. P., Donelan, K., & Tubbs-Cooley, H. L. (2021). Top priorities for the next decade of nursing health services research. *Nursing outlook*, *69*(3), 265-275. |

# **Total Compensation**

**Operational Definitio**n: All forms of payment received by an employee from an employer in the form of a salary, wages, and benefits.

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| **Recommended Action:**  Organization wide formalized and customizable total compensation program for nurses that is stratified based upon market intelligence, generational trends and an innovative and transparent pay philosophy needs and inclusive of benefits such as PTO for self-care and wellness, wealth planning. | | | |
|  | Comprehensive/ flexible compensation philosophy | Educate and reframe the narrative that appropriate nurse staffing is fundamental for optimizing available revenue | Consider compensation added value “intangibles” for nurses |
| **Definition** | A shift in approach to compensation that addresses variety of needs/interests | How investing in appropriate staffing has a return to the organization and not simply an expense/cost. | Examine and consider new approaches specific to the population that provide direct care |
| **Who is this targeting?** | Health care workforce-Nurses - hourly and exempt, all levels of commitment status | Nurses and Nursing Leadership, Revenue Cycle, Finance, Administration | Nurses and nursing leadership |
| **Scope of Impact** | Health care workforce Nurses | Nurses, managers, educators | Nurses |
| **Accountable Entity** | Human resources, health system leaders Nursing leadership, CFOs | Professional nursing organizations, nursing researchers, human resources and nursing leadership, CFOs | Human resources, health system leaders nursing leadership, CFOs |
| **Timeline** | 12 months | 6-9 months | 6 months |
| **Measurable Outcome(s)** | Within 1 year, the organization’s flexible approach to total compensation is available provided to and shared with all employees and nurses. | Within 9 months, the financial value of appropriate staffing is articulated Share data results from compensation survey. |  |
| **Action Steps/ Steps Toward Implementation** | * Conduct routine market analysis to inform compensation include inflation, external agency compensation, market changes * Consider and execute independent contractual models with nurses in addition to traditional models of employee agreements. * Stratify comp plan by generational needs. * Consider gain sharing models, lifting capitations on tuition reimbursement and loan forgiveness. * Prevent salary compression issues with low merit increases not keeping up with new hire salaries with regular reviews and action. * Gather input on compensation plan from frontline, include generational diversity * Embrace and accept nurse mobility and migration. * Maintain an agile/adaptable process- rapid cycles of change when needed * Make available/ be transparent regarding philosophy/plan for compensation * Include exempt employees. * Creative compensation for hard to fill shifts and days (holidays and family days like Halloween). | * Identify and disseminate evidence of nursing as revenue supporting (not only as an expense/cost). For example, providing appropriate time to document completely throughout the shift ensures correct coding, charges for procedures, supplies, services and acuity and reduces risk to the organization. * Engage state and county legislative officials for support and advocacy and maintain as a high agenda item for nurses. * Conduct compensation surveys with nurses on a recurring basis and share results. * Educate, empower and support nurses to advocate for policy changes. * Revisit and revise metrics that are used primarily or solely for expense allocation, recording and reduction to allow for understanding of revenue production, staff safety and satisfaction – such as productivity, HPPD, midnight census, skill mix. * Look at the cost of lawsuits due to poor documentation, lost charges, reduced coding, common dropped procedures and supplies. * Add leading practice/case studies of comp program examples – share innovative, effective practices | * Create a system for rewarding nurses who maintain direct care role (changed from “stay at bedside”). * Eliminate philosophies and communication to nurses that seek additional compensation to do more to deserve an increase in salary. Clinical ladders are supplemental increases to appropriate base pay and should not make up the difference with market adjustments. * Make it attractive for nurses in non-clinical skilled departments to provide direct care with appropriate compensation. * Build systems that support secondary job codes and proper compensation for nurses to engage in internal movement and migration to explore other opportunities as long as their safety and workload is not impacted. * Reinstate, maintain and implement meaningful pay policies to support nurses for precepting, mentoring and clinical advancement. * Review policies for total hours considered and counted for total nursing experience in all settings of care and not implement punitive policies for nurses that have breaks in their employment experience. * Understand and address issues with bonus payments versus hourly increases for prospective hires and incumbents. * Be open and flexible with salary negotiation with new hires and provide a seamless access and partnership between nursing leadership and HR for nurses on staff who have salary concerns. Address any feelings of guilt. * Provide reward for floating and additional competencies * Partnerships with local businesses to improve wellbeing with discounted memberships, daycare, dry cleaning pickups and delivery, healthy food available on all shifts and days of the week. * Invite community leaders to engage with nurses to build lasting relationships. * Assess nurses “shadow” non-nursing skills that would benefit the organization and compensate appropriately and showcase. Most nurses have numerous other skillsets – writing, artistic, IT, etc. or are entrepreneurs. * Regularly review equity in compensation differences based on gender, race, sexual orientation, disability and all other discriminatory implications. * Add PTO category for self-care and mental health * Provide accessible wealth planning. * Evaluate compensation impact on both intrinsic and extrinsic motivation; adjust approach as needed based on input. |
| **Supporting Evidence:** | Letvak, S. A., Ruhm, C. J., & Gupta, S. N. (2012). Nurses' presenteeism and its effects on self-reported quality of care and costs. AJN The American Journal of Nursing, 112(2), 30-38. | Duru, D. C., & Hammoud, M. S. (2021). Identifying effective retention strategies for front-line nurses. Nursing Management, 28(4). | Bradley, C. (2021). Utilizing Compensation Strategy to Build a Loyal and Engaged Workforce. Nurse Leader, 19(6), 565–570. https://doi-org.proxy-hs.researchport.umd.edu/10.1016/j.mnl.2021.07.006 |