# Georgia Healthcare Workforce Commission
# Additional Information from Interested Stakeholders- part 2

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Georgia Statewide AHEC Network

STATEWIDE AHEC NETWORK PROGRAM OFFICE

Augusta University / 1120 15th Street, Room AA 1057 / Augusta, Georgia 30912 / (706)-721-8331 / www.augusta.edu/ahec

November 17, 2022

Commissioner Caylee Noggle, Chair
And Honorable Members of the Georgia Healthcare Workforce Commission
2 Peachtree Street NW
Atlanta, GA 30303

**VIA ELECTRONIC SUBMISSION**

Dear Commissioner Noggle and Members of the Commission,

I am very sorry that I was unable to come before you at your recent meetings, but am submitting for your review the presentation I had prepared as well as this letter summarizing the recommendations of the Georgia Statewide Area Health Education Centers Network around solutions to our state's health workforce challenges. The presentation provides an overview of who we are and the work we accomplish in Georgia. We have existed as a Statewide Network since 1992, and have six regional centers who collectively serve all 159 Georgia counties. We are an established infrastructure with "boots on the ground" across the state.

A partnership coordinated by Augusta University, the Georgia Statewide AHEC Network is a complex, multi-disciplinary effort which responds to the problems of health professional supply and distribution in rural and underserved areas of the state. We operate in three main program areas which together span the pipeline of the healthcare workforce. These are RECRUIT, TRAIN, and RETAIN. Our efforts in these areas is more fully explained in the Power Point presentation provided or you can visit our website at www.augusta.edu/ahec for more information.

At this point, I am sure you are each acutely aware of the challenges facing Georgia. You have heard numerous entities describing the obstacles and hurdles they face. I would like to respectfully offer some proposed recommendations for your consideration. You will note that some are specific to AHEC and others speak to other established programs in Georgia. I will note in parenthesis the recommendations as they apply to our three program areas; recommendations without these parentheses indicated broader recommendations at the macro level.

**PROPOSED RECOMMENDATIONS:**

1. I would implore you to not create more programs and units without first considering expansion and strengthening what already exists. We need less complexity in our systems, not new players and approaches which focus on individual silos or institutions.

**AHEC Specific Recommendations**

2. ***(RETENTION AND TRAINING)*** Support the reauthorization of the Preceptor Tax Incentive Program administered by the Statewide AHEC in partnership with the Georgia Department of Revenue. Georgia was the first state nationally to create this program and it will sunset in December 2023 without renewal. This program provides tax incentives to Georgia physicians, advanced practice nurses, and physician assistants who provide ***uncompensated*** community based clinical training for medical, osteopathic, APRN, and PA students ***from Georgia educational programs*** to maintain and grow this necessary preceptor cohort to continue providing this critical service for the training of our health care workforce. Since inception, the Medical College of Georgia has

provided full administrative costs to the Statewide AHEC to administer the program on behalf of ALL eligible health profession programs in the stat. **NO COST**

3. ***(RECRUIT)*** Fund the Statewide AHEC to hire new staff focused on intensive health careers programs (spanning a minimum of 20 hours per student), manage labor intensive programs such as our AHEC Scholars interdisciplinary care 2 year programs that engage approximately 180 students from 12+ academic programs in intensive learning about interprofessional team care and social determinants of health and other programs such as our Summer 4 week residential Pathways to Medicine Programs. These positions would focus on college level training and recruitment for health careers. We already employ health career coordinators at all six centers and these would focus on earlier components of the pipeline such as middle and high school students. Estimated cost: $75,000 x 6 positions (includes salary and benefits) to be located at the six regional AHECs. These professionals need to be more seasoned than entry level positions. **Total ask: $450,000.**
4. ***(RECRUIT)*** The Statewide AHEC offers several signature programs, one of which is Pathway to Medicine which focuses on assisting college students from rural and underserved communities to become better prepared and more competitive applicants to our state's medical schools. Currently, this four week residential intensive program is offered in two AHEC regions, Southwest Georgia (SOWEGA-AHEC) and Northeast Georgia (Foothills AHEC) for 18 students each year. Data prove a very high rate of return on this program, and participants are tracked into practice. We would like to expand this program to three other regions. Costs cover housing of students, 80 hours of clinical shadowing, travel stipends, limited food, and staff time. **Total ask: $75,000.**
5. ***(TRAIN)*** One of the biggest challenges in health workforce distribution is the need to create training opportunities remote from academic campuses. Unlike other professions, heath care programs require substantial clinical training in addition to rigorous didactic (classroom) learning. Data indicate that students are more likely to practice in areas similar to where their clinical training occurs, thus underscoring the need to create more training opportunities in our rural and underserved communities. The largest barrier to this for students is the need for temporary housing while on these rotations. Students must retain their full time living accommodations at their home campus, while seeking housing for 4-6 week rotations in other areas. The AHECs provide community based housing across the state and serve medical, advanced practice nurses, PAs, pharmacy, dental, physical therapy, occupational therapy, public health, social work, and other students with free accommodations while completing their community based clinical training. Housing costs for existing housing has increased by approximately 23% over the past year, and new housing is needed as well to meet the demand. We are asking for $184,000 in new funds to sustain existing housing, and an additional $500,000 to open new beds across the state. **Total ask: $684,000.**
6. ***(RETAIN)*** While recruitment into the health professions is critical and efforts must not be diluted, the need to retain our existing workforce has become a paramount challenge. Georgia has been hit hard by the "Great Resignations" and especially in healthcare. Coupled with an aging workforce, we need to focus significant resources on provider wellness end creating healthier workplaces in health care settings. We have begun an initiative to create resiliency and wellness programs for health profession students, practitioners, and workplace employers but need assistance in fully developing the program. We envision this initiative to be centered at the AHEC Network Program Office, through our partners at Morehouse School of Medicine, and will serve the entire state. **Total ask: $75,000.**
7. ***(TRAIN)*** Through focus groups with health care employers held in 2020, we learned that the lack of clinical skills of newly graduating nurses is an ongoing frustration and significantly impedes their immediate use at the bedside. Nursing programs focus on theory and science (which they should) but do not focus on clinical skill development per se when in training. These programs are often forced to "teach to the NCLEX exam" which is required for licensure but does not focus on clinical skills. To combat this the Statewide AHEC would like to develop a series of new nurse graduate "boot camps" to focus solely on clinical skills. To begin, we would like to partner with simulation centers already existing in the state and pilot this project at 1-3 locations. We envision a 2-4 week experience, with space for 40 newly graduated nurses. Small stipends would need to be paid to participants, and faculty time would need to be purchased. Housing for the participants may also need to be

addressed. We would ask for $100,000 to pilot this initiative in FY 24. Metrics would be established to measure impact and outcomes and based on the data, future requests may be forthcoming. **Total Ask: $100,000**.
***TOTAL AHEC ASK: $1,384,000***

**Other Recommendations:**

8. **Uniform and codified data agreements** between health professions licensing boards and the Georgia Board of Health Care Workforce. To date, these agreements have been highly dependent on the relationships between the individuals on these boards. The Georgia Board for Health Care Workforce is the logical repository for these data and have proven their analytical capacity to utilize data to create informed workforce supply and demand reports and projections. There may need to be staff funded at the GBHCW to fully actualize this recommendation. I would yield to the Board and its staff to address this critical issue.
9. **Support and fund the transition to use ACEMAPP** – use one repository system in Georgia for documentation required by clinical facilities for student onboarding and for clinical placement. This would decrease cost and time for students to complete requirements and would increase ease of using multiple facilities for clinical rotations. Use of ACEMAPP would increase ease of academic programs using one system.

In conclusion, I would ask that the Commission look for solutions and not bandaids to our challenges. You have all worked very hard to hear from a broad spectrum of advocates and programs and I do not envy your challenge of assimilating the information you have heard into a feasible plan. Please know that you have both my gratitude and full support and you may call upon me for any assistance or clarifications.

Most sincerely,

*Denise D. Kornegay, MSW*

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Augusta University
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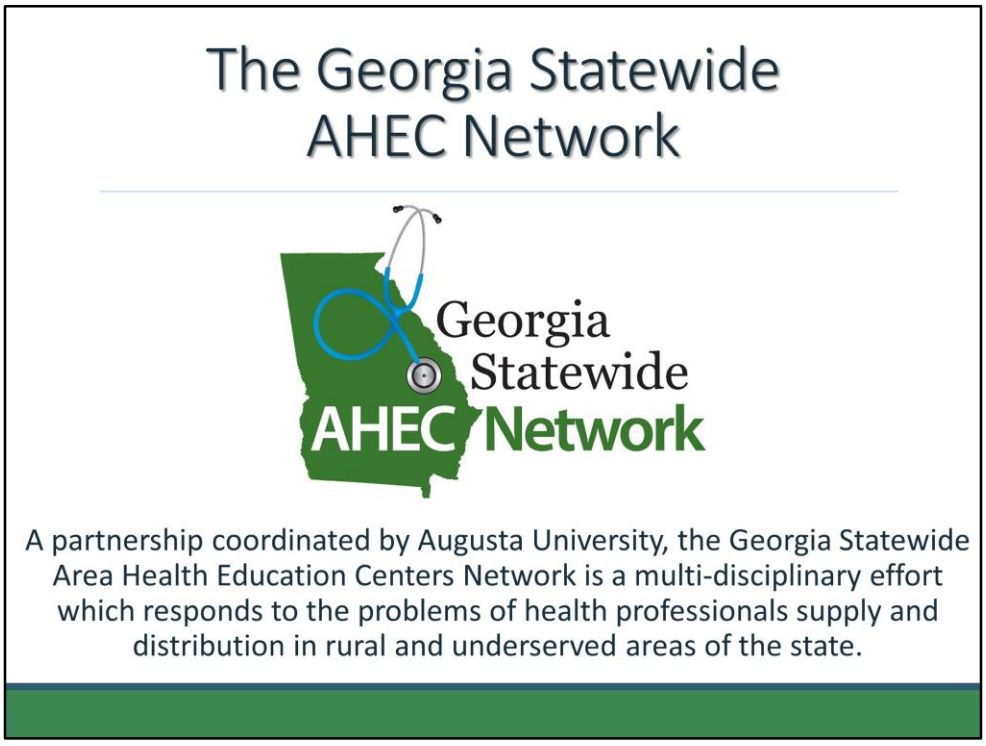
Associate Professor, Family Medicine
Medical College of Georgia @ Augusta University

# The Georgia Statewide AHEC Network

Denise Kornegay, MSW
Executive Director

November 30, 2022




Why are we here? Because we have been doing this work statewide since 1992. We are an academically neutral program managed through Augusta University/ MCG and have six independent non-profit centers across the state staffed to work along the health professions pipeline to meet community needs.

# The Georgia Statewide AHEC Network

**Georgia Statewide AHEC Network Program Office-Augusta University**

**Blue Ridge AHEC**

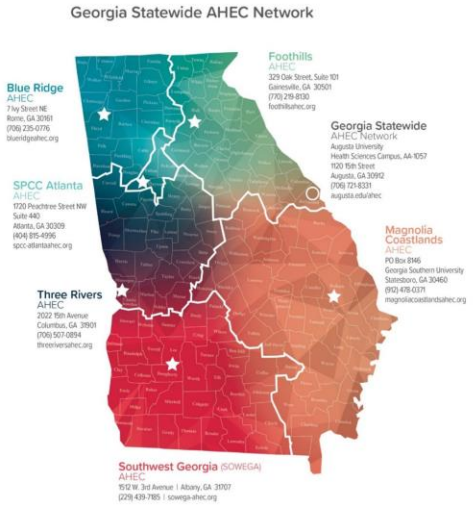
**Foothills AHEC**

**Magnolia Coastlands AHEC**

**SPCC-Atlanta AHEC**

**SOWEGA AHEC**

**Three Rivers AHEC**



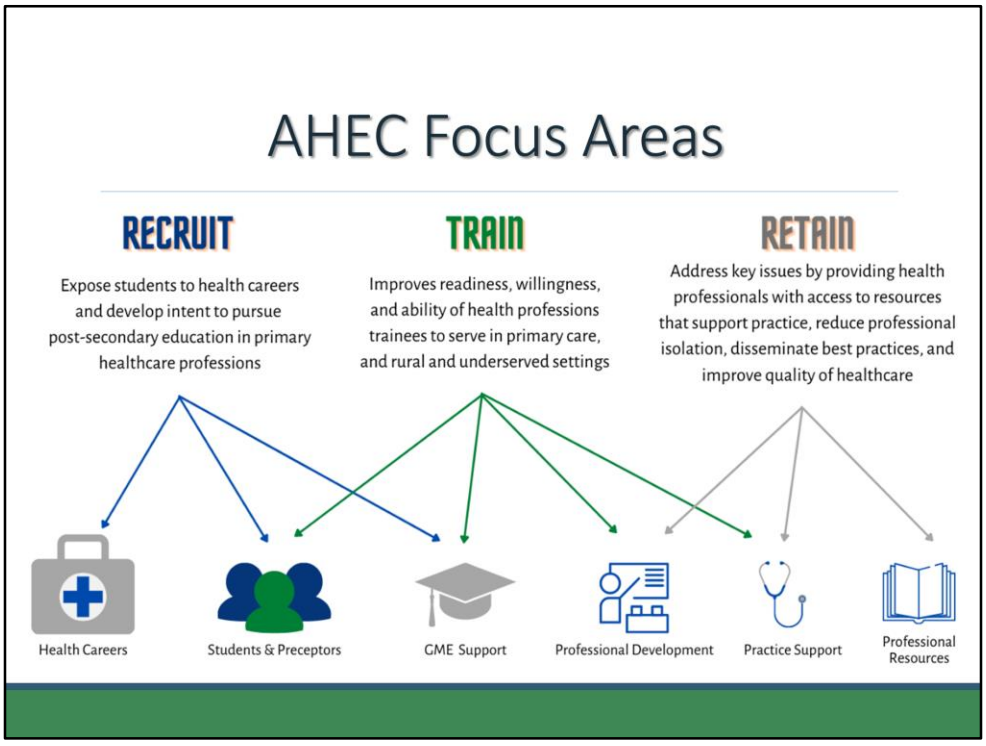

The initial purpose of AHEC was to create leverage for communities to engage with academic programs to meet local health workforce needs.

The AHEC program was begun by the federal government in the early 1980's; Morehouse School of Medicine began the AHEC Program in Georgia and opened three centers in the state: SPCC-Atlanta, Dublin CHEP-AHEC (later relocated to Statesboro and renamed Magnolia Coastlands AHEC), and the SOWEGA AHEC.

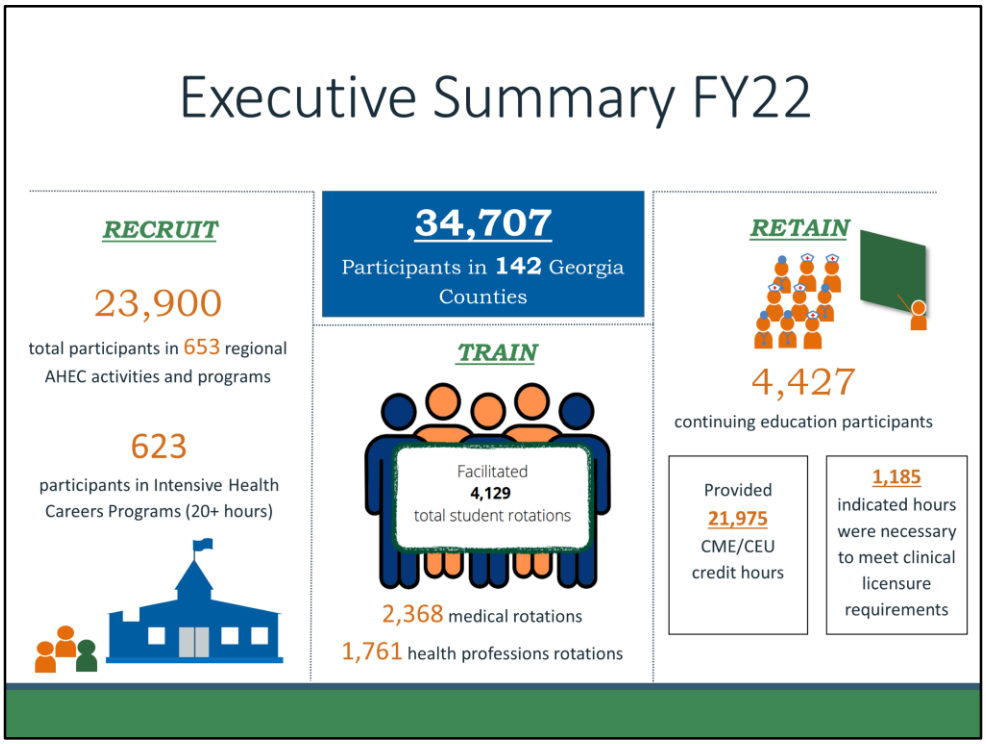
In 1992, with the agreement of all four medical schools in the state at the time, it was agreed that the program should be statewide, academically neutral, and managed by the Medical College of Georgia. The grant was written and funded and the Georgia Statewide AHEC Network was born. Three Rivers, Blue Ridge, and Foothills AHEC regional centers were opened and coupled with the existing centers to ensure that all 159 counties would be served by an AHEC led by a regional board of directors.

State and federal funds for AHECs flow through the Statewide AHEC Network Program Office located at Augusta University.

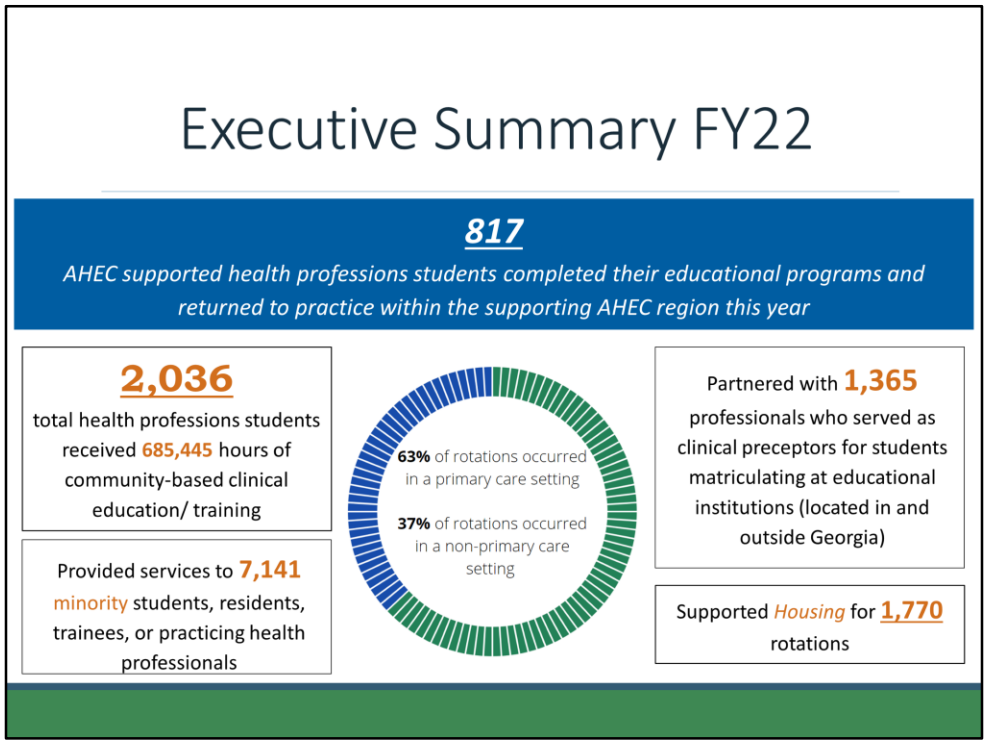
Other than the Program Office staff in Augusta, AHEC employees are not employed by the state but by the Board of Directors for each Center, all of whom are incorporated 501C3 non-profits.




AHEC programming can be viewed through the 3 lenses described above. We often refer to “cradle to grave” programming as our work spans the continuum between career selection, education, training, practicing, and retention of providers in Georgia.




To demonstrate the volume of our work, the FY 22 executive summary in this and the next slide provides a glimpse into the amount and impact of our programs.




We also provided travel support for an additional 1,140 rotations

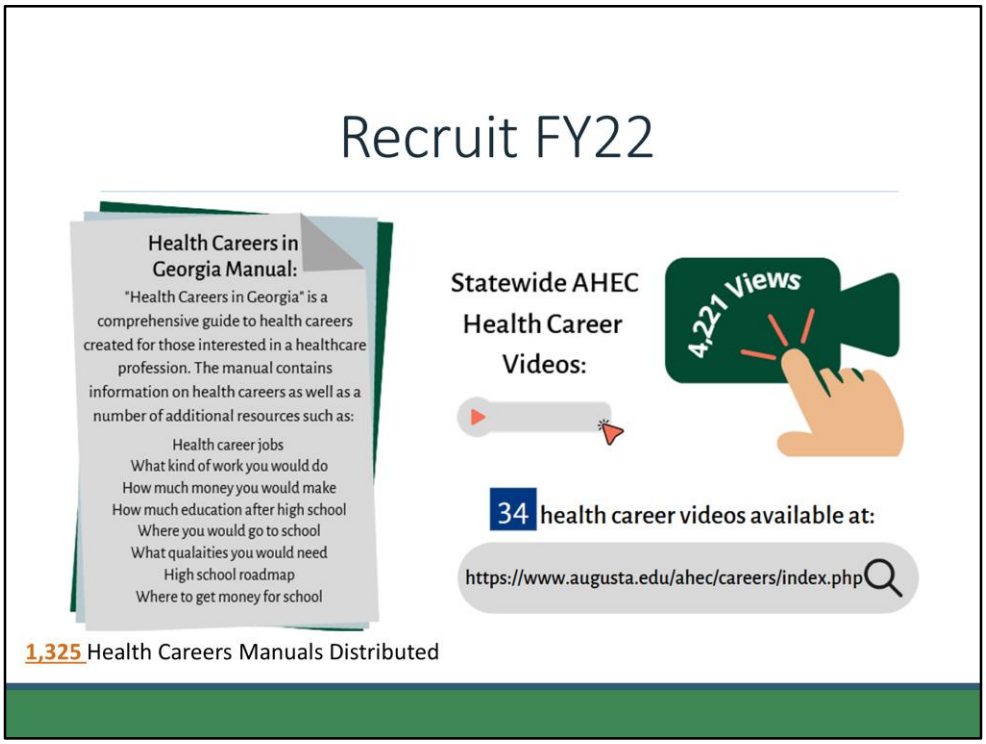
But the most important number is 817- the number of AHEC supported health professions students who completed their educational programs and returned to practice within the supporting AHEC region this year.

The pipeline is not linear in that students do not enter and exit at the same times. So, a student in 2022 who began working with AHECs through a high school health careers camp at age 16 would not exit the pipeline towards medicine for at least 10 years. But a student who completed the AHEC Pathways to Medicine Program in 2022 as a college junior or senior could be expected to complete the educational pathway within 3-6 years.

And these are not just physicians, but all levels of health care providers including nursing, advanced practice nursing, physician assistants, dentists, pharmacists, physical therapist, etc.


What we call “Recruit” is often called “Pipeline Programs” by others. This is an intensive effort to expose youth to the varieties and realities of potential health careers.

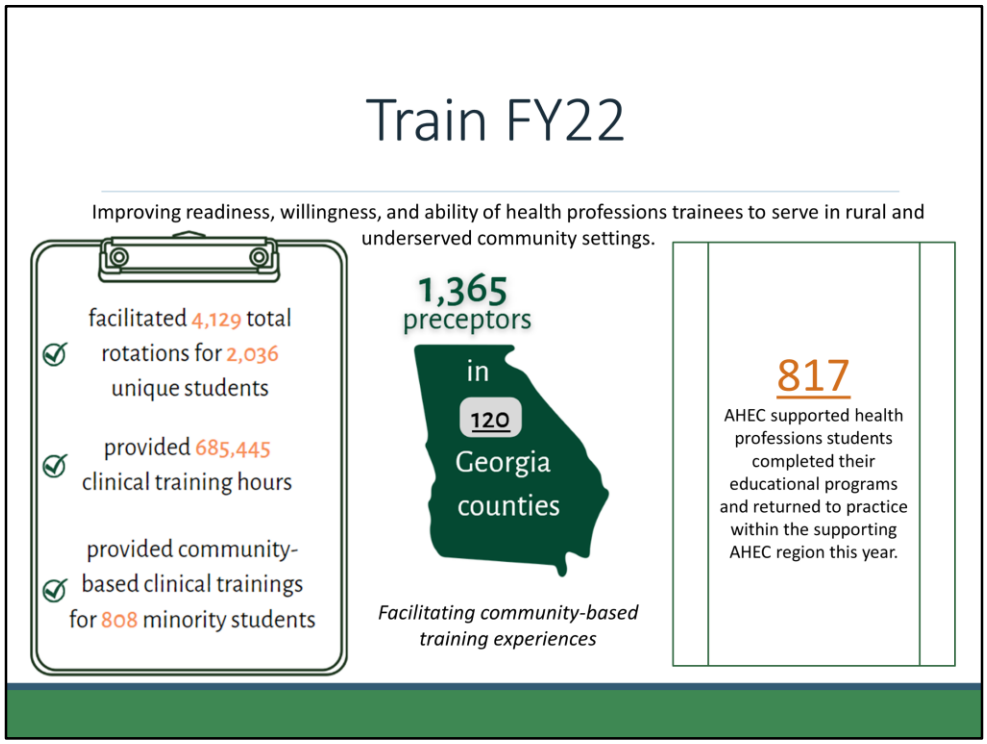
Intensive programs are those that have at least 20 hours of direct programming. We have found a high return on investment in these programs and have increased our offerings in this area in the past 5 years. This was a direct reflection of utilizing our data system to track participants and developing evidence that intensive programming, while labor intensive, yields tangible results. Prior to this programming change, we would have around 50,000 health careers participants each year but in classroom presentations and health fairs as opposed to hands on programs.




Some of the tools we have developed and offer include our Health Careers in Georgia Manual, published every three years and provided free of charge to every hospital, public library, health occupation teacher, and guidance counselor in the state. Additionally, the manual is available on our website www.augusta.edu/ahec

Our health career video site was created to assist classroom teachers in rural and underserved areas who wanted to expose their students to the broad array of health careers but did not have local resources to assist them, such as providers or facilities for tours.

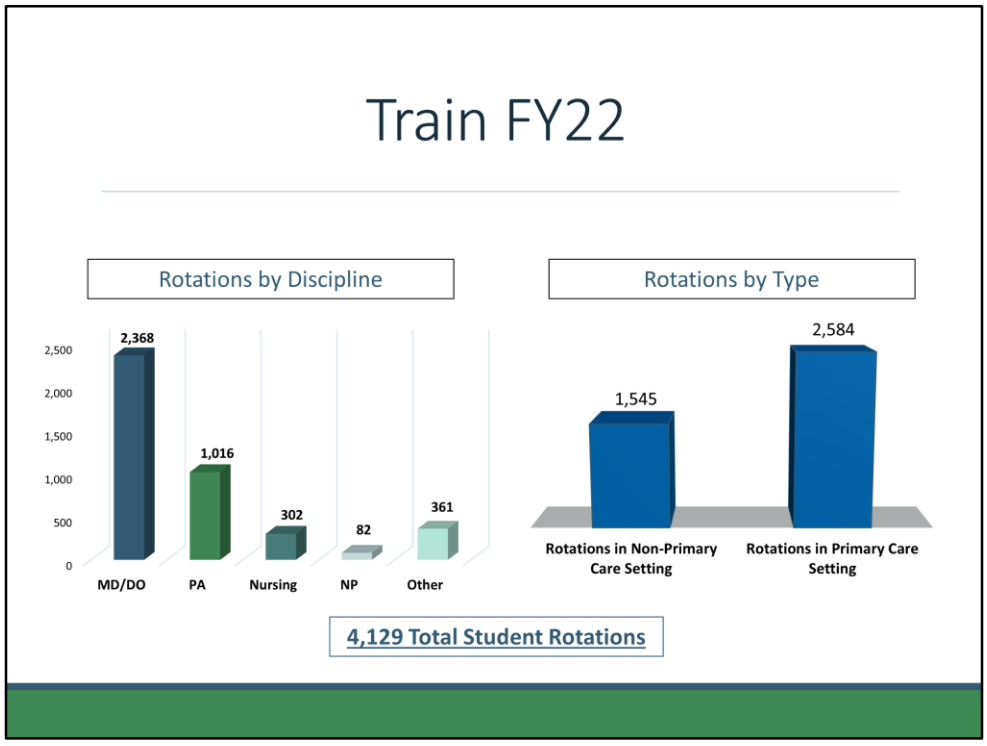
Pathways to Medicine is another signature program offered in our southwest and northeast regions. It is a four week summer residential program for rural and/or minority college students seeking to apply to medical school. It provides over 80 hours of clinical shadowing, a research project, and assistance with application processes and tips.



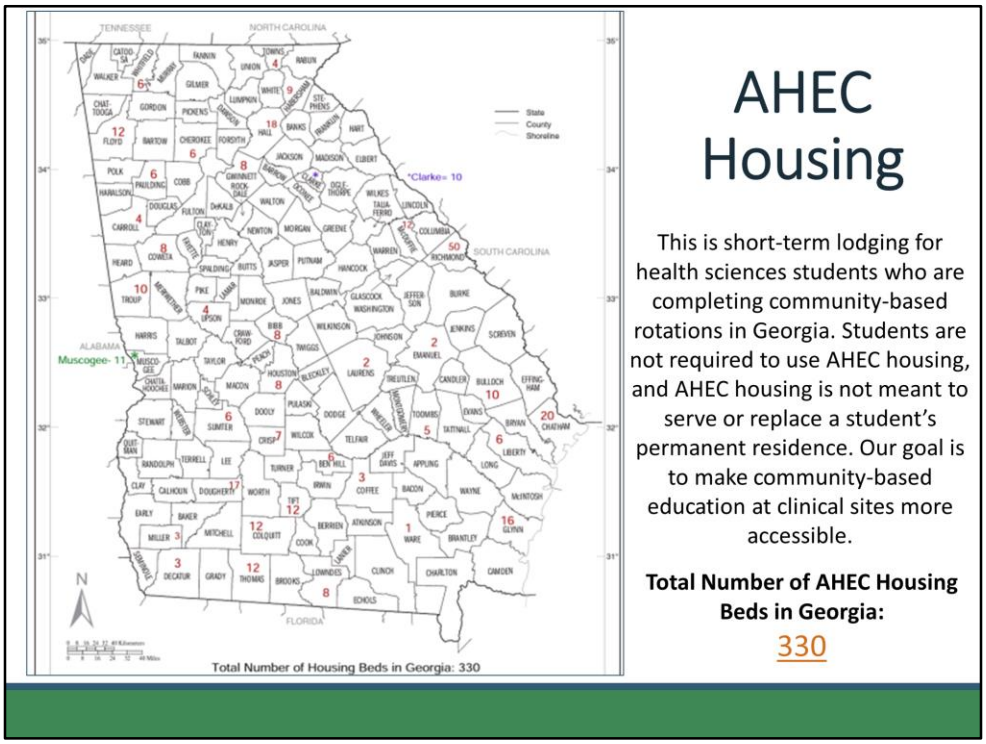

This is the most labor intensive and challenging part of what we do- identifying and managing viable training sites with community partners and community-based training for students in locations remote from their academic campus. Evidence indicates that the location of student rotations and clerkships is highly correlated to their eventual practice sites. To meet the state's needs, we have to have students training in communities across the state and not just in our urban or tertiary hospitals and practices.

To do this well, we have to have two systems in place. The first is a housing plan so that students who move to a rural community for a 4-6 week rotation have a place to stay. Housing is the biggest barrier for students considering to do off campus rotations. Remember, the students are already paying rent wherever they are in school, and locating and paying for temporary housing elsewhere is not feasible. So the AHECs fill this gap by providing safe and free housing across the state, which you can see on an upcoming slide.

Second, we must have well prepared community-based faculty preceptors willing to take the students into their practice for a month or more. We must support them, reward them, and acknowledge them- because we do NOT pay them. These are volunteer heroes.

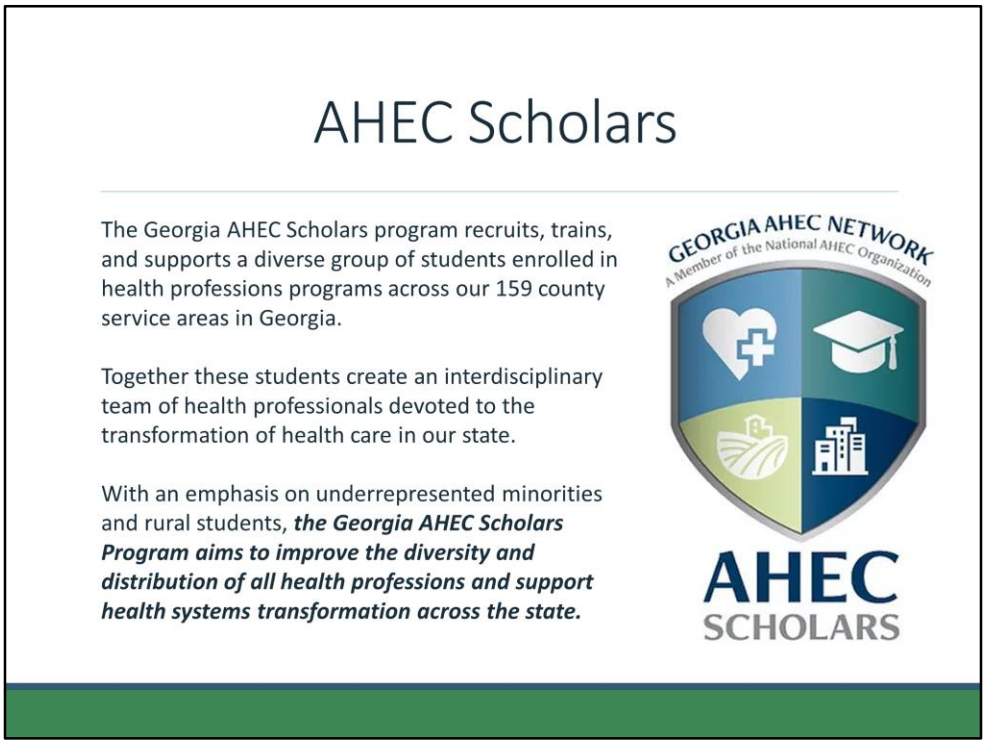



While the majority of rotations are provided for medical and osteopathic students, a significant number of other disciplines are supported as well. We strive to not only identify community-based training sites in underserved and/or rural areas, but also in primary care settings. We need to support non-primary care training rotations as well as primary care rotations as every student in training must complete rotations across the primary care and specialty practice spectrums.




AHEC housing is not just renting an apartment. It is furnishing apartments, maintaining apartment inventories of basic necessities (kitchen ware, furniture, beds, etc.). It is paying all utilities, internet, pest control. It is also paying for monthly housekeeping and in some locations, lawn maintenance. We must ensure that housing beds are managed such that students do not overlap, and we must insure gender division as well. Most AHEC housing units are 2-3 bedroom units sleeping 4-6 students. We do not guarantee private rooms.

Since the pandemic, our housing costs have soared. Existing rental agreements have increased approximately 23% and cleaning costs have more than doubled. We are struggling to sustain our existing housing, while clearly needing to open more units.




The AHEC Scholars Program goal is to train students of different health professional disciplines how to work in a team-based model to deliver care before they graduate from their academic programs. While the work environments have embraced interprofessional team-based care, academic programs are still teaching in silos, such that some students do not work with other professions until they enter the workforce.

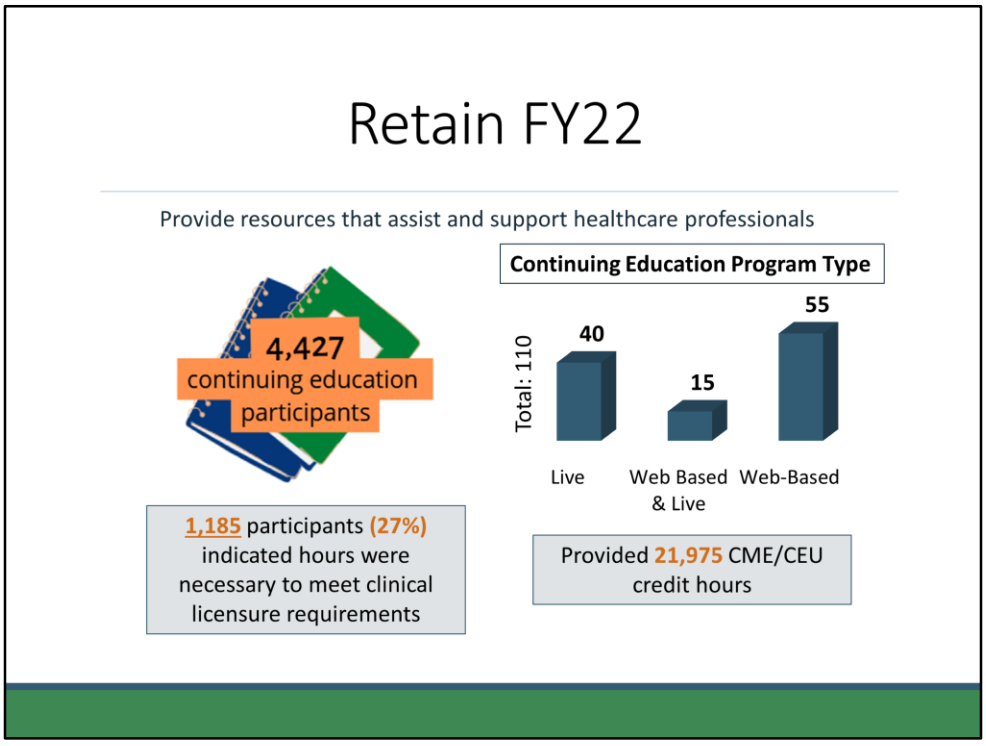
The Georgia AHEC Scholars Program began in 2018. We admit 90 students statewide each year into a two year program, and have approximately 180 Scholars active at any one time. We have eight core topic areas we teach and explore, as well as myriad experiential learning opportunities. Each Center hosts 15 scholars per cohort, meaning that each is working with 30 scholars each year representing the 2 cohorts.

# AHEC Scholars

**Our academic partners:**

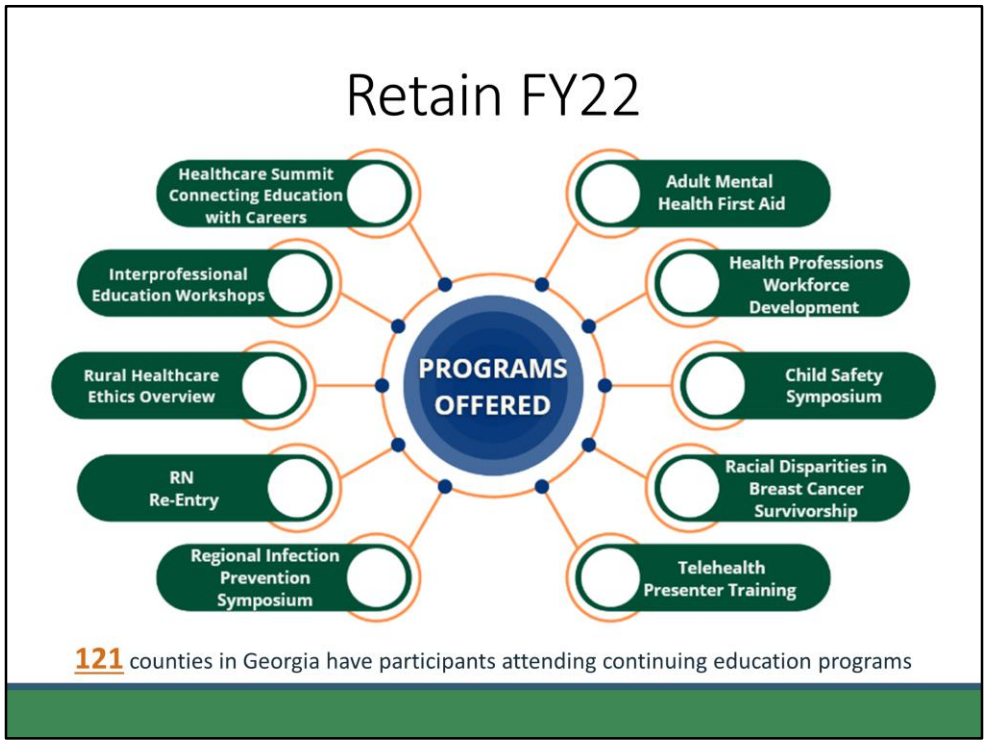
- Augusta University/MCG Southwest
- Clayton State University
- Dalton State University
- GA-PCOM
- Georgia Southern University/Armstrong
- Georgia Southwestern State University
- Gwinnett Technical College
- University of Georgia Albany
- Middle Georgia State University
- Columbus State University
- Shorter College
- Albany State University
- Berry College
- Brenau University

Once again I stress that we are trusted partners and academically neutral in our programming. This is but one example of how this is reflected in our programming. You will see public and private institutions, and institutions reflecting every corner of the state.

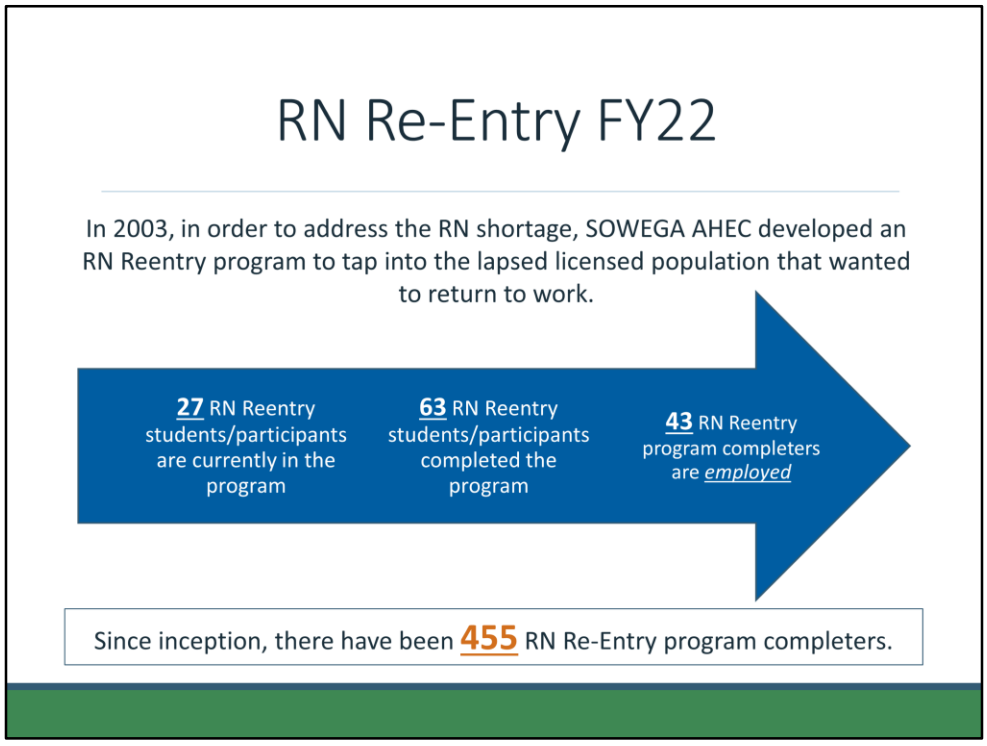



The need to retain health care providers has exploded with the Great Resignation and the aftermath of the intense months of the pandemic. People are tired.

While we will continue to offer Continuing education for providers to allow them opportunities to remain clinical competent and competitive, we are seeing a larger need to begin programming in wellness, healthy workplaces, and sustaining our workforce. The generational differences in expectations are also astounding, and we need to work to educate employers about this new wave of workforce.

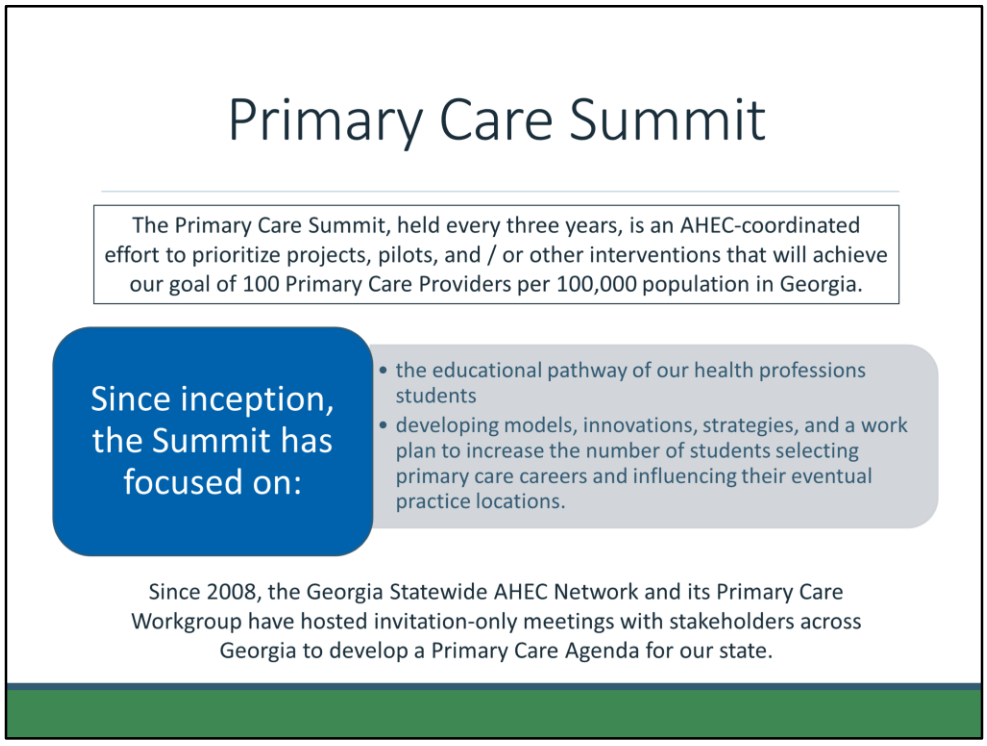



These are some of the topics we offered training in this year for our existing providers. We do not focus on large conferences or events, but rather focus our programming mostly on lunch and learns, webinars, asynchronous events, and providing programming in smaller communities. This is a reflection that employers no longer have the resources to send staff to the city for 2-3 days conference to get their CME/CEUs but that the provider themselves must pay for these required continuing education units and must do it on their own time. Again, AHEC tries to remove or lessen these burdens.




The program began in 2003 and nearly 20 years later approximately 455 nurses have completed the Re-Entry program. Other GA AHEC Centers followed suit with the success of the program. These are nurses from across Georgia who for various reasons let their license lapse and needed to renew their education in order to have that license reinstated. With recent help from the General Assembly, we are moving the entire didactic component to an online format. There is a clinical component that requires us to partner with sites across Georgia where these nurses can refresh their clinical skills using a uniform curriculum. This is a cost effective and convenient way to help return nurses to the workforce.


MHFA is an international program and has been adopted by SAMSA as the training program preferred by the federal government for lay persons. We recently had 12 more MHFA instructors trained, increasing our capacity to offer these programs statewide. Every AHEC Center has trained instructors available to provide certification training for partner programs and providers. We have the capacity to offer this intensive training fully online, hybridly with part online and part in person, or fully in person.



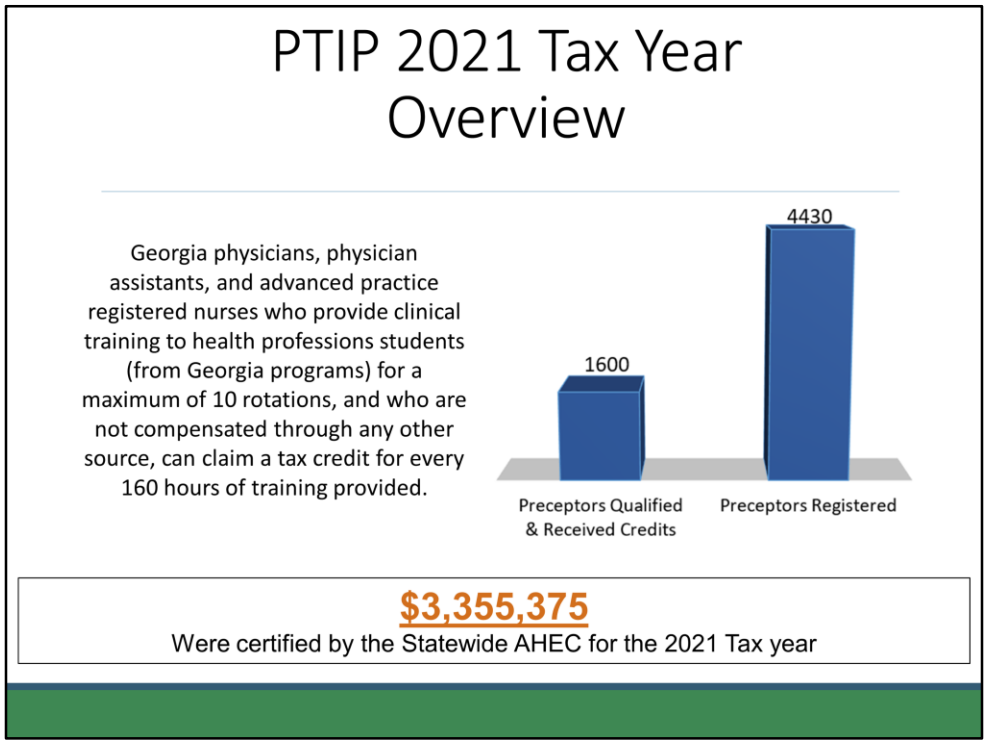

In 2008 the Statewide AHEC Primary Care Workgroup asked the AHEC Program Office to convene stakeholders in resolving our states primary care challenges. The goal was to create a mutually agreed agenda that could be presented to our Legislators and other partners as part of the Primary Care Plan for Georgia.

Currently, there are 183 stakeholders invited to participate; with a format of problem solving and solution identification rather than Keynote Speakers and other expert presenters. We assume the invitees are well versed in these issues and use their time to problem solve rather than to educate them on topics for which they are experts.


Please know we did not accomplish any of the above by ourselves. It was through partnering with others, joining voices with stakeholders, that these changes occurred.

Beginning in 2022, the Statewide AHEC will recommend a component of the health professions pipeline upon which to focus. The first topic selected is RETENTION. The workgroup will assist with defining questions for research surrounding this topic, what research needs to be collected, and how to engage stakeholders in the process. Choosing a focused topic does not mean we will not look at Train and Recruit, but we will primarily focus on Retention for the next few years.

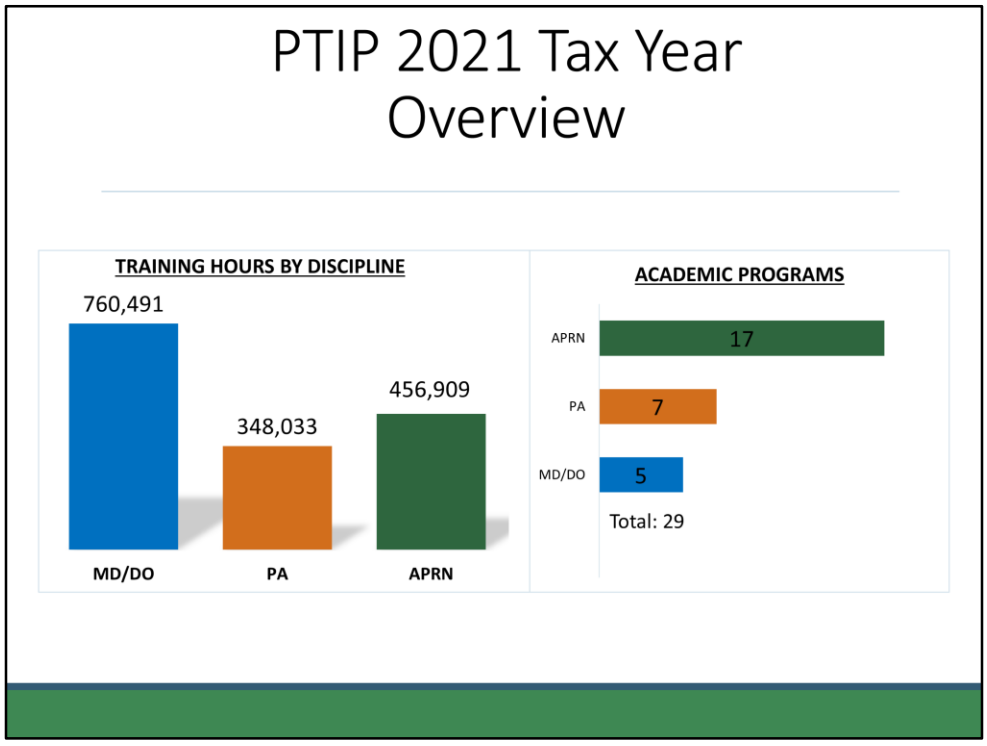
Shelley Nuss, MD Campus Dean of the AU/UGA Medical Partnership and DIO and Associate Dean for GME, Carolyn Clevenger, DNP Associate Dean for Clinical and Community Partnerships at Nell Hodgson Woodruff School of Nursing at Emory University, and Jim Hotz, MD Clinical Services Director at Albany Area Health Care will provide leadership for our AHEC Primary Care Workgroup.




Georgia was the first state in the nation to seek to develop this innovative and highly successful program. In an effort to recognize the contributions of our invaluable community-based faculty AND with a commitment to support Georgia primary care education programs, we created PTIP.

Programs cannot afford to pay preceptors across the board, While the medical schools may find a way to do it, the other professions such as APRNs and PAs could not. Providing tax credits was viewed as a way that they were rewarded by the AHEC and the state of Georgia for their contributions, on behalf of all of the primary care academic programs.

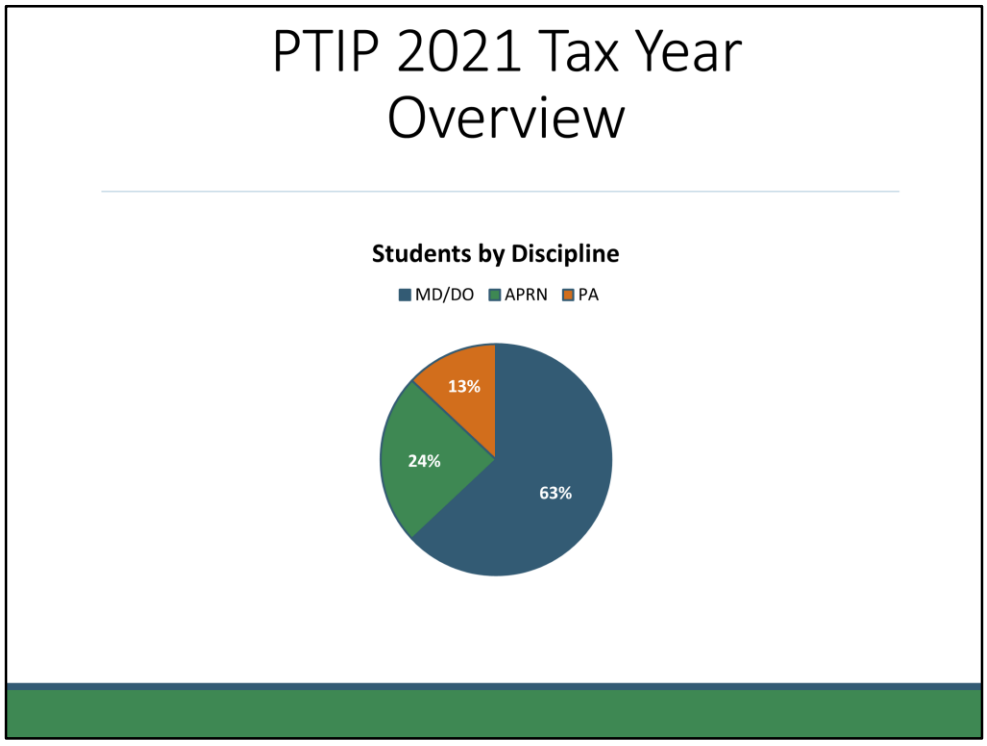
The program is administered through the Statewide AHEC Program Office at AU.




Preceptors must register (one time) through our website portal. They will receive an email three times a year telling them what programs have certified completed student rotations with them, and how many hours were certified by the academic program(s).

Academic programs are required to submit rotation data three times annually. They submit the number of hours of the rotation when the rotation is complete, and certify the preceptor who provided the community based training. This provides checks and balances for audit purposes.

In January, the Statewide AHEC issues a letter to qualified preceptors with the amount of the tax credit they have earned for the previous calendar year.



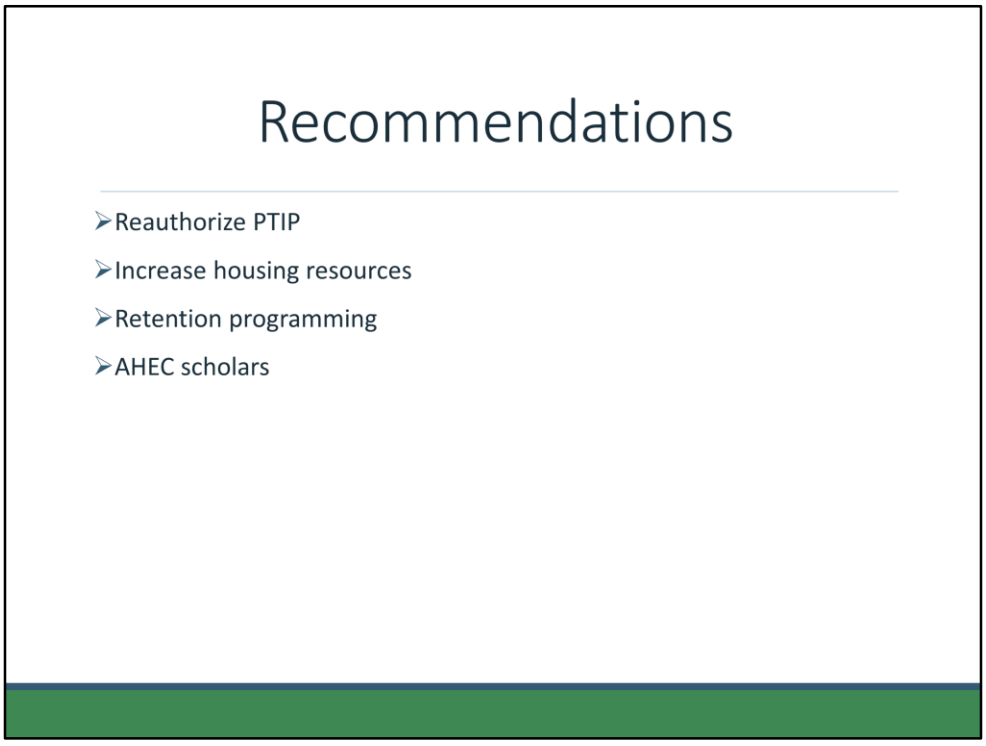

PTIP is limited to students in medicine/osteopathic medicine, advanced nurse practitioners, and physician assistants. The only recipients of the credit are Physicians, APRNs, and PAs.

The bill will sunset in December 2023, so a new bill reauthorizing PTIP, will be introduced in the 2023 General Assembly. We could use your help!

# Statewide AHEC Matrix

| County | # of Participants in Continuing Education Programs | # of Participants in Health Career Programs | # Primary Care Rotations | # Preceptors Provided Training (may precept in multiple counties) | # of Graduates Remaining in Sponsoring AHEC Region | # Medicine Rotations | # Physician Assistant Rotations | # Nursing Rotations | # Nurse Practitioner Rotations | # Other (includes Oral Health) Rotations | Total # of Student / Resident Rotations | Total # of Contacts in County |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Appling | 3 | 0 | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 5 |
| Atkinson | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |
| Bacon | 6 | 118 | 2 | 2 | 1 | 2 | 0 | 0 | 0 | 0 | 2 | 129 |
| Baker | 1 | 0 | 1 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 3 |

Finally, I would share what we call “the Matrix”. All politics are local and this reflects that knowledge. This is a table found at the end of our annual reports that provides AHEC activity and programming by every county in Georgia. This provides further evidence to our claims of being statewide and well distributed.




So what do we recommend?

1. Assist us with reauthorizing PTIP so that we can continue to support our academic programs in Georgia who are providing our primary care workforce. It would be helpful to have the Commissions recommendation for reauthorization on record.

2. Housing is expensive, and as I shared earlier, our costs are escalating on existing housing AND we need to expand our inventory to meet the demands of our academic programs. We are requesting $550,000 increase with $100,000 allocated to our five more rural centers and $50,000 for our SPCC-Atlanta AHEC who does not provide housing but does provide travel assistance for students.

# Contact Information

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# Information from the Georgia Board of Nursing

AMERICAN ASSOCIATION of CRITICAL-CARE NURSES

ANA AMERICAN NURSES ASSOCIATION

AONL American Organization for Nursing Leadership™

hfma healthcare financial management association

Institute for Healthcare Improvement

# Nurse Staffing Think Tank: Priority Topics and Recommendations

## Foreword

The nurse staffing crisis has no simple fix. Research shows that optimized nurse staffing is integral to high-level patient care, better patient/family experiences and nurse well-being. Adequate investment in appropriate nurse staffing is also essential to a health care institution's performance, reputation and financial viability. However, prevailing approaches to deploying nursing resources are not fully realizing the benefits of appropriate staffing. This is an urgent, high-stakes patient safety issue that represents a health care system imperative—not simply a nursing one—that must be tackled in new and bold ways. Nurse staffing is a complex process that is affected by the health of the work environment and changes in the workforce, including nursing shortages, turnover and nurse competencies. Additionally, the economic pressures on the health care system pose challenges to appropriate staffing.

## Preface

In light of these challenges and opportunities, a group of organizations came together in 2018 to form the Partners for Nurse Staffing in a collaborative effort to explore new solutions for nurse staffing issues. This group includes representatives from the following organizations:

- American Association of Critical-Care Nurses (AACN)
- American Nurses Association (ANA)
- American Organization for Nursing Leadership (AONL)
- Healthcare Financial Management Association (HFMA)
- Institute for Healthcare Improvement (IHI)

The Partners for Nurse Staffing is focusing on ideas that maximize the investment in nurse staffing while creating the greatest value for patients, families, interprofessional health care teams, hospitals and payers. The objectives of the coalition are:

- Elevate awareness of the evidence-based link between appropriate nurse staffing and optimal patient care, as well as links to better patient experience, a thriving nurse workforce and optimizing the value of care.
- Identify and promote examples of staffing successes.
- Incubate bold innovations and transformative approaches.

***Preface** (continued)*

The **National Nurse Staffing Task Force** (launching in Spring 2022) and **Think Tank** aim to provide a forum for powerful dialogue that will develop recommendations on a national scale to address critical challenges related to the nurse staffing crisis that have plagued the profession for decades. The **Task Force,** consisting of stakeholders, subject matter experts (internal and external to nursing), and patient and family advocates, will focus on the acute and critical care setting during the initial phase of the work. The **Task Force** will work over a nine-month period to develop innovative strategies that will address longer-term, complex and persistent systemic issues in nurse staffing.

# Executive Summary

On January 11, 2022, the Partners for Nurse Staffing, a collaboration of five professional organizations, launched the Nurse Staffing Think Tank. Charged with identifying recommendations to address the nurse staffing crisis within a 12-18 month implementation timeframe, the group met every other week for a total of six meetings. The first meetings focused on identifying high-priority areas. Subsequent work conducted in small groups identified recommendations within each high-priority area, as well as action items and measurable outcomes. The target audience for this work includes nurses, health care leaders and policymakers. The result of this work provides an action plan for the necessary cultural shift in health care delivery that can drive improved nurse retention, healthier work environments and better patient outcomes. The recommendations described here are actionable for health system and hospital leaders. Actions under the category, "Healthy Work Environment," also pertain to regulatory bodies, policymakers and specialty nursing organizations.

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| **Think Tank Purpose** | The American Association of Critical-Care Nurses (AACN), American Nurses Association (ANA), 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 three months to develop actionable strategies set to implement within 12-18 months 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 Spring 2022 by providing:<br>• Strategic advice on broad ideas and direction based on data that identifies the root causes of the nursing shortage<br>• Input on workforce trends, challenges and issues hindering progress toward feasible and practical staffing solutions<br>• Strategic direction for broader goals<br>• Options for action, including associated outcomes |

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*Executive Summary* *(continued)*

**Think Tank Participants and Representatives from Organizational Partners for Nurse Staffing**

***Think Tank Participants***

- **Janet Ahlstrom,** *University of Kansas Medical Center*
- **Carol Boston-Fleischhauer,** *The Advisory Board*
- **Danielle Bowie,** *Bon Secours Mercy Health*
- **Natalia Cineas,** *NYC Health + Hospitals*
- **Pamela Cipriano,** *University of Virginia, International Council of Nurses*
- **Amber Clayton,** *Society for Human Resource Management*
- **Vanessa Dawkins,** *NewYork-Presbyterian/Weill Cornell Medical Center and NewYork-Presbyterian Westchester Behavioral Health Center*
- **Vicki Good,** *Mercy Health*
- **Melinda Hancock,** *Sentara Healthcare*
- **April Hansen,** *Aya Healthcare Group*
- **Helen Haskell,** *Mothers Against Medical Error*
- **Kiersten Henry**, *MedStar Montgomery Medical Center*
- **Peggy Lee,** *VA of Southern Nevada and Nevada Action Coalition*
- **Ryan Miller,** *ChristianaCare Health System*
- **Sherry Perkins,** *Luminis Health Anne Arundel Medical Center*
- **Larry Punteney,** *Avantas*
- **Rosanne Raso,** *NewYork-Presbyterian Weill Cornell Medical Center*
- **David Tam,** *Beebe Healthcare*
- **Sarah Wells,** *Acute care nurse and Founder, New Thing Nurse*

*Special Contributor for Diversity, Equity and Inclusion, and Inclusive Excellence:* **Rumay Alexander**

***Representatives from Organizational Partners for Nurse Staffing***

- **Connie Barden,** AACN
- **Robyn Begley,** AONL
- **Katie Boston-Leary,** ANA
- **Linda Cassidy,** AACN
- **Wendy Cross,** AACN
- **Sarah Delgado,** AACN
- **Patricia McGaffigan,** IHI
- **Kendra McMillan,** ANA
- **Todd Nelson,** HFMA
- **Cheryl Peterson,** ANA

The Partners for Nurse Staffing wish to thank Regina Black-Lennox, the Satell Institute, for serving as the group facilitator, and Karen Thomas and Melissa Jones for their editorial expertise.

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***Executive Summary*** *(continued)*

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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.<br>• Specialty nursing organizations should investigate evidence related to scope of practice and minimum safe staffing levels for patients in their specialty. |
| | **Diversity, Equity and Inclusion (DEI)** | • Implement Inclusive Excellence, a change-focused iterative planning process whereby there is deliberate integration of DEI 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.<br>• Incorporate well-being of nurses as an organizational value. |
| | **Innovative Care Delivery Models** | • Implement tribrid care delivery models that offer a holistic approach with three components, including onsite care delivery, IT integration of patient monitoring equipment, and ambulatory access and virtual/remote care delivery. This approach will improve access, patient and staff experience, and resource management, with continuous measurement for improvement and adjustment for sustainability and support. |
| | **Total Compensation** | • Develop an organization-wide formalized and customizable total compensation program for nurses that is stratified based on market intelligence, generational needs and an innovative and transparent pay philosophy that is inclusive of benefits such as paid time off for self-care and wellness and wealth planning for all generations. |

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# Healthy Work Environment

***Operational definition:*** A healthy work environment is 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. In these environments, nurses and other team members can provide their optimal contribution and derive fulfillment from their work and patients can achieve the best possible outcomes.

**Recommended action for policymakers and health system leaders:**
Elevate clinician psychological and physical safety to equal importance with patient safety through federal regulation.

| | **Workplace violence: Address physical safety** | **Work environment: Ensure psychological safety** |
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| **Definition** | Nurses' hazards include:<br>• Lifting and moving patients<br>• Handling sharps; chemical, radiation or infectious exposures<br>• Chronic stress from high-stakes work<br>• Workplace violence | • Psychological safety may be defined as the ability to be oneself without fear of negative consequences.<br>• In a psychologically safe environment, teams feel that interpersonal risk-taking is safe.<br>• Incivility, bullying and lateral violence are not tolerated. |
| **Targets** | Clinician physical safety in work environment | • Health care teams<br>• Health care leaders |
| **Scope of impact** | Every U.S. acute, critical access and long-term care hospital | National impact via federal regulation; institutional impact if adopted by leaders |
| **Accountable entities** | • Health care leaders and health systems<br>• Professional nursing organizations to advocate for policy/ regulatory change<br>• Federal and state policymakers and regulators to codify workplace violence tracking and prevention | • Centers for Medicare & Medicaid Services (CMS)<br>• Health systems<br>• Federal government<br>• Professional nursing organizations for advocacy<br>• Health care leaders for institutional implementation |
| **Timeline** | Within 12 months | Within 12-18 months |

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***Healthy Work Environment*** *(continued)*

| | Workplace violence: Address physical safety | Work environment: Ensure psychological safety |
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| **Measurable outcomes** | • Decrease in rates of physical violence against health care professionals in the organization<br>• Implementation of federal legislation and/or CMS regulation that requires health care facilities to track workplace violence and to put in place measures to ensure the physical safety of their employees (regular and contracted)<br>• Decrease in Workers' Compensation claims for violence | • Implement a process for routinely measuring the health of the work environment.<br>• Implement a quality control process for acting on data about the work environment to move toward improvement.<br>• Implement a CMS Condition of Participation that addresses the health of the work environment.<br>• Collect unit-level data on the safety of the work environment routinely on a quarterly basis and use the data to drive needed change.<br>• Collect, stratify and report data on workplace safety and harms (physical and nonphysical) to assess equity in the work environment. |
| **Action steps/ Steps toward implementation** | • Implement processes to track and prevent workplace violence within health systems.<br>• Enact federal legislation and CMS regulations to protect and give employees a bold voice against physical violence in the workplace (with exemptions to be specified for patients with illness-related delirium and other organic processes).<br>• Advocate for implementation of federal legislation to protect health care professionals.<br>• Advocate for implementation of a standard or Condition of Participation by CMS requiring that hospitals protect health care professionals.<br>• Consider using the Quadruple Aim as a framework for equating patient and professional safety. | • Develop and enforce anti-violence principles, policies and processes for employee protection on an organizational level.<br>• Discuss with CMS Deputy Administrator.<br>• Advocate for clinician experience as a criterion in the CMS Hospital Value-Based Purchasing program (mirroring patient experience).<br>• Advocate to create a CMS Condition of Participation that requires organizations to regularly assess/measure the health of the work environment and demonstrate evidence of continual improvement. |
| **Supporting evidence** | • Dyer O. U.S. hospitals tighten security as violence against staff surges during pandemic *BMJ* 2021; 375:n2442<br>• OSHA. 2016 report on healthcare workplace violence.<br>• U.S. Bureau of Labor Statistics. Fact Sheet on Workplace Violence in Healthcare. | • Aiken, L. H., Cimiotti, J. P., Sloane, D. M., Smith, H. L., Flynn, L., & Neff, D. F. (2012). "Effects of nurse staffing and nurse education on patient deaths in hospitals with different nurse work environments," *The Journal of Nursing Administration*, 42(10 Suppl), S10–S16.<br>• American Association of Critical-Care Nurses. Standards for Establishing and Sustaining Healthy Work Environments.<br>• Clark, T. R. (2020). *The 4 stages of psychological safety: Defining the path to inclusion and innovation*. Berrett-Koehler Publishers. |

***Healthy Work Environment*** *(continued)*

**Recommended action for specialty nursing organizations:**
Investigate evidence related to scope of practice and minimum safe staffing levels for patients in their specialty.

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| **Topic** | • Investigation of minimum safe staffing levels for specific patient populations<br>• Development of staffing standards to address the needs of patients in specialty populations |
| **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.<br>• Staffing standards are defined according to patient needs and existing evidence that correlates staffing levels and patient outcomes. The standards include consideration for the range of patient acuity and skill mix available in different organizations. |
| **Targets** | Specialty nursing organizations, direct care nurses and nursing leaders |
| **Scope of impact** | National impact |
| **Accountable entities** | Specialty nursing organizations |
| **Timeline** | • Six months for investigation of minimum staffing levels<br>• Twelve months for development of staffing standards |
| **Measurable outcomes** | • Specialty organizations:<br>— Assess applicability and report that they have undertaken this work within six months<br>— 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.<br>• Organizations play a role in creating standards that delineate staffing requirements for optimal care.<br>• Organizations apply a process that engages key stakeholders, including direct care nurses, in the development of staffing standards.<br>• Consider using the work of other specialty organizations, such as AWHONN, that have created staffing standards as exemplars. |
| **Supporting evidence** | • Aiken, L. H., Cerón, C., Simonetti, M., Lake, E. T., Galiano, A., Garbarini, A., Soto, P., Bravo, D., & Smith, H. L. (2018). Hospital nurse staffing and patient outcomes. *Revista Médica Clínica Las Condes*, *29*(3), 322–327.<br>• Ball, J. E., Bruyneel, L., Aiken, L. H., Sermeus, W., Sloane, D. M., Rafferty, A. M., Lindqvist, R., Tishelman, C., & Griffiths, P. (2018). Post-operative mortality, missed care and nurse staffing in nine countries: A cross-sectional study. *International Journal of Nursing Studies*, *78*, 10–15.<br>• Lasater, K. B., Sloane, D. M., McHugh, M. D., Cimiotti, J. P., Riman, K. A., Martin, B., Alexander, M., & Aiken, L. H. (2021). Evaluation of hospital nurse-to-patient staffing ratios and sepsis bundles on patient outcomes. *American Journal of Infection Control*, *49*(7), 868–873.<br>• McHugh, M. D., Rochman, M. F., Sloane, D. M., Berg, R. A., Mancini, M. E., Nadkarni, V. M., Merchant, R. M., & Aiken, L. H. (2016). Better nurse staffing and nurse work environments associated with increased survival of in-hospital cardiac arrest patients. *Medical Care*, *54*(1), 74–80. |

# Diversity, Equity and Inclusion

***Operational definition:*** 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. This definition of Inclusive Excellence describes a change-focused iterative planning process whereby there is deliberate integration of diversity, equity and inclusion (DEI) 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 shuts down the typical comments of lowering quality in order to achieve diversity (Williams, Berger, McClendon, 2005).

Building a diverse nursing workforce is a critical part of preparing nurses to address social determinants of health (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, which in turn has an impact on retention.


**Recommended action for leaders of health systems and hospitals:** 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. Diverse includes diversity in sexual orientation, gender, race, ethnicity, and physical and psychological ability.

| | Increase diversity in nursing leadership | Build a diverse nursing workforce | Provide psychological safety to attract/retain a diverse workforce | Establish a nursing diversity dashboard |
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| **Definition** | Inclusive Excellence is 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. Four stages include inclusion safety, learner safety, contributor safety and challenger safety. | A nursing diversity dashboard tracks workforce demographics and measures alignment with the community, state and nation. |

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

| | **Increase diversity in nursing leadership** | **Build a diverse nursing workforce** | **Provide psychological safety to attract/retain a diverse workforce** | **Establish a nursing diversity dashboard** |
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| **Targets** | Nurse leaders | Direct care nursing staff | Health care workforce | • Nursing<br>• Nursing leadership<br>• C-suite |
| **Scope of impact** | • Managers<br>• Directors<br>• Administrators<br>• C-suite | • Patients<br>• Nurses<br>• Schools of nursing<br>• Faculty | Health care teams | Health care teams |
| **Accountable entities** | • Nursing leadership<br>• C-suite | • Nursing leadership<br>• C-suite | • Nursing leadership<br>• C-suite | • Nursing leadership<br>• C-suite |
| **Timeline** | 12 months | 12 months | 12 months | 6 months |
| **Measurable outcomes** | • Data dashboard of nursing leaders will show improvement in diversity within one year.<br>• Dashboard should align with the diversity in the population served by the facility. | • Data dashboard of nursing workforce will show improvement in diversity within one year.<br>• Dashboard should align with the diversity in the population served by the facility. | • Data measuring psychological safety will show improvement within one year. | • Data dashboard will be available within six months. |

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

| | Increase diversity in nursing leadership | Build a diverse nursing workforce | Provide psychological safety to attract/retain a diverse workforce | Establish a nursing diversity dashboard |
|---|---|---|---|---|
| **Action steps/ Steps toward implementation** | • Review the leadership team. Direct all current and upcoming vacancies to be diverse hires (in accordance with labor laws and human resources (HR) guidelines). Note that "diverse hires" should be defined beyond race/ethnicity.<br>• Monitor the speed and trends at which underrepresented groups are hired and move up the corporate ladder.<br>• Review turnover data for staff who are Black, Indigenous and People of Color (BIPOC) and other underrepresented groups.<br>• Define diversity broadly. Specific groups mentioned in the Think Tank, in addition to BIPOC, include gender (which, like race, is specifically not diverse in nursing) LGBTQ, differently abled professionals and those with substance use disorders. | • Nursing schools recruit and support diverse students that reflect the populations they will serve. Include the following in defining diversity: Gender, LGBTQ, BIPOC, ethnicity, ableism, psychiatric/mental health/substance use.<br>• Embrace LPNs and ADNs as a strategy to diversify workforce. They must be treated and respected similar to RNs. Support and respect their desire to pursue advanced degrees.<br>• Institute diversity awards and publicize demographics of awardees for awards granted with award program. | • In orientation sessions, include commitment to diversity and zero tolerance for assaults on another's self-esteem.<br>• 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), and RN satisfaction.<br>• Be transparent with data. Develop meaningful DEI dashboards for staff and community audiences. Webpage visibility of workforce demographics and activities should be 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 that incorporates time for professional development and leadership engagement such as shared governance

**Recommended action for leaders of health systems and hospitals:**
Build a flexible workforce and flexible work environment with flexible scheduling, flexible shifts of variable start times and duration, and flexible roles.

| | Site float pool | Multihospital 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 | Multisite enterprise float pool where appropriate in a defined geographical region for daily or long-term placement | Expansion and contraction of clinical and nonclinical workforce as needed to accommodate predictable seasonal fluctuations (i.e., seasonal trends, geography, demographics of patient population served)<br>• Retired workforce picking up assignments based on demand<br>• Per diem/part-time workforce picking up full-time assignments to bump up FTE<br>• 0.6 FTE who work 0.3 during the summer and 0.9 FTE | • Interdisciplinary team for shift-based tasks, e.g., resource nurse, ancillary staff, admissions, discharge, medication pass nurse, break nurses, weekend coverage. etc.<br>• Staff in this category follow nontraditional hours and shifts to support peak volume and tasks and can be hired into float or nonfloat departments.<br>• Consideration is also given to use of support provided through virtual roles and resources. |
| **Targets** | • Group of clinicians who float by specialty within their scope of practice and competency and licensure<br>• For the future, consider a float pool comprising nonclinical staff for surges. This was leveraged successfully during the COVID-19 pandemic. | • 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.<br>*Nonfloat:* 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.<br>*Nonfloat:* Group of clinicians assigned to a dedicated unit to practice within their scope of practice and competency and licensure. Also includes ancillary staff. |

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***Work Schedule Flexibility*** *(continued)*

| | Site float pool | Multihospital system float pool | Seasonal and surge PRN to full-time float pool | Interdisciplinary care team |
|---|---|---|---|---|
| **Scope of impact** | • Patient care quality and safety<br>• Staff satisfaction<br>• Cost<br>• Management | • Patient care quality and safety<br>• Staff satisfaction<br>• Cost<br>• Management | • Patient care quality and safety<br>• Staff satisfaction<br>• Cost<br>• Management | • Patient care quality and safety<br>• Staff satisfaction<br>• Cost<br>• Management |
| **Accountable entities** | • Nursing<br>• Finance<br>• HR<br>• Hospital leadership | • State boards of nursing to support compact licensure and multistate practice, scope of practice<br>• Nursing<br>• Finance<br>• HR<br>• Hospital leadership | • State boards of nursing to support compact licensure and multistate practice, scope of practice<br>• Nursing<br>• Finance<br>• HR<br>• Hospital leadership | • State boards of nursing to support compact licensure and multistate practice, scope of practice<br>• Nursing<br>• Finance<br>• HR<br>• Hospital leadership |
| **Timeline** | Three to six months for change management, hiring, training and deployment | Six to 12 months for change management, hiring, training and deployment | Three to six months for change management, hiring, training and deployment | Six to 12 months for change management, hiring, training and deployment |
| **Measurable outcomes** | • Frontline employee engagement<br>• Patient experience<br>• Reduction in agency overtime<br>• Reduction in vacancy and turnover rates | | | |

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***Work Schedule Flexibility*** *(continued)*

| | Site float pool | Multihospital system float pool | Seasonal and surge PRN to full-time float pool | Interdisciplinary care team |
|---|---|---|---|---|
| **Action steps/ Steps toward implementation** | • Do a cost analysis to build the program. (Review unit-level spending to scope specialty to include premium and agency spend.)<br>• Understand workflow trends and data to build flexible schedules that will allow for continuity of patient care.<br>• Build a job description.<br>• Review pay structure/total compensation and benefits.<br>• Set up organizational structure for management.<br>• Develop education structure (orientation, competency).<br>• Upskill and cross train the workforce.<br>• Provide education and change management for the organization about the new team. Include organizational definition of flexible workforce and definition of internal contingency and float pool rules.<br>• Define ways to deploy for operational use.<br>• Include an assessment of outcomes to address concerns about impact on patient care/ potential fragmentation. | • Do a cost analysis to build the program. (Review unit-level spending to scope specialty to include premium and agency spend.)<br>• Understand workflow trends and data to build flexible schedules that will allow for continuity of patient care.<br>• Build a job description.<br>• Review pay structure/total compensation and benefits.<br>• Set up organizational structure for management.<br>• Develop education structure (orientation, competency).<br>• Upskill and cross train the workforce.<br>• Provide education and change management for the organization about the new team. Include organizational definition of flexible workforce and definition of internal contingency and float pool rules.<br>• Define ways to deploy for operational use. | • Do a cost analysis to build the program. (Review unit-level spending to scope specialty to include premium and agency spend.)<br>• Understand workflow trends and data to build flexible schedules that will allow for continuity of patient care.<br>• Do a seasonal trend and volume analysis to build the team.<br>• Build a job description<br>• Review pay structure/total compensation and benefits.<br>• Set up organizational structure for management.<br>• Develop education structure (orientation, competency).<br>• Upskill and cross train the workforce.<br>• Provide education and change management for the organization about the new team. Include organizational definition of flexible workforce and definition of internal contingency and float pool rules.<br>• Define ways to deploy for operational use.<br>• Offer flexibility in scheduling for nonfloat, i.e., hiring regular staff who agree to work more hours during seasonal/ predictable surge periods. | • Do a quantitative and qualitative data analysis of shift-based needs to build unique roles such as break nurses, resource, preceptor pool, etc.<br>• Do a cost analysis to build the program. (Review unit-level spending to scope specialty to include premium and agency spend.)<br>• Understand workflow trends and data to build flexible schedules that will allow for continuity of patient care.<br>• Do a seasonal trend and volume analysis to build the team.<br>• Build a job description.<br>• Review pay structure/total compensation and benefits.<br>• Set up organizational structure for management.<br>• Develop education structure (orientation, competency).<br>• Upskill and cross train the workforce.<br>• Provide education and change management for the organization about the new team. Include organizational definition of flexible workforce and definition of internal contingency and float pool rules.<br>• Define ways to deploy for operational use.<br>• Offer flexibility in scheduling for nonfloat. |

# Stress Injury Continuum

***Operational definition:*** Stress injury continuum is inclusive of burnout syndrome, compassion fatigue, moral distress, anxiety, depression, post-traumatic stress disorder (PTSD) and other phenomena and refers to the range of negative consequences from stress exposure.

**Recommended action for leaders of health systems and hospitals:**
Address burnout, moral distress and compassion fatigue as barriers to nurse retention.

| | Routine assessment of stress injury | Resources to provide (including peer support and mental health services) | Dedicated team to collect and analyze data | Data to inform the development of further resources |
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| **Definition** | Routine use of a standardized tool to measure stress injury | Resources to support the breadth of impacts stress injury can have (which vary among individuals). | Organizational leader or team or outside group (such as Employee Assistance Program, or EAP) is accountable for assessing aggregate data from the assessment tool. | A team that includes leaders and frontline staff uses data to inform further resource development. |
| **Targets** | The whole of the nursing workforce | | • EAP personnel<br>• Chief wellness officer, or<br>• Wellness team | |
| **Scope of impact** | • Frontline nurses and frontline leaders<br>• Impact includes bringing attention to individual and group well-being and raising awareness of resources | | • Leaders<br>• Wellness team<br>• EAP personnel<br>Note that demonstrating the impact of data on action may enhance trust between clinicians and leaders. | |
| **Accountable entities** | • Frontline staff (doing uptake)<br>• Leadership (providing time and emphasizing importance of use) | | Depending on organizational structure:<br>• Wellness team<br>• Wellness officer<br>• HR personnel, or<br>• EAP personnel | |
| **Timeline** | 3 months | 3 months | 3-6 months | 12 months |

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***Stress Injury Continuum*** *(continued)*

| | Routine assessment of stress injury | Resources to provide (including peer support and mental health services) | Dedicated team to collect and analyze data | Data to inform the development of further resources |
|---|---|---|---|---|
| **Measurable outcomes** | ***Metrics that demonstrate the impact of recommendation implementation***<br>• Changes in absenteeism among nurses and nurse leaders.<br>• Changes in nurse retention and nurse turnover (that is attributable to stress injury).<br>• Response to changes in data on stress injury severity: Is action taken when the numbers rise?<br>***Metrics that evaluate the process of implementing the recommendation***<br>• Correlate the rate of screening to the use of services to assess whether they align.<br>• Track the use of screening tool (similar to hand hygiene tools).<br>• Extrapolate from existing measures that institutions use to measure, e.g., engagement and satisfaction surveys, to assess whether recommendation impacts these. | | | |
| **Action steps/ Steps toward implementation** | • Identify (or develop or adapt) screening tool. Consider a downloadable, very short, electronic tool (like this sample tool).<br>• Ensure anonymity in collecting aggregate data.<br>• Establish a structure for escalation, i.e., where to send people who screen as urgent.<br>• Address Americans with Disabilities Act (ADA) considerations.<br>• Partner with HR on programs that address stress injury. | • Catalog existing resources and identify gaps.<br>• Include clinical services, such as ethics, palliative care and pastoral care, that may offer support for well-being or may be expanded to do so.<br>• Provide a continuum of support that includes peer support and access to mental health care.<br>• Identify common sources of distress and target root causes.<br>• Don't put the burden on the individual; it's everyone contributing to the culture that supports well-being. | • Codify use of the screening tool as part of practice so that aggregate data can be collected.<br>• 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.<br>• Arrange for frontline staff using paid time to attend meetings and contribute to this work. |
| **Supporting evidence** | American Association of Critical-Care Nurses. (2020). *Recognize and address moral distress*.<br>American Nurses Association. (2018). *A call to action: Exploring moral resilience toward a culture of ethical practice*.<br>National Academy of Medicine. (2022). *Resource compendium for health care worker well-being*.<br>Ofei, A.M.A., Paarima, Y., Barnes, T., & Kwashie, A.A. (2020). *Stress and coping strategies among nurse managers*. *Journal of Nursing Education and Practice,* 10(2), 39-48. | | | |

***Stress Injury Continuum*** *(continued)*

**Recommended action for leaders of health systems and hospitals:** Organizations should incorporate the well-being of nurses as an institutional value. This recommendation aligns with the work of the National Academy of Medicine Action Collaborative on Clinician Well-Being and Resilience.

| | **Recognition of the continuum of stress injury** | **Actions that promote well-being are imperative** | **Individuals and organizations share responsibility for team member well-being** |
|---|---|---|---|
| **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 and help processing experiences in the health care workforce. | Institutions have an obligation to provide support and individuals have a corollary responsibility to accept it. |
| **Targets** | • Direct care staff<br>• Hospital leaders | • Direct care staff<br>• Hospital leaders | • Direct care staff<br>• Hospital leaders |
| **Scope of impact** | • All employees (greater impact on those without awareness of stress injury) | • All employees | • Increase in trust between organization and its employees |
| **Accountable entities** | • Professional organizations<br>• Health care leaders | • Professional organizations<br>• Health care leaders | • Health care leaders<br>• Direct care staff |
| **Timeline** | 3 months | 3-6 months | 6-12 months |
| **Measurable outcomes** | Include risk of stress injury in orientation, evaluation, huddles/meetings and other standard procedures and interactions. | Track use of resources with aim of increasing use. | • Binary adoption of well-being as a value (yes/no)<br>• Collection of data on number of hospitals taking this approach by professional organizations /National Academy of Medicine |

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***Stress Injury Continuum*** *(continued)*

| | **Recognition of the continuum of stress injury** | **Actions that promote well-being are imperative** | **Individuals and organizations share responsibility for team member well-being** |
|---|---|---|---|
| **Action steps/ Steps toward implementation** | • Build conversations about well-being into employee evaluations, staff meetings, unit/ shift huddles and other communications: "What are you doing to stay well and how can I support that?"<br>• Raise awareness of resources and risk for suicidality among nurses. | • Provide time off for mental health, commensurate with established policies for physical health.<br>• Create safe spaces for mental health conversations within the clinical space/ work time.<br>• Standardize breaks during a shift; *end* a culture that values working without a break.<br>• Identify strategies that include travel nurses' well-being.<br>• Consider a system that rates hospitals for the well-being of their employees (the way hospitals are rated for safety and patient experience) as this might motivate greater attention to the work environment. | • Professional organizations invest in creating and/or disseminating "wellness as a value" toolkits.<br>• Offer modified duty/alternate work site to accommodate changes in mental health status/stress status.<br>• Support flexible staffing options to mitigate/prevent stress injury, e.g., a different schedule or an opportunity to engage differently (serving as an educator, a leader, cross training to another clinical space). |
| **Supporting evidence** | Havaei, F., Ji, X.R., MacPhee, M., & Straight, H. (2021). Identifying the most important workplace factors in predicting nurse mental health using machine learning techniques. *BMC Nursing,* 20 (1), 1-10.<br><br>Pearman, A., Hughes, M.L., Smith, E.L., & Neupert, S.D. (2020) Mental Health Challenges of United States Healthcare Professionals during COVID-19. *Frontiers in Psychology*, 11:2065. | Melnyk, B.M., Tan, A., Hsieh, A.P., Gawlik, K., Arslanian-Engoren, C., Braun, L.T., Dunbar, S., Dunbar-Jacob, J., Lewis, L.M., Millan, A., Orsolini, L., Robbins, L.B., Russell, C.L., Tucker, S., & Wilbur, J. (2021). Critical Care Nurses' Physical and Mental Health, Worksite Wellness Support, and Medical Errors. *American Journal of Critical Care*, 30 (3): 176–184.<br><br>Wei, H., Roberts, P., Strickler, J., & Corbett, R.W. (2019). Nurse leaders' strategies to foster nurse resilience. *Journal of Nursing Management,* 27(4), 681-687. | American Nurses Foundation, Well-being Initiative.<br><br>All In: WellBeing First for Healthcare. (2022). Healthcare Workforce Rescue Package. |

# Innovative Care Delivery Models

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

## Challenges to Health Care System and Delivery

**Improving access to behavioral health and improving effectiveness of interventions** for individuals with behavioral and mental health conditions, including care integration, nurses in accountable care organizations and emerging delivery systems, and providing suicide, gun violence protection and substance abuse treatment.

**Improving access to primary care and improving effectiveness of primary care delivery systems.** Overcoming access barriers involving scope of practice, payment, shortages and distribution of primary care providers, and improving the effectiveness of nonspecialized health care, especially wellness/primary prevention activities and delivery systems.

**Improving maternal health.** Care related to sexual and reproductive health, especially prenatal care of women through the first year after pregnancy and addressing pregnancy-related deaths. This challenge especially concerns care in the context of the social determinants of health and racial/ethnic health disparities.

**Improving care of the nation's aging population, including frail older adults** whose numbers are growing rapidly. Of particular concern are those living in rural and other underserved areas.

**Helping to control health care expenditures, costs and increasing the value of nurses** require greater involvement by nurses. Opportunities exist to increase nurses' value, particularly as payment shifts to value-based payment models.

## Inputs Affecting Health Care System and Delivery

**Informatics/Health IT.** The design, development, adoption and application of IT-based innovations in health care services delivery, management, and planning, including telehealth.

**Workforce.** The people working within the health care sector who deliver or assist in the delivery of health services, particularly RNs and APRNs. This concerns the supplies of various provider types, maldistribution issues, diversity and training adequacy.

**Delivery system.** The structures and processes that comprise health care delivery in the U.S. This includes the involvement of all health care organizations, professional groups, and private and public purchasers.

**Payment.** The structure and processes of reimbursement from public and private payers to health care delivery systems or providers and how dynamics of this system affects incentives for health care quality and access.

**Social determinants of health.** Conditions in the places where people live, learn, work and play affect a wide range of health risks and outcomes, including stable housing, education, income level, neighborhood safety, absence of social isolation and health equity.

## Key Questions

1. What are the current challenges facing health care delivery related to each challenge in terms of each health care input?
2. How can the challenges facing health care be addressed by improving aspects of each health care input?
3. What evidence is needed to help stakeholders facing each challenge, focusing on research in the area of each health care input?
4. How might RNs and APRNs provide valuable contributions to improve each challenge?

Source: 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.

## *Innovative Care Delivery Models* *(continued)*

**Recommended action for leaders of health systems and hospitals:** A tribrid care delivery model offers a more holistic approach that has three components, including onsite care delivery, IT integration of patient monitoring equipment, and ambulatory access and virtual/remote care delivery. This approach will improve access, 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 tribrid 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 |
| **Targets** | Nursing leadership collaborating with other key health care professionals and nurses who provide direct patient care to lead and own execution | | | |
| **Scope of impact** | • Patients<br>• Families<br>• Nurses<br>• Other health care professionals | • Patients<br>• Families<br>• Nurses<br>• Other health care professionals | • Patients<br>• Families<br>• Nurses<br>• Other health care professionals | • Patients<br>• Families<br>• Nurses<br>• Other health care professionals |
| **Accountable entities** | • Nursing and health system leadership with key focus of total cost of care and other key metrics for value-based purchasing and accountable care<br>• Requires support from C-suite and board of directors | | | |
| **Timeline** | 6-9 months | 3- 6 months | 3-6 months | 12 months |

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***Innovative Care Delivery Models*** *(continued)*

| | 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 tribrid care models | Test and implement |
|---|---|---|---|---|
| **Measurable outcomes** | • Transparent and comprehensive assessment report of the current state of care delivery models<br>• Pre-pandemic and pandemic data on skill mix, nursing hours per patient day, nurse vacancies, nurse turnover, number of days to fill positions (particularly in specialty areas such as ED and ICU), core measures and other patient outcomes<br>• Nurse-sensitive indicators, e.g., pressure injuries, falls and hospital-acquired infections | • Measure and publish data on the impact of changes to care delivery model.<br>— Track measures and nurse-sensitive quality indicators that are measurable on a frequent basis, including falls, core measures, restraint use, hospital-acquired infections, nurse satisfaction, surveys of patient safety and workforce safety culture, nurse engagement and likelihood to leave vs. remain in practice.<br>— Include patient experience as a measurable outcome, i.e., how innovation impacts patient experience. | | |

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***Innovative Care Delivery Models*** *(continued)*

| | 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 tribrid care models | Test and implement |
|---|---|---|---|---|
| **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.<br>• Ensure meaningful engagement of nurses at all levels, other care team members and patient/ family representatives in the assessment process.<br>• Review baseline data with patient outcomes (morbidity, mortality, National Database of Nursing Quality Indicators, patient satisfaction and engagement), surveys of safety culture, nurse satisfaction/ engagement and efficiency, workforce safety and well-being.<br>• Review models of care, i.e., primary, functional, team, etc.<br>• Obtain feedback from patient advisers on existing model and patient- and family-centered considerations with new models. | • Recruit talent and human resources needed to execute the plan, e.g., scribes for admission assessment documentation; LPNs for administering medications, as appropriate; documentation during assessments.<br>• Obtain, recruit and onboard resources (equipment, materials, etc.) to reduce nurses' workload and improve responsiveness to patients' needs, including nurse transcription services, device integration with regularly used equipment, virtual health, early warning system, surveillance systems and artificial intelligence.<br>• Review and improve EHR documentation systems on a regular basis to support new care models and reduce documentation burden on nurses.<br>• 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 (i.e., RNs, scribes, LPNs, MAs, EMTs, paramedics, APRNs, PCTs) to incorporate as members of the care delivery team and support and augment care. Include clinicians and nonclinicians.<br>• Codesign model with active engagement of patient/family advisers.<br>• 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.<br>• Review scopes of practice from licensing boards and revise competencies as needed to adjust to the new plan. Craft new job descriptions as needed.<br>• Determine how the revised model compares to existing models, including anticipated cost considerations.<br>• Formalize, define, communicate and educate all stakeholders and set a launch date/month/year. | • Use go-live infrastructure similar to EHR implementation go-lives (i.e., mini-command center, check-ins, response for problem solving).<br>• Conduct rapid cycle testing of new models, beginning with small tests of change and using PDSA. Build in critical success factors for continuous assessment and measurement. Post and publish the new plan and use it for orientation and onboarding for core, float and temporary nurses and nursing support staff.<br>• Engage master's and doctoral nursing students and interprofessional teams on staff and through clinical affiliations to conduct studies and publish research on clinical decision-making. Offer grants to students to conduct research on clinical decision-making effectiveness for internal use and publication.<br>• Revisit list of improvements and pain points removed or mitigated.<br>• Celebrate milestones and wins! |

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***Innovative Care Delivery Models*** *(continued)*

| | 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 tribrid care models | Test and implement |
|---|---|---|---|---|
| *Action steps/ Steps toward implementation (continued)* | • Assess competencies and capabilities of the existing team in preparation for change.<br>• Use appreciative inquiry, that is, list what resources are working well (i.e., human, supplies, equipment, technology), in addition to barriers and challenges.<br>• Design future state, i.e., determine what could be added/modified/stopped to improve care delivery.<br>• Research and select model(s) of care suitable for implementation. Understand cost implications and unintended consequences.<br>• Engage support from patient and family advisers.<br>• Obtain buy in and support from human resources, finance and other members of the C-suite.<br>• Review and improve EHR documentation systems on a regular basis to reduce documentation burden on nurses. | • Ensure role clarity, particularly for APRNs (CNS and NP) who can contribute differently than other providers and direct care nurses. Align their roles with scope of practice and support distinction.<br>• Note that regulatory agencies' uptake/openness to consider alternative ways to deliver care is a critical success factor. (Use of remote care escalated during COVID-19.) | • Determine metrics that will be used to evaluate models and establish plans for regular review for effectiveness and evolution.<br>• Identify and list improvement opportunities expected with the new model. Consider combining and hybridizing models. Conduct failure modes and effects analysis to assist with selection process.<br>• Support development of necessary skills for nurses in delegation, conflict resolution, leading teams, etc.<br>• Hire APRNs to lead care delivery teams in the acute care setting. | *See p. 21.* |

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***Innovative Care Delivery Models*** *(continued)*

| | **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 tribrid care models** | **Test and implement** |
|---|---|---|---|---|
| **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 definition:*** All forms of payment received by an employee from an employer in the form of salary, wages and benefits

**Recommended action:** Develop an organization-wide formalized and customizable total compensation program for nurses that is stratified based on market intelligence, generational needs and an innovative and transparent pay philosophy that is inclusive of benefits such as paid time off for self-care and wellness and wealth planning for all generations.

| | **Comprehensive/flexible compensation philosophy** | **Narrative that appropriate nurse staffing is fundamental for optimizing available revenue** | **Compensation-added value "intangibles" for nurses** |
|---|---|---|---|
| **Definition** | A shift in approach to compensation that addresses a variety of needs and interests | How investing in appropriate staffing has a return to the organization and is not simply an expense/cost | New approaches specific to direct care nurses |
| **Targets** | • Health care workforce<br>• Nurses and APRNs, both hourly and exempt, at all levels of commitment status | • Nurses<br>• Nursing leadership<br>• Revenue cycle<br>• Finance<br>• Administration | • Nurses<br>• Nursing leadership |
| **Scope of impact** | • Health care workforce<br>• Nurses<br>• APRNs | • Nurses<br>• Nurse managers<br>• Nursing educators | • Nurses |
| **Accountable entities** | • Human resources (HR)<br>• Health system leaders<br>• Nursing leadership<br>• Chief financial officers | • Professional nursing organizations<br>• Nursing researchers<br>• HR and nursing leadership<br>• Chief financial officers | • HR<br>• Health system leaders<br>• Nursing leadership<br>• Chief financial officers |
| **Timeline** | 12 months | 6-9 months | 6 months |
| **Measurable outcomes** | Within 12 months, the organization's flexible approach to total compensation is available, provided to, and shared with all nurses and other employees. | Within 9 months, the financial value of appropriate staffing is articulated. Data results from compensation survey are shared. | |

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***Total Compensation*** *(continued)*

| | Comprehensive/flexible compensation philosophy | Narrative that appropriate nurse staffing is fundamental for optimizing available revenue | Compensation-added value "intangibles" for nurses |
|---|---|---|---|
| **Action steps/ Steps toward implementation** | • Conduct routine market analysis to inform compensation. Include inflation, external agency compensation and market changes.<br>• Consider and execute independent contractual models with nurses in addition to traditional models of employee agreements.<br>• Stratify compensation plan by generational needs.<br>• Consider gain-sharing models, lifting caps on tuition reimbursement and loan forgiveness.<br>• Prevent salary compression issues (i.e., low merit increases not keeping up with new hire salaries) with regular reviews and action.<br>• Gather input on compensation plan from frontline staff; include generational diversity.<br>• Embrace and accept nurse mobility and migration.<br>• Maintain an agile/adaptable process with rapid cycles of change, when needed.<br>• Be transparent regarding philosophy and plans for compensation.<br>• Include exempt employees.<br>• Implement creative compensation for hard-to-fill shifts and days (e.g., holidays and other days off that are in high demand). | • 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.<br>• Engage state and county legislative officials for support and advocacy. Maintain this as a high-priority agenda item for nurses.<br>• Conduct compensation surveys with nurses on a recurring basis and share results.<br>• Educate, empower and support nurses to advocate for policy changes.<br>• 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, nursing hours per patient day, midnight census, and skill mix.<br>• Factor in costs due to lost charges, reduced coding, common dropped procedures and supplies, and the cost of lawsuits due to poor documentation.<br>• Add leading practices and case studies of compensation program exemplars. Share innovative, effective practices. | • Create a system for rewarding nurses who maintain direct care role.<br>• Work to change the mindset that nurses who seek additional compensation should 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.<br>• Make it attractive for nurses in nonclinical skilled departments to provide direct care with appropriate compensation.<br>• 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 are not impacted.<br>• Reinstate, maintain and implement meaningful pay policies to support nurses for precepting, mentoring and clinical advancement.<br>• Review policies for total hours considered and counted for total nursing experience in all care settings.<br>• Avoid punitive policies for nurses who have breaks in their employment experience.<br>• Understand and address issues with bonus payments versus hourly increases for prospective hires and incumbents. |

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***Total Compensation*** *(continued)*

| | Comprehensive/flexible compensation philosophy | Narrative that appropriate nurse staffing is fundamental for optimizing available revenue | Compensation-added value "intangibles" for nurses |
|---|---|---|---|
| *Action steps/ Steps toward implementation (continued)* | *See p. 25.* | *See p. 25.* | • Be open and flexible with salary negotiation with new hires and provide seamless access and partnership between nursing leadership and HR for staff nurses who have salary concerns. Address any feelings of guilt.<br>• Reward floating and additional competencies.<br>• Partner with local businesses to improve well-being with discounted memberships, daycare, dry cleaning pickups and delivery, and healthy food available 24/7.<br>• Invite community leaders to engage with nurses to build lasting relationships.<br>• Provide opportunities for nurses to "shadow" non-nursing skills. Nurses often have other skillsets that can benefit the organization. Compensate them appropriately. Showcase success stories.<br>• Regularly review equity in compensation differences based on gender, race, sexual orientation, disability and all other protected classes<br>• Add paid time off category for self-care and mental health.<br>• Provide accessible wealth planning services.<br>• 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, 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. |