Redefining the Model of Care: The 8 Processes to Increase Efficiency and Standardization in Patient Care Services for Market Competitiveness

Session ID 377
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Objectives

By attending this presentation, the learner will ……

1. **Learn**
   innovative ways to redesign the model of care to increase financial and operational viability while maintaining patient safety and satisfaction through 8 processes.

2. **Identify**
   ways to incorporate frontline staff into operational improvements, increasing frontline staff engagement.

3. **Understand**
   how to sustain model of care changes through the advancement of nurse manager and clinical unit leader.
Background

Now more than ever, health providers are under incredible pressure to decrease the cost to care for patients to maintain viability and longevity while improving quality and patient satisfaction.

Payment Complexity
Increase in federal and state funding versus tightened reimbursement rates

Patient satisfaction and readmission rate factored in reimbursement

Shift to Pay-For-Performance and Value-Based Care

Increasing Costs
Surging cost of drugs, medical equipment, services and labor

Increased IT expenditure

More employed physicians

High turnover rates versus physician and nurse shortage

Competition and Consolidation
Independent competitors with lower costs due to smaller size and simpler infrastructure

Higher market concentration due to horizontal and vertical consolidations

Increased Demand
Aging population

Expanded health insurance coverage

Recovery from economic recession

In order to meet the demands of the ever changing healthcare environment, a large multistate integrated health system focused efforts to standardize care in patient care services.
Core Team Joint Efforts across Organization

A core team including frontline staff and clinical leaders from across the organization was formed and chartered to identify ways to standardize care and reduce cost while sustaining a remarkable patient experience.

Core Team

Team Leader:
President of a Major Hospital

11 Team Members
from Different Hospitals:
1 Pulmonary RN
1 Critical Care Unit (CCU)
Clinical Unit Leader (CUL)
1 CCU RN
2 House Supervisors
1 Labor & Delivery Nurse Manager (NM)
1 Med/Surg CUL
2 Med/Surg RNs
2 RNs, Central Staffing/Scheduling Office (CSSO) in Charlotte and Winston–Salem

Project Charter

Design Duration:
16 Weeks

Focus:
- Design nursing to provide every patient with a remarkable experience
- Drive productivity improvements by aligning inpatient unit performance to industry benchmarks, examining both direct and indirect worked hours
- Design solutions that do not favor a specific market or facility but rather for the future success of the health system as a whole

Care Standardization  Cost Reduction  Patient Experience
Novant Health Overview

Novant Health is an integrated network of physician clinics, outpatient centers and hospitals that consists of more than 1,100 physicians with annual revenue over $4.1B. It is headquartered in Winston–Salem, N.C. and cares for patients throughout North Carolina, Virginia, South Carolina, and Georgia.

<table>
<thead>
<tr>
<th>Novant Health Company Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical centers</td>
</tr>
<tr>
<td>Partnership hospital</td>
</tr>
<tr>
<td>Licensed beds</td>
</tr>
<tr>
<td>Physician clinic locations</td>
</tr>
<tr>
<td>Medical group physicians</td>
</tr>
<tr>
<td>Primary service area</td>
</tr>
<tr>
<td>Employees</td>
</tr>
<tr>
<td>Emergency department visits</td>
</tr>
<tr>
<td>Surgeries</td>
</tr>
<tr>
<td>Newborn deliveries</td>
</tr>
<tr>
<td>Inpatient discharges</td>
</tr>
<tr>
<td>Physician medical group visits</td>
</tr>
</tbody>
</table>

Sources of Revenue

Operating Revenue as of Dec 31, 2015: $4.1 B

- Outpatient ancillary services: 40%
- Inpatient ancillary and other services: 30%
- Outpatient clinic and emergency services fees: 20%
- Inpatient routine services: 8%
- Other operating revenue: 2%

Distribution of Expenses

Operating Expenses as of Dec 31, 2015: $3.9 B

- Labor and benefits: 56%
- Supplies and other: 36%
- Depreciation and interest: 8%
**Strategic Vision**

8 processes were utilized to redesign the model of care which resulted in 11 key initiatives to successfully close a $22.6M gap between the system’s productivity and its most competitive peer set.

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Design</th>
<th>Implementation, Monitoring and Sustaining</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 weeks</td>
<td>16 weeks</td>
<td>On going</td>
</tr>
</tbody>
</table>

**Cost competitiveness against industry benchmark**

- **$22.6M**
  - Total Variance to Benchmark

**8 processes to redesign the model of care**

1. Identify and Leverage Best Practices
2. Determine Nursing Workflow Improvements with Support Services
3. Standardize Staffing and Scheduling Policies
4. Standardize Nursing Roles and Responsibilities
5. Standardize Orientation Duration and Enhanced Preceptor Use
6. Review Safety Attendant Use
7. Align Staffing Resources By Level Of Care and Develop Staffing Tools
8. Develop and Organize Nursing Leadership Trainings

**Implement 11 design initiatives and continuously track performance**

- **$28.7M**
  - Current Run Rate Annualized

- **$18.9M**
  - YTD Benefit Realized
The Process of Redefining the Model of Care

The rest of the presentation will walk through the 8 processes to redesign the model of care together with 2 areas that led to new innovative designs among the 11 initiatives implemented.

1. Identify and Leverage Best Practices in Organization

2. Determine Nursing Workflow Improvements with Support Services

3. Standardize Staffing and Scheduling Policies Using Predictive Analytics

4. Standardize Nursing Roles and Responsibilities

5. Standardize Orientation Duration and Enhanced Preceptor Use

6. Review Safety Attendant Use

7. Align Staffing Resources By Level Of Care and Develop Staffing Tools

8. Develop and Organize Nursing Leadership Trainings
Site Visit Observations

Site visit observations were conducted on 57 units in 12 hospitals to gain an understanding of inpatient nursing care delivery at the system and facility level in order to identify and leverage existing best practices.

**Objectives**

1. Gain an understanding of the overall landscape of inpatient nursing services in the health system.
2. Identify notable practices, as well as areas for improvement at each facility.
3. Use findings to drive standardization where appropriate and implement best practices focusing on the following themes:
   - Nursing Staffing and Scheduling
   - Orientation / Education
   - Transformation Adoption
   - Leadership Support / Structure
   - Technology Integration
   - Support Resources
   - Quality Measures

**Site Visit Fast Facts**

- **Hospitals Visited:** 12
- **Units Toured:** 57
  - Mother Baby / L&D
  - Behavioral Health
  - Med Surg
  - Telemetry
  - Intermediate Care
  - ICU/CCU/PICU
High Level Findings from Site Visits

• **Variation across the organization in:**
  - Role, Responsibility and Utilization
  - Adoption and Implementation of The Transformation Model
  - Communication of Best Practices and Knowledge Sharing
  - Orientation / Education Programming and Policies
  - Staffing and Scheduling Policies and Practices

• **Varying degrees of support services from facility to facility with lower than expected service levels**
  - Dietary
  - Pharmacy
  - Transport

• **Unit instability due to high employee turnover resulting in elevated levels of training and orientation as compared to industry reports**

Variation observed indicated opportunities of care standardization and efficiency improvement by leveraging best practices in the system.
Polling Check Point

<table>
<thead>
<tr>
<th>Question 1</th>
<th>Question 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>What was key driver in creating a collaborative environment to drive nursing changes at Novant Health?</td>
<td>What was the most important process to initiate the model of care redesign at Novant Health?</td>
</tr>
<tr>
<td>A. Leadership Support</td>
<td>A. Standardize Orientation Timeframes</td>
</tr>
<tr>
<td>B. Staff Involvement</td>
<td>B. Complete Nursing Leadership Financial Workshop Training</td>
</tr>
<tr>
<td>C. Site Observations</td>
<td>C. Conduct Site Visits to Identify and Leverage Best Practices in Organization</td>
</tr>
<tr>
<td>D. In-depth data analysis</td>
<td>D. Review Safety Attendant Use</td>
</tr>
</tbody>
</table>

**B. Staff Involvement**

**C. Conduct Site Visits to Identify and Leverage Best Practices in Organization**
## Process Improvements to Address Day to Day Workflow Barriers

The “Day in the Life” exercise stimulated valuable discussion about the current pain areas in nurses’ daily work, as well as what could be done to make an RN’s day run more smoothly.

### EVS
- Timely and thorough room cleans including Dimensions computers
- Support EVS by having RNs assist room clean process (e.g. strip linens, put away medications)
- Improve team morale – request EVS to stock NH Remarkable Cards in patient rooms to enable staff recognition
- Ensure KPIs are included in EVS contractual agreements to ensure accountability and high service levels
- Include EVS staff in team huddles to ensure team alignment

### DIETARY
- Examine the benefit of dining on demand vs. 4-Serve
- Timely meal deliveries
- Increase hours of food availability
- Review food options for behavioral health patients

### PHARMACY
- Stock Pyxis appropriately
- Administer medications on a regular basis
- Allow RNs to administer oral meds in liquid vs. solid form without a new physician’s order
- Communicate when/why medication is not available or when a substitute is available
- Implement a “No Call Zone” during med pass so that RNs are not pulled away for calls while administering medications

### TRANSPORT
- Timely transport
- Increase transparency (i.e. communicate expected time of arrival) - Patient Flow team to address Dimensions solution for real time feedback
- Consider dedicating 1 or 2 wheelchairs to each unit to ensure timely discharge during peak transport times
Process Improvements to Address Day to Day Workflow Barriers

The “Day in the Life” exercise stimulated valuable discussion about the current pain areas in nurses’ daily work, as well as what could be done to make an RN’s day run more smoothly.

**CNAs, LPNs, & CULs**
- Improve reliability, accountability and collaboration of CNA staff
- Consider use of applause awards to recognize those who are doing an outstanding job
- Clearly define the roles and responsibilities of CNA I, CNA II, and CNA +4
- Review patients prior to the start of the shift; clarify shared responsibility between RNs and CNAs
- Allow CULs to solely focus on leadership responsibilities and staff development; keep them out of staffing

**COMMUNICATION**
- Reduce junk mail
- Consider distributing weekly or monthly communication newsletters that cover
  - Important issues of note
  - Policy changes
  - Employee recognition
  - Explanation of any new initiatives

**EDUCATION**
- Consolidate meetings
- Decrease orientation time
- Standardize orientation across facilities
- Consider employing predictive hiring, which can potentially decrease orientation time

**SUPPLIES/ MATERIAL MGMT**
- Standardize what and how supplies are stored across all units
- Ensure equipment is in good working condition before delivery (i.e. no dead batteries or punctured tubing)
- Timely delivery of all supplies
- Appropriate par levels for stocked materials and supplies
- Ensure sterile processing is available to avoid RNs being pulled to clean instruments
Standardize Staffing and Scheduling Policies and Centralize Scheduling through CSSO

The standardization and centralization of scheduling would enable better coverage of CSSO services and improved employee satisfaction.

1. Establish a standardized scheduling process across all Inpatient Nursing Units to ensure balanced scheduling
   - Create standardized policies/guidelines around staffing and scheduling for the system
   - Ensure that Nurse Managers are accountable for balanced staffing on their units
   - Ensure units have split of full time, part time staff and PRN staff appropriate to the volume variation on the unit

   **Benefits**
   - Allow CSSO to better cover units that need staffing
   - Improve employee satisfaction due to better predictability and fewer staff cancellations

2. Centralize System Scheduling to CSSO and Align CSSO Staffing to System Needs
   - Enable CSSO to review scheduling across ENTIRE organization, manage scheduling gaps and meet the daily changing needs of the units while aligning CSSO resources to new core staffing patterns

   **Success Factor**
   - Right size the throughput leveraging analytics of daily census, turnover and retention
Key Areas in Staffing and Scheduling Guidelines

**Manager Expectations**
- Structured staffing and scheduling roles and responsibilities

**Holiday Coverage**
- Expectation for Full Time staff
- Expectation for Part Time staff
- Weekend swaps approval

**Weekend Shift Coverage**
- Expectation for Full Time staff
- Expectation for Part Time staff
- Weekend swaps approval

**Call-In Policy**
- Call-in to the unit and the CSSO
- Two hours prior notice is required
- Penalty for call offs on holidays

**Scheduling process**
- Approval of PTO/Training/Meeting requests

**Cancelling staff**
- A standard policy for cancelling

The clarification of roles and responsibilities is crucial to standardize staffing and scheduling practice across the system.
### Staffing and Scheduling Roles and Responsibilities

Structured staffing and scheduling roles and responsibilities aimed to facilitate smooth and timely coordination.

<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibilities</th>
</tr>
</thead>
</table>
| Nurse Manager               | • Accountable for **balanced staffing** on the unit  
                              | • Ensure accurate schedules in the **timekeeping software**  
                              | • Responsible for maintaining **overall unit productivity** |
| House Supervisor            | • **Coordinate float resources** with CSSO  
                              | • Encourage and maintain **open communications** with all department leadership  
                              | • **Communicate unit staffing needs** across facility and with CSSO |
| Clinical Unit Leader        | • Assist Nurse Managers with staffing on the unit  
                              | • **Approve shift swaps**  
                              | • **Oversee** day-day staff scheduling  
                              | • Maintain unit productivity |
| CSSO                        | • **Coordinate float resources** with Nurse Managers, CULs and House Supervisors  
                              | • **Prioritize float resources** to the units with most need |
| Scheduler / Admin Time Keeper | • Review and update **timekeeping for payroll**; maintain time and attendance tracking, as needed  
                                 | • Based on the number of employees a scheduler/ Admin time keeper can be assigned to enter **schedules on the timekeeping software** under the guidance of the CUL/ NM |
Polling Check Point

Question

What responsibilities below are part of the Nurse Manager’s role in staffing and scheduling?

A. Accountable for balanced staffing on the unit
B. Ensure accurate schedules in the timekeeping software
C. Responsible for maintaining overall unit productivity
D. All of the Above

**D. All of the Above**
Changes in Scheduling

Previously all staff including Full Time (FT), Part Time (PT) and PRN on the unit and all CSSO staff had been scheduled at the same time. It was proposed that the Unit FT/PT staff schedule went first, followed by PRN and CSSO staff, in order for the CSSO staff to be assigned to units with most need.

<table>
<thead>
<tr>
<th>Week 1</th>
<th>Week 2</th>
<th>Week 3</th>
<th>Week 4</th>
<th>Week 5</th>
<th>Week 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unit FT/PT, PRN and CSSO self schedule</td>
<td>Manager/ CSSO Balance Schedule</td>
<td>Schedule Published / Trades offers</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Recommendation

Previously all staff including Full Time (FT), Part Time (PT) and PRN on the unit and all CSSO staff had been scheduled at the same time. It was proposed that the Unit FT/PT staff schedule went first, followed by PRN and CSSO staff, in order for the CSSO staff to be assigned to units with most need.
Use of Predictive Analytics in Scheduling

The analytics and visualization of historical data of Admission, Discharge, Transfer (ADT) empowered the prediction of daily changing needs of the units.

Facility- and Unit- Specific ADT Model

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By Time of Day

- Admission
- Transfer In
- From ED
- Discharge
- Transfer Out
- Census
- Census Mode
- % Churn
Use of Predictive Analytics in Scheduling

The analytics of ADT data provided insights valuable to scheduling. Organizations can build this model in house using EHR information.

**ADT Model of MED / SURG at Hospital A**

**Interpretation Guide**

- **Admission**: Patients admitted to the unit who did not receive initial treatment from the ED
- **Transfer In**: Patients transferred into the unit from another inpatient unit within the facility
- **From ED**: Patients admitted to the unit who received initial treatment from the ED
- **Discharge**: Patients discharged from the unit into the community
- **Transfer Out**: Patients transferred from the unit to another unit within the facility
- **Census**: Patients who are assigned to the unit and are in a bed
- **Census Mode**: Most frequent number of patient in beds by the hour
- **% Churn**: Time of day with highest average admissions, discharges, and/or transfers

**ILLUSTRATIVE**
Polling Check Point

Question

Is your organization using any analytics such as ADT (admission, discharge, transfer) data in staffing and scheduling?

A. Yes
B. No

The result is...
Care Team Model Proposed

The team-based model proposed emphasized clear communication, delegation of tasks, and teamwork among staff to ensure coordinated patient care and a remarkable patient experience.

*Based on unit need and staffing patterns
Right-size Non-Productive Time
Alignment of worked hours for meetings, orientation, and education with industry targets and the internal practice environment was a key management consideration.

Alignment to achieve the efficient allocation of non-productive time for meeting, orientation and education.
Implement Preceptor Program Across Inpatient Nursing Services

Implementation of Preceptor Program across inpatient nursing services helped to ensure standard and effective orientation delivery to new hire / transfer staff

<table>
<thead>
<tr>
<th>Novant Health</th>
<th>Unit Leadership</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Appoint someone to oversee the nursing preceptor program</td>
<td>• Invest the required resources in the orientee’s learning efforts to ensure their success on the unit</td>
</tr>
<tr>
<td>• Adopt the mindset that developing new hires is a system and a unit effort, not solely a preceptor effort</td>
<td>• Refrain from assigning the preceptor-orientee pair an increased patient assignment or a patient assignment with a higher acuity</td>
</tr>
<tr>
<td>• Senior leadership, unit leadership, and unit peers will all ensure the preceptor and the orientee feel supported on the unit</td>
<td>• i.e. The orientee is someone with legitimate learning needs, not a helper or an extra set of hands</td>
</tr>
<tr>
<td>• Refrain from tasking assignments to the preceptor because of a perceived “lighter load”</td>
<td></td>
</tr>
<tr>
<td>• Ensure the preceptor and the orientee are supported throughout the orientation</td>
<td>• Proactively adjust expected length of orientation if orientees require little or no oversight</td>
</tr>
<tr>
<td></td>
<td>• Be engaged and actively participate in orientation rather than considering preceptorship a time to relax</td>
</tr>
</tbody>
</table>

ORIENTEE

<table>
<thead>
<tr>
<th>Peers on the Unit</th>
<th>Preceptors</th>
</tr>
</thead>
</table>

Unit Leadership

• Invest the required resources in the orientee’s learning efforts to ensure their success on the unit
• Refrain from assigning the preceptor-orientee pair an increased patient assignment or a patient assignment with a higher acuity
• i.e. The orientee is someone with legitimate learning needs, not a helper or an extra set of hands
• Proactively adjust expected length of orientation if orientees require little or no oversight
• Be engaged and actively participate in orientation rather than considering preceptorship a time to relax
Innovative Design #1 to Reduce Safety Attendant Use

The first initiative to standardize safety attendant (SA) policies and procedures was designed as following:

1. Implement policies and procedures to operationalize appropriate use of patient safety attendant

2. Reduce overall safety attendant use to 3% of total worked hours to better align with industry standards and implement use of alternative measures to monitor patients as needed (e.g. bed alarms)

3. Remove facility budgeted safety attendant positions and consolidate all positions for distribution under the CSSO

Benefits

- Standardize the use of safety attendants system wide to provide more consistent service to all patients
- Improve collaboration and communication with patient families
- Achieve estimated savings of $2.3M if the proportion of total nursing worked hours on SA reduces to 3%

Costs

- Invest in cost effective alternatives to safety attendant use with little to no impact on patient experience or quality (e.g. therapeutic activity kit)
Action Plan to Delivery

The group completed the following steps in the development of a standard Safety Attendant policy:

**Defined how to assess need for Safety Attendant staffing**
- Examined assessment tools being utilized at Novant Health and compared to industry
- Defined differences in patient needs such as suicide vs IVC and fall risk patients
- Evaluated current process for monitoring Safety Attendant requests

**Created a current state process flow for Safety Attendants requests**
- Discussed how and why units were requesting Safety Attendants
- Created current state process flow and highlighted opportunity for improvement

**Examined policies that monitor Safety Attendant use**
- Evaluated ongoing methods to monitor Safety Attendant (e.g. whether patients continue to need Safety Attendants)

**Identified gaps and create future state request policy**
- Created future state process for requesting Safety Attendants that could be standardized across the system

**Developed checklist of alternatives to Safety Attendant use**
- Brainstormed best practice alternatives to Safety Attendant use
- Reported out to Core Nursing group on recommended policies and procedures

The goal of the subgroup was to recommend a policy and process for requesting and monitoring Safety Attendant use that could be standardized across the Health System.
Innovative Design #2 to Reduce Safety Attendant Use

The implementation of therapeutic activity kit on nursing units was the other initiative designed to reduce safety attendant use.

Implement Therapeutic Activity Kits on Nursing Units

**Incorporate “Diversion Boxes” on nursing units**
- A diversion box is a carefully selected collection of tactile, auditory, and visual items to help aid in the treatment of confused, flight and fall risk patients.
- Therapeutic Activity Kits (also called diversion boxes) can provide a great deal of solace to patients and have demonstrated impact on clinical outcomes.
- Kits will be incorporated on all nursing units, excluding Critical Care and Women’s Services.

**Benefit**
- Improve interaction between caregiver, patient, and family.
- Improve clinical outcomes including reduced depressive symptomatology, improved motor functioning, and reduced falls.

**Cost**
- Expense to maintain materials/equipment.
- Procurement of supplies and materials.
Inside the “Therapeutic Activity Kits”¹

It was recommended to purchase “Therapeutic Activity Kits” for nursing units, the cost of which would be offset by the decrease in Safety Attendant utilization²

<table>
<thead>
<tr>
<th>Item³</th>
<th>Activity</th>
<th>Activity Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peg Board</td>
<td>Place pegs in resistive board</td>
<td>Sense of purpose, relaxation</td>
</tr>
<tr>
<td>Art Supplies</td>
<td>Drawing, painting, etc.</td>
<td>Self-expression</td>
</tr>
<tr>
<td>Wash Cloths</td>
<td>Fold/stack towels</td>
<td>Coordination, depth perception</td>
</tr>
<tr>
<td>Fit-a-space puzzle</td>
<td>Assemble and take apart pieces</td>
<td>Enjoyment/stimulation</td>
</tr>
<tr>
<td>Cones</td>
<td>Stacking cones</td>
<td>Sequencing, attention span</td>
</tr>
<tr>
<td>Toy Doll</td>
<td>Play with doll</td>
<td>Motor planning</td>
</tr>
<tr>
<td>Finger Fidgets</td>
<td>Exercise fingers with ball</td>
<td>Bilateral integration</td>
</tr>
<tr>
<td>Playing Cards</td>
<td>Play games, sorting, etc.</td>
<td>Sustained attention</td>
</tr>
<tr>
<td>CD</td>
<td>Listen to music</td>
<td>Auditory relaxation</td>
</tr>
<tr>
<td>Videos</td>
<td>Watch movie</td>
<td>Visual attention</td>
</tr>
</tbody>
</table>

Education around Therapeutic Activity Kits should be incorporated into Safety Attendant policy changes

1. Based off “Therapeutic Activity Kits” in the literature. The Hartford Institute for Geriatric Nursing, 2013
2. Women’s and Critical Care Units Excluded
3. The kit contents are under review and might change
Align RN / CNA to Patient Staffing Ratios to Industry Standard

Staffing ratios for RNs and CNAs were designed against industry standard based on Level of Care. The team also looked at ways to operationalize proposed night ratios on the evening shift.

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Transformation Ratio</th>
<th>Day Shift Ratio</th>
<th>Evening Shift Ratio</th>
<th>Night Shift Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Med-Surg</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intermediate</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Level Intermediate</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICU</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

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Core Staffing Pattern Template

The alignment of nurse to patient ratios to industry level and the predictive analytics of ADT helped to develop the core staffing pattern below

This section includes descriptive unit data and displays several metrics calculated based on the core staffing pattern

<table>
<thead>
<tr>
<th>Unit Information</th>
<th>Facility</th>
<th>Cost Center</th>
<th>Cost Center Name</th>
<th>Medical Surgical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Available Beds</td>
<td>46</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline ADC¹</td>
<td>26</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current ADC²</td>
<td>23</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct Caregiver WHPPD</td>
<td>7.4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indirect Caregiver WHPPD</td>
<td>1.6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Core Staffing WHPPD</td>
<td>8.95</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safety Adj. WHPPD</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overtime WHPPD</td>
<td>0.5%</td>
<td>0.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target Overtime WHPPD</td>
<td>2.0%</td>
<td>0.18%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orientation / Education</td>
<td>11.3%</td>
<td>1.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target Orientation / Education</td>
<td>5.0%</td>
<td>0.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total WHPPD at Target</td>
<td>9.56</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total WHPPD at Current</td>
<td>10.01</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orientation / Education % incl Residency CC</td>
<td>14.5%</td>
<td>1.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total WHPPD at current incl Residency CC</td>
<td>10.31</td>
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<tr>
<td>RN Skill Mix</td>
<td>56%</td>
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<tr>
<td>Budgeted PTO %</td>
<td>10%</td>
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<table>
<thead>
<tr>
<th>Core Staffing Pattern at FY14 ADC</th>
<th>RN</th>
<th>LPN</th>
<th>CNA</th>
<th>WSTFC</th>
<th>MUR</th>
<th>CUL</th>
<th>TL (Out) / ADT</th>
<th>NM</th>
<th>Other</th>
<th>Cost Center Level</th>
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</thead>
<tbody>
<tr>
<td>Day</td>
<td>5.0</td>
<td>4.5</td>
<td>4.0</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>0.7</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Eve</td>
<td>4.0</td>
<td>3.5</td>
<td>3.0</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<td>-</td>
</tr>
<tr>
<td>Night</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<table>
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<tr>
<th>Impact</th>
<th>Avg Wage Rate</th>
<th>Core FTEs</th>
<th>Paid FTEs</th>
<th>Labor $ PPD</th>
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</thead>
<tbody>
<tr>
<td>RN to Patient Ratio</td>
<td>5.2</td>
<td>5.8</td>
<td>6.5</td>
<td>19.0</td>
</tr>
<tr>
<td>RN Skill Mix (Direct)</td>
<td>56%</td>
<td>56%</td>
<td>57%</td>
<td>14.7</td>
</tr>
<tr>
<td>CNA to Patient Ratio</td>
<td>5.6</td>
<td>7.4</td>
<td>8.7</td>
<td>2.8</td>
</tr>
<tr>
<td>Licensed to Patient Ratin</td>
<td>5.2</td>
<td>5.6</td>
<td>6.5</td>
<td>2.0</td>
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<tr>
<td>TL (Out) / ADT</td>
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<td>1.6</td>
<td>0.7</td>
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<tr>
<td>NM</td>
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<td>-</td>
<td>-</td>
<td>40.6</td>
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</tbody>
</table>

The number of staff members for each position and each shift is input in the light blue section of the grid; this is considered the core staffing pattern and drives productivity and metric calculations

This block displays the average wage rate for each position, the future state core FTEs, paid FTEs and the labor expense per patient day for each position
**4 Hour Productivity Tool**

The 4 Hour Productivity Tool compares the impact of actual staffing to target staffing levels, as well as how this effects unit productivity. It consists of the core staffing plan – which will remain static – and the portion of the tool where staffing and census information is inputted.

### Core Staffing Plan

- **Facility Costs**
- **Cost Center**
- **Cost Center Name**
- **Available Beds**
- **Via Average Daily Census**

### Targets

- **Direct Caregiver**
- **Indirect Caregiver**
- **Core Staffing**
- **Other WHPPD**

### Total WHPPD at Target

- **RN Staff Mix**
- **Budgedt FTO %**
- **Level of care**

### Staffing Input

1. **Overview/Summary | Education | Meetings**
2. **Add a new grid each day**
3. **Enter Census at the beginning of each 4 hour period (i.e. at 7am, 11am, 3pm, 7pm, 11pm, 3am)**
4. **The target staffing for the census is automatically populated from the Flexible staffing grid**
5. **Enter Actual staffing for the four hour period**
6. **The final column allows for comments detailing any variance to targets**

---

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Duty Shift</th>
<th>Core Staffing at 2016 VIA ADC</th>
<th>Paid FTEs</th>
<th>Other Hours based on Paid FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sunday, Aug 21</td>
<td>7 AM</td>
<td>RN</td>
<td>5</td>
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<tr>
<td></td>
<td>11 AM</td>
<td>LPN</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3 PM</td>
<td>CNA</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>7 PM</td>
<td>WSTEC</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>11 PM</td>
<td>MUR</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3 AM</td>
<td>TL (Out) / ADT</td>
<td>5</td>
<td></td>
<td></td>
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<table>
<thead>
<tr>
<th>Date</th>
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<th>Duty Shift</th>
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<th>Paid FTEs</th>
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</thead>
<tbody>
<tr>
<td>Monday, Aug 2</td>
<td>7 AM</td>
<td>RN</td>
<td>5</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>11 AM</td>
<td>LPN</td>
<td>5</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>3 PM</td>
<td>CNA</td>
<td>5</td>
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<tr>
<td></td>
<td>7 PM</td>
<td>WSTEC</td>
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<td>5</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>3 AM</td>
<td>TL (Out) / ADT</td>
<td>5</td>
<td></td>
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</tbody>
</table>
Financial and Operational Workshops
Designed for Nursing Leadership

The “Putting Together the Numbers” workshops provided valuable opportunity of knowledge transfer and communication critical to successful implementation.

Objectives

- Obtain an overview of value and integration acceleration inpatient nursing activities to date
- Discuss key financial and operational concepts and how they integrate into daily practice
- Explain process and key assumptions used in the budgeting process
- Recognize key concepts, strategies and leading practices to enhance ability to manage resources
- Discuss practice solutions and innovative approaches to respond to variance in volume and activity
- Prepare for Nurse Manager 1:1 sessions

Outputs

- Budget and key performance metrics associated with building a new hospital unit
- Core staffing pattern at budgeted average daily census and resulting worked hours per patient day
- Definition and calculation of indirect worked hours (meetings, councils, education, orientation)
- Flexible staffing patterns
- Making assignments based on patient complexity

Progress

- 12 Workshops were delivered over a 5 month time period
- 100 out of 115 nurse leaders attended the training
- The knowledge transfer workshop was recorded for future trainings
1:1 Sessions with Each Nurse Manager

The following content was shared with each nurse manager during 1:1 sessions; content was tailored for each unit.

1. Baseline to Current State WHPPD Performance
2. Worked hour breakdown
3. No Lunch
4. Unit Turnover
5. Proposed Staffing Grid
6. Position Control
7. Weekender Program
8. Recommended Weekend Staff
9. Admissions, Discharges, Transfer Data
Nursing-HR Collaborative Partnership to Sustain Success

Nursing Leader Development involves the following programs:
• Nursing Leadership Renewal Program
• Acute Care Nurse Manager Academy

Team members who work beyond regular schedule at acute care facilities and ambulatory surgery are eligible to participate in the program established with the following components:
• High vacancy incentive pay for additional hours worked each pay period
• Completion bonus at the end of 12-week period based on number of additional hours worked

Two projects have been implemented:
• Project Re-Engage aims to collect real time data on why people are leaving before they physically leave and perhaps keep some people if the organization can quickly troubleshoot their reason for leaving
• Project Return aims to leverage the pool of proven talent who knows the organization and may be converted from passive candidates to those interested in returning if made aware that the organization is interested
Lessons Learned - Summary
?? Questions ??
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Post inspiring moments from the conference to the mobile app!
#AONE2016
References

1. Novant Health 2014 Annual Report
2. 2014 Labor Management Industry Reports