HealthLeaders Virtual Roundtable
Healthcare System of the Future: CNO

THE DRIVING FORCE OF HEALTHCARE STARTS AT THE BEDSIDE

Nurses make up the largest segment of the healthcare workforce and, therefore, have the potential to drive the healthcare industry's evolution. To meet the demands of an increasingly value-based care environment, nurses must possess a different mix of knowledge, skills, education, and competencies than they have in the past as workplaces, care settings, and care teams look different than ever before.

Nursing undoubtedly will affect the ability of healthcare systems to achieve their goals. This executive Roundtable explored the strategies nurse leaders can take to ensure the nursing workforce and healthcare system is equipped to improve outcomes, reduce healthcare costs, and reshape healthcare delivery.

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HIGHLIGHTS

HealthLeaders: *The recent The Future of Nursing, 2020-2030: Charting a Path to Achieve Health Equity by the National Academy of Medicine said that all state and federal policy changes in response to the COVID-19 pandemic that expanded scope of practice should be made permanent. How likely is that to happen, and what effect will that have going forward?*

Kathleen Sanford: It's going to be a mixed bag about how likely that will be. Right now we're all coming down from this high of how it worked when we all got together and got these policy changes made for the good of our patients, but there will be those who are more comfortable with pre-COVID policies. We will make some progress because more people have realized that we can maintain quality at a lower expense. The struggle going forward will be to not only have people work at the top of their license, but to stop working at the bottom of their license. It's a waste of money and it's a waste of resources.

April Kapu: Last March, our walk-in clinics, retail clinics, and primary clinics were busier than ever. To offer COVID testing options, we created temporary COVID clinics in the community. NPs staffed these temporary clinics. When considering how we were going to submit all of the state-required paperwork and chart review for the NPs there, I remember having a conversation with our COVID czar, Alex Jahangir. I explained that if we are going to try to fulfill our requirements for the state, we will have talented physicians confined to an office going through and doing the chart review for these hundreds of patients that the nurse practitioners are seeing. It makes no sense when the NPs are educated to take care of these patients. The physicians should be on the front line caring for patients too, rather than performing retrospective chart reviews for hundreds of patients who are undergoing COVID testing. Whereas the NPs are clinically trained; they're board certified. They have the credentials to provide the care.

Anne Dabrow Woods: It's about taking all the data and the evidence that we have and highlight what we were able to do during the pandemic to show that we haven't done any harm. We actually improved outcomes. And then we need to teach our nurses and advanced practice nurses how to really lobby the state and the federal legislatures so we can make changes.

Cynthia Lockyear: When you think about the states that have the practitioner reviews, what does that process actually look like, and how has that actually driven safer patient care? If the data is showing that the care is safe and the data's showing that changes aren't being made as a result of that, what COVID gave us the opportunity to prove is that our advanced practitioners really can function independently and in a safe way and not have poor patient outcomes.

Claire Zangerle: I [like the idea of] alliances between other disciplines too, such as respiratory and pharmacy. Our respiratory therapists were very happy to receive the attention to their practice. So were our pharmacists, who were so instrumental during the pandemic. Perhaps sometimes those groups are the unsung heroes. So, I think it's time to elevate their profile in the organizations, too, as part of the care team.

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HealthLeaders: *Specializing is on the rise right now, in terms of both specialties offered and the number of nurses specializing. What effect will that have on nursing in general? And how do you balance that with an all-hands-on-deck mentality like was required with the pandemic?*

Zangerle: We learned that OR nurses make terrific ICU nurses with a bit of help from actual ICU nurses. That was truly helpful. We learned that ambulatory nurses could practice in the hospital as well. We've proven that we can put all hands on deck, but the attitude is not "a nurse is a nurse is a nurse." They like to specialize, and that's OK. We will continue to support that, but when needed, we can open it up and allow them to move to different places.

Jesus Cepero: Having worked most of my career in children's and women's hospitals, I believe in specialties [in] nursing practice, and I know that the outcomes do improve with specialty nursing services, but this pandemic showed us that we could be flexible in that nurses can learn new competencies and they will always step up in emergencies. That's why we're the most trusted profession in the world. But I believe it's still a very

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important point that we continue to assess and promote specialty practice because we always see improved outcomes with specialty nursing practice.

Kimberly Hunter: It's a challenge. Many nurses want to specialize, and we want them to. During COVID, nurses wanted to help out others and remain flexible, and even though they might not have been working in their comfort zone, the nurses they went to support helped pull them in and make it a more positive experience. So, do you create positions where nurses spend a certain amount of time in one area, and then spend a certain amount of time in another, like crossover from inpatient to ambulatory? Would it give them a mental break so that they are not subspecialized into one area all the time? There may be some different ways to think about it.

Woods: For us to have an agile, flexible workforce, we need to have more nurses who are cross-trained and are multispecialty across the adjacent specialties. So while I absolutely agree specialties are important, we need to be really careful here and recognize that what really worked is multispecialty nurses who could go between adjacent areas, and that's where hospitals need to focus.

Lockyear: We have an internal pool that does some of that, and we've grown that to be 20% of our staffing in each of our departments. We also have an existing tool where, regardless of where a nurse [is] coming from, the nurse self-identifies their competency and skill set. We look at what the competency and skill set for the unit is, and then we match that competency and skill set of the nurse that's coming into the unit with a partner in that unit. They determine division of work, and that's worked really well for us.

Kapu: During the time of disaster, everyone was so flexible and willing to help their teammates in the inpatient and ambulatory settings. But I did see a lot of the nurses glad to go back to their focus and their love, whether that be back in pediatrics or back in the OR. So we're always going to see the subset of nurses who want to float and to do something different—but for the most part, our nurses really liked going back to what they really love to do.

Sanford: Would you put a pediatrician in the OR to do surgery? Would you put a surgeon to work as a behavioral health physician? When we say that nurses are not specialists, they become a commodity. During COVID, I was surprised to find that many people who were not nurses truly did believe "a nurse is a nurse is a nurse." They couldn't understand why we couldn't take the nurses who've been in family practice clinics for 20 years and throw them into critical care. We could use nurses from different specialties but only in team models where there was a specialist directing the nursing care.

We have to be careful that we don't think of our nurses as a commodity. If you talk about them as being able to go everywhere, they become a commodity, and that's one of the reasons the nursing voice has not been heard the way that it should be heard in our organizations.

HealthLeaders: *Some have said that the pandemic will forever change care and staffing models. What changes do you all anticipate?*

Zangerle: The nursing shortage has been an issue since before the pandemic, and the pandemic just made it worse. We're facing the worst shortage we have ever faced in my 30 years as a nurse. Just today, we presented an opportunity to our nursing leadership team on piloting a blended team nursing concept on units so that we can bring LPNs back to the bedside. We just don't have a choice; we can't find enough patient care assistants, we can't find enough nurses, so we have to be creative.

Kapu: Because I happened to have the additional hat of being over the labor pool for the last 16 months, one of the things we saw is the benefit of having a system-wide labor management tracking tool. We have realized that we can be pretty inefficient where we have lower volume in some areas and we're sending nurses home, whereas other areas we have extreme shortages. With multiple hospitals, each hospital had their own system; but going through the pandemic, we were able to bring everybody into one larger system for labor tracking, which was very helpful.

Hunter: Many of us aren't going to have that much of a choice because nationally, we have more needs than there are resources. Some areas of the country—such as Iowa; we're not the most populous state—are competing with larger metropolitan areas for the same resources. We need be creative in how we provide excellent nursing care for our patients.

HealthLeaders: *Research shows that the reasons nurses leave are the same ones that have been around for decades: a stressful work environment, inadequate staffing, burnout, lack of management. What will it take to finally achieve healthy staffing levels?*

Sanford: We have to be honest with ourselves, pick up a mirror, and figure out what our part has been as nurse leaders for all these years where we have not been able to fix what we needed to fix,

and what part our organizations have had. We are going to have to involve people at the very front line—staff nurses, wherever they are—to tell us what it will take, to tell us what they need, to tell us why they're frustrated. Then we must act on this input.

Lockyear: There's a place here for looking at technology and how it can help remove workload both from our nurses at the bedside taking care of our patients and our nurse leaders. There's a lot of data science going on behind what nursing is inputting, what the system is inputting from tests and results, what physicians are inputting, and making a lot of analysis and feeding that information. So where we're busier than we've ever been, with sicker and higher-acute patients than we've ever had, being able to automate many of the things that we've had to do manually are the things that will help alleviate that burnout and create better environments.

Cepero: In the last eight months to two years we've seen a significant amount of moral distress in our staff, and our three key initiatives have been to increase our resilience in care support, increase our ethics counsel, and increase rounding for depression screenings within our staff, because we know suicide risks in nursing have grown in the last year.

Zangerle: I think the moral distress that we sometimes ignore are things that we can actually control, and that's the behavior of some of our teams—nurses, physicians, other members of the care team. We have to hold people accountable for their behavior. Our nurses continue to suffer from some of the decisions that have to be made and that they have to make with their staff, but we're controlling the things we can control.

Kapu: Before the pandemic I was very interested in looking into burnout, and what we could do for advanced practice nurses, so we surveyed our APRNs and conducted focus groups. The APRNs wanted more opportunities for professional growth and development, whether that be horizontal or vertical. The basis for that was not only to grow professionally, but they were at the point of burnout in that they needed a change to help them have a fresh perspective to continue to grow in their career.

Woods: For us to combat all the burnout and moral distress that people have experienced, we have to focus on well-being and fostering resilience across the whole workforce. We have to look at some of these new care models and implement them; we simply don't have the resources available to take care of all the people that need to be cared for.

HealthLeaders: *COVID has taken a brutal toll on the mental health of nurses. Where do you think nurse leaders should focus their efforts now and for the future to help the nurses heal from the fallout that might be happening in the next few months?*

Sanford: One thing to look at are resources we might not have looked at before. For example, I'm a retired Army nurse, and one of our docs is a retired Navy admiral. We approached the military and said, "We both know a little bit about PTSD; we both served in times of war and we think what clinicians are going through with COVID will result in the same kind of problems." Our military colleagues said, "Yes, it's very similar and clinicians could experience similar issues." So, we borrowed best practices from them. If you have any local military colleagues, they probably have best practices that they would share and you could adopt.

Lockyear: One of my biggest takeaways in the last year is we have to be intentional in giving people permission to say "I'm not OK" or "I'm overwhelmed" or "I need help" because traditionally—and we've done it to ourselves—nurses have just always become the fix-it-all for everything. So there has to be very intentional permission.

Woods: We need, as organizations, to work on our employee assistance programs (EAP) so they're easy to access and they're easy to utilize because right now they're really not. They're pretty much a deterrent to getting help. You get those long lists of providers to help out the staff, but everybody's totally booked up. There's no one available for the staff to see or to talk to.

Cepero: We've been intentional about setting some time at the beginning of a meeting or at the end of a leadership meeting, spending 10 or 15 minutes of check-in time, celebration times talking about weddings or new babies in the groups.

Zangerle: We recognized in our nurse managers that they would walk in the door and it would be chaos all day until they left to go home and they didn't feel like they were accomplishing anything. They didn't block time to engage with their staff or to do the things that fulfill them professionally. To mitigate the chaos for them, we engaged a psychologist whose expertise is time management to teach a 21-day time management course for all of our nurse leaders. The post-survey results of the course were remarkable. They said, "The chaos is still there, but I feel more in control of the chaos, and I'd go home at night thinking I've accomplished more."

We provided the course for the chief nursing officers, nursing directors, and nurse managers. Now, the nurse managers want their assistant nurse managers and supervisors

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—April N. Kapu, DNP, APRN, ACNP-BC, FAANP, FCCM, FAAN
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to take the course. They recognized the need to cascade the same valuable information to this group of newer nurse leaders so they could also learn how to prioritize tasks, deal with the unexpected, and block out time appropriately. They figured a lot of this out themselves and they felt like it was such a gift. And it was. They feel that they're a lot more in control, and that contributes significantly to their wellness.

HealthLeaders: *Some forecasters say that hospitals eventually will go away. Do you believe that?*

Kapu: The pandemic propelled a lot of new thought around the concept and need for hospitalization. One of the programs we put in place early on was a COVID-to-Home program, which was for patients who had come into the ED and [been] found to be COVID positive, but could probably go home and get nursing care in the home. We sent them home and had a combination of nurse practitioners, nurses, and telehealth for those patients who went home, and that just propelled thought into what can we do above and beyond to expand our home care services. That's just one thing that opened my eyes that yes, we're able to do a lot more in the home than I ever thought possible.

Hunter: We had a similar type of program and found it to be very successful, but I don't think hospitals will, at least not in our lifetime, ever go away. In the United States, we offer such subspecialized quaternary care—that will continue to exist to some level in the hospital.

Cepero: The med/surg beds are shrinking because we've learned that we could discharge patients sooner and hospital-to-home care is effective, safe, and actually cheaper. But the specialty hospitals—women's hospitals for women's services and deliveries and OB care—are going to become more specialized, so I don't see that ever going away in the next 100 years.

Sanford: Everyone in healthcare will probably have a different opinion about that. My colleague just said he believes hospitals will be around for the next 100 years. My forecast is closer to 30 years, at which time there will be critical care hubs and that will be it. I think that care will move more and more into ambulatory services and the home due to new technology and acceptance by the public.

HealthLeaders: *Through their interactions with patients, how do you get nurses engaged with social determinants of health as they deliver care to drive positive health outcomes?*

Kapu: This is what we do really well; we consider the whole patient and their full context of living. We can continue to improve, of course, but this is a good time to step up and say, "This is what nurses do. This is what we've been doing for hundreds of years. We do it very well." Certainly, there's always room for more education and more understanding, but it's also an opportunity for us to highlight our value in this space right now.

Woods: I would just like to point out in our electronic health records (EHR), when you're looking at the social determinant of health variables, the questionnaire is extremely lengthy and to get through all those questions at one time takes a lot for the nursing staff to do. And not only is nursing doing it, myself as a practitioner is having to do it, and physicians who are doing an admission are doing it. We need to stop duplication and all document on one questionnaire.

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