Washington State Department of Social and Health Services

Transforming Lives

REPORT TO THE LEGISLATURE

State Hospital Clinical Staffing Model and Acuity Tool – Implementation Progress

Engrossed Substitute Senate Bill 6032, Section 204 (2)(n)

September 1, 2018

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EXECUTIVE SUMMARY

The 2018 State Legislature enacted Engrossed Substitute Senate Bill 6032 – the 2018 Supplemental Operating Budget. Section 204 (2)(n) of the bill, provides for the Department of Social and Health Services and requires following:

> "… develop and implement an acuity based staffing tool at western state hospital and eastern state hospital in collaboration with the hospital staffing committees. The staffing tool must be designed and implemented to identify, on a daily basis, the clinical acuity on each patient ward and determine the minimum level of direct care staff by profession to be deployed to meet the needs of the patients on each ward. The department must also continue to develop, in collaboration with the office of financial management's labor relations office, the staffing committees, and state labor unions, an overall state hospital staffing plan which looks at all positions and functions of the facilities and is informed by a review of the Oregon state hospital staffing model.." "…establish, monitor, track, and report monthly staffing and expenditures at the state hospitals, including overtime and use of locums, to the functional categories identified in the recommended staffing plan. The remainder of the funds must be used for direct care staffing needed in order to implement the acuity based staffing tool. The allotments and tracking of staffing and expenditures must include all areas of the state hospitals, must be done at the ward level, and must include contracted facilities providing forensic restoration services as well as the office of forensic mental health services. By September 1, 2018, the department and hospital staffing committees must submit a report to the office of financial management and the appropriate committees of the legislature that includes the following:
> (a) Progress in implementing the acuity based staffing tool;
> (b) a comparison of average daily staffing expenditures to budgeted staffing levels and the recommended state hospital staffing plan by function; and
> (c) metrics and facility performance for the use of overtime and extra duty pay, patient length of stay, discharge management, active treatment planning, medication administration, patient and staff aggression, and staff recruitment and retention. The department must use information gathered from implementation of the clinical staffing tool and the hospital-wide staffing model to inform and prioritize future budget requests for staffing at the state hospitals…"

Background

Washington has two state-operated adult inpatient psychiatric facilities: Eastern State Hospital (ESH) and Western State Hospital (WSH). Each of the facilities has been in operation for over 100 years. The hospitals operate more than 1,100 beds and employ more than 3,000 professionals.

The Department of Social and Health Services (DSHS), in accordance with Engrossed Substitute Senate Bill 6656, contracted with OTB Solutions in the summer of 2016 to produce a staffing model to meet state hospital patient care demands. The OTB work was completed, but due to limited time constraints, did not include a full hospital staffing model. In fall 2017, the Behavior Health Administration put together a State Hospital Team with the primary task of

developing a full hospital model, building and expanding from the OTB ward model. To assist with this task, DSHS secured the expertise of the former superintendent of Oregon State Hospital (OSH).

Basis for the Staffing Model

There are no meaningful national staffing benchmarks and/or comparable resources for inpatient psychiatric hospital models. However, there are similarities between Washington's current staffing circumstances and the circumstances OSH faced approximately seven years ago. Following recent Joint Commission review, it was recommended that OSH apply for a Baldrige Award. Given the effectiveness and success of the OHS approach, DSHS decided to use the OSH staffing structure as the foundation for construction of a single staffing model for Washington's state psychiatric hospitals.

Features:

- Single statewide acuity model that would be implemented consistently in both hospitals
- 24/7 model for all staffing needs that adjusts for seasonal patterns, vacancy levels, on-call and non-clinical time
- Incorporates acuity assessment methodology to evaluate and adjust staffing to meet patient care and safety needs
- Detailed analysis that provides information with which to make decisions related to staff deployment
- A guideline for staffing that demonstrates the full range of hospital operations as well as a break down for ward based staffing models specific to the three populations served: Forensic, Geriatric, and Adult

Basis for the Acuity Tool

Staffing and costs are directly tied to patient care. Nurses are able to improve acuity assessment skills, provide quality bedside care, and feel engaged on staffing decisions. Nurses and financial managers value the transparency and rational data the systems provide. Hospitals are confident in their ability to deliver quality outcomes, achieve metrics, manage costs, and maintain a stable nursing workforce.

According to Acuity- Based Staffing as the *Key to Hospital Competitiveness: Why the Smartest Hospitals are Tying their Nurse Labor Investment to Patient Care* by Frost & Sullivan (2015), the key to an acuity staffing model is to drive optimal use of resources and assure quality of care. Currently, acuity is measured in the State Hospitals based upon budgeted staff and census of patients. To fully work within the State Hospitals' budgetary constraints, an electronic acuity tool must be developed to account for care of psychiatric patients to include, but not limited to:

- Patient Census
- 2:01 Nursing-patient ratio due to patient's high acuity
- 1:01 Nursing-patient ratio due to a patient requiring constant observation
- Admits
- Discharges
- Transfers
- Medical, Legal and Other On- and Off-site Appointments
- Seclusion or Restraint

Leading hospitals have a commitment to acuity-based staffing, and technology solutions are seen as a key component of the strategic nurse workforce plan. Acuity-based staffing solutions enable a proactive, prospective, efficient and fiscally responsible approach.

HISTORY OF HOSPITAL STAFFING

Washington has two state-operated adult inpatient psychiatric facilities: Eastern State Hospital (ESH) and Western State Hospital (WSH). Each of the facilities has been operating for over 100 years. The hospitals collectively operate over 1,100 beds and employ more than 2,500 professionals.

The hospitals have developed operational models largely independently of each other over the past century. While some of this is functional in nature, it has resulted in variation in most areas of operation such as organizational structure, treatment approaches, and culture. Work began in earnest over the past five years to bring hospital operations in closer alignment to ensure consistency in care, quality, and safety, as well as leverage resources to achieve better cost efficiency, some of which has resulted in improved outcomes.

Legislation passed in 2016 (ESSB 6656) directed DSHS to address ward-level staffing concerns at the two state hospitals. Following from this legislation, OTB Solutions (OTB) was contracted to recommend a staffing model to meet state hospital patient care demands.

OTB presented their model to the Governor's Select Committee on Quality Improvement in State Hospitals in November 2016. The Select Committee recommended to the Governor that the state move to adopt an acuity-based staffing model at the state hospitals informed by the model recommended by OTB, with modifications based on input from state hospital administrators and Legislative appropriations.

Substitute Senate Bill 5883, Section 204(2)(h), which reads in part:

"…The department must submit a financial analysis to the office of financial management and the appropriate committees of the legislature which compares current staffing levels at eastern and western state hospitals, at the ward level, with the specific staffing levels recommended in the state hospitals' clinical model analysis project report submitted by OTB Solutions in 2016. To the extent that the financial analysis includes any differential in staffing from what was recommended in the report, the department must clearly identify these differences and the associated costs…"

OTB Model

As written in the OTB 2016 report, a Staffing Plan Assessment commissioned by the Oregon State Hospital concludes that due to the uniqueness of each psychiatric hospital and perhaps other factors, there are no meaningful national staffing benchmarks and/or comparable resources for inpatient psychiatric hospital models. Furthermore, each hospital has treatment methodologies and outcome goals that influence staffing. Consistent feedback, including input from the Director of Quality for the National Association of Psychiatric Health Systems and The Joint Commission, Inpatient Psychiatric Hospital Standards Division, supports this conclusion.

The state hospitals conducted the required financial analysis, however, the exercise proved difficult. As the OTB report noted, the model presented only took the state hospitals "about 80 percent" toward the goal of defining staffing requirements. The OTB model did not account for:

- Weekend staffing, seasonality patterns, nonproductive time
- Current vacancy levels and on-call coverage
- A ward by ward detailed analysis, such as variation in duties across wards
- Acuity – this not an acuity-based model, and ward-level analysis is not a good substitute for acuity
- The model includes direct care staff only; it does not include other clinical staffing needs and non-clinical staffing needs
- Permanent versus temporary positions
- Differing roles within a job description (for example, how MHT1, MHT2, MHT3 are used)

Oregon State Hospital Model

There are few psychiatric hospitals to use as benchmarks because, in part, most struggle to acquire, train and retain enough high performing staff and operate in poorly designed and maintained physical environments. That said, there are practices emerging in a few states where hospitals, like ESH and WSH, have been charged with making significant improvements in quality of care. Because each hospital varies in size, scope and intensity in the services provided, the types of patients treated, and the care model used, it is difficult to draw any meaningful conclusions or insights from the data. Using emerging models and promising practices is proving more useful because they can be deployed to different

environments with appropriate adjustments made by the professionals in each hospital.

Given the similarities between Washington's current experience and the past experience of Oregon, working with OSH was a logical approach. OSH based its model on Columbia University Medical Center Department of Psychiatry and New York-Presbyterian Hospital (ranked respectively at #8 and #4 in the nation in the field of Psychiatry by US News and World Report 2017-2018). Following recent Joint Commission review, it was suggested that OSH apply for a Baldrige Award. Given these factors, DSHS decided to use the OSH staffing structure as the foundation for construction of a single staffing model for Washington's State Psychiatric Hospitals.

On September 27, 2017, BHA contracted with the former superintendent of Oregon State Hospital to assist with a state hospital workgroup to examine the OTB Model and complete the work started by OTB. The workgroup was charged with completing specific tasks that would yield a staffing model January 29, 2018.

Recommended Model for ESH and WSH

The state hospital teams developed a recommended staffing model for WSH and ESH. The model summarized in Table One below represents recommended WSH and ESH staffing numbers to align with existing best practices from psychiatric hospital structures.

Positions are organized into key functional categories that include ward-based direct clinical care staff, other clinical staff (such as pharmacists); and non-clinical staff (such as housekeeping). The recommended model considered and accounts for:

- 24/7 clinical care in all wards including weekend staffing, seasonality patterns, non-clinical time
- Current vacancy levels and on-call coverage
- A ward by ward detailed analysis to minimize duplication or inefficient variation in job roles and functions

Table One: Recommended Staffing Model Summary

Functional Category	Oregon State Hospital	Western State Hospital	Eastern State Hospital
Administration	24	36	22
Physical Medicine	77	81	42
Psychiatry	43	59	22
Psychology	70	96	36
Social Work	45	74	30
Rehabilitation	95	132	56
Non-Direct Care	158	146	42
Direct Care	990	1,342	523
Treatment Malls	98	80	32
Ward Manager	-	-	-
Treatment Team Coordinators	24	30	11
Legal Services	42	10	9
Quality Management	60	67	35
Business Office	52	10	6
Facilities	49	6	1
Housekeeping	70	120	45
Food Services	90	141	49
Warehouse & Laundry	12	12	2
Security	103	152	46
Staff Training & Development	24	33	16
Total	2,126	2,627	1,025
# of Beds	620	842	317
Ratio	3.43	3.12	3.23
# of Wards/Units	24	30	11
# of Treatment Malls	6	5	2
# of Centers	4	10	3

Note: Shaded rows represent direct clinical care staff

Necessary modifications were needed to account for differences between OSH, ESH and WSH that impact operational and staffing needs such as:

- Facilities—Oregon invested over $500 million to build a new, state of the art facility in Salem, OR. This facility is comprised of a single building as opposed to ESH and WSH which operate out of aging, multiple buildings spread out over each campus.

- Food Service—OSH provides meals to most patients in a single cafeteria. WSH does not have such a facility which requires transport of all meals to the wards. This creates a very different staffing need than would be seen in OSH's model.
- Organization and delivery of Forensic Services—In 2015, the Washington Legislature (SB 5889) directed the Department to establish the Office of Forensic Mental Health Services (OFMHS). Non-inpatient competency evaluation services are operated by this new office; and therefore, not included in this model. In addition, the Residential Treatment Facilities (RTF) at Maple Lane and Yakima are operated by OFMHS and therefore not included in the proposed model. Competency Restoration services and inpatient Competency Evaluation services are provided in the State Hospitals and included in the proposed model.
- Central Business Functions—DSHS operates key business functions like maintenance, payroll and accounting in an enterprise department structure which does not easily align with OSHs model. The model provides recommendations for how to better align these functions in the future but is likely to require further review and adjustment.

The recommended model provides, for the first time, a single statewide hospital organizational structure that would be implemented consistently in both hospitals. The synergy created as the hospitals worked together to build a unified structure will be replicated for future collaboration that leads to better care, enhanced quality, improved safety, and greater efficiency.

Key features of the recommended model include:

- 24/7 model for all staffing needs that accounts for seasonal patterns, vacancy levels, on-call and non-clinical time
- Application of acuity assessment methodology to evaluate and adjust staffing to meet patient care and safety needs
- Detailed analysis that provides information with which to make decisions related to staff deployment—for instance, the model recommends higher nursing levels in the evening shifts because data shows increased patient acuity, escalated behaviors, and safety risks increase during this shift.
- A guideline for staffing that demonstrates the full range of hospital operations as well as a break down for ward based staffing models specific to the three populations served: Forensic, Geriatric, and Adult
- Use of interdisciplinary teams—collaboration across disciplines will support better outcomes. For instance, the model allows charge nurses to focus their expertise on clinical care leadership and oversight. Unit Administrators will partner with nurse leadership to ensure non-clinical administrative functions—such as ensuring patient charts are current and complete—are maintained in a timely and effective manner.

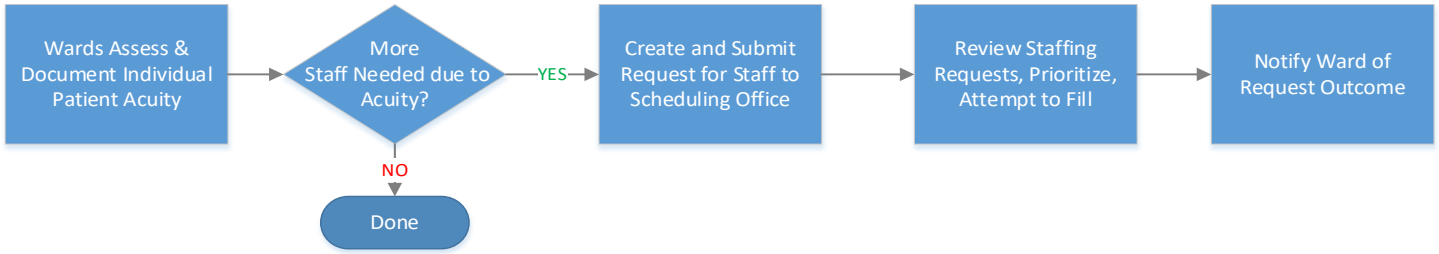
Adoption of the recommended model will:

- Foster a sustainable culture of wellness and recovery that improves recruitment and retention of staff
- Increase responsiveness to patient needs
- Promote consistency in practice and procedure that yields more consistent care for people receiving treatment at ESH and WSH
- Support leveraging of resources and expertise across both hospitals
- In addition, the model recommends a transition from the use of Mental Health Technicians (MHT) to Certified Nurse Assistants (CNA) to provide appropriate medical care needs for patients served in Washington States psychiatric hospitals.

ACUITY MODEL – APPROACH TO IMPROVE CURRENT STATE

The acuity-based staffing model includes base staffing to enhance the current staffing methodology used at ESH and WSH. The current process is conducted by nurse managers who determine the best core staffing pattern for every shift, based on patient census and budgeted staff. However, this manual process creates delays in identifying the staffing pattern required to meet patient needs. The department is in the early stages of building an acuity-based staffing database that will result in a timelier, more efficient process. Without the database in place, the hospitals experience regular delays in having a complete picture of the needed staffing for patient acuity on any given day.

Both adult hospitals currently assess and document individual patient acuity each shift, however separate systems are in use. Information is provided to the staffing / scheduling office to prioritize and determine additional staffing to schedule for each shift. A basic flow is depicted below.



An IT Business Analyst has been assigned to thoroughly review and document the complete workflow from the ward patient acuity assessments through to the staffing / scheduling office at each hospital. This will include investigation of the connections and data flow between all applications touched by the individual or ward acuity levels. The Business Analyst will meet with the Chief Nursing

Officers, IT technical resources, and other relevant to the process at both hospitals.

After documenting the current workflow, a "gap analysis" will be conducted to document differences between the current applications in use and the desired future state.

The gap analysis will be complete at the end of September 2018 and the results presented to the Department's State Hospital Staffing Committee to include alternatives and a recommendation for the technology path forward to meet the needs of the hospitals and oversight.

PROGRESS ON IMPLEMENTING AN ACUITY-BASED STAFFING TOOL

In April 2018, the BHA Assistant Secretary sponsored and tasked the State Hospital teams to continue developing the State Hospital acuity model and tracking tool, an effort which began under the previous Assistant Secretary. The tool should be able to capture, monitor and report to the financial scheduling office. The two system approach will ensure the continued quality of care based upon on the patient population served and the budget allotments to the wards.

As part of this effort the Joint Nursing Staff Committee was convened to develop and oversee implementation of an annual nurse staffing plan. The Committee meets monthly and is co-chaired by the Chief Nursing Officer (CNO) at WSH and a union-appointed member. The Committee is comprised of direct patient care RNs appointed by SEIU and staff appointed by the CNO. Additionally, the Union Management Communications Committee meets monthly where the nurse staffing model is discussed.

Acuity-based staffing solutions seek to support nursing practice with valuable workflow, analysis and reporting. They enable nursing to easily define a proactive six- or 12-month plan, confidently set staff for the next 24 hours, and manage staffing in real time. For entities with tight financial constraints, the solutions are particularly helpful in supporting the case for nurse staffing levels. For hospitals, they support system-wide efforts to standardize and improve safety, quality and cost.

Acuity-based staffing solutions provide nursing with:

- Transparent classification
- Complexity of care
- Discharge management
- Patient-care assignment
- Outcomes management

- Management reporting

The State Hospital team recognized the gaps within the current model to account care of psychiatric patients to include, but not limited to:

- Patient Census
- 2:01 Nursing-patient ratio due to patient's high acuity
- 1:01 Nursing-patient ratio due to a patient requiring constant observation
- Admits
- Discharges
- Transfers
- Outings and Appointments
- Seclusion or Restraint

The team looked at several models and decided upon a combination of the Johnson Acuity Model and the Vermont Psychiatric Care Hospital acuity model shown in Table Two below.

Table Two: Acuity Rating Scale

Level	Applies to Patient
1	Ready for discharge or transfer No longer meets criteria for hospitalization
2	Independent with ADLs Cooperative with program
3	Assessment/documentation/engagement requiring< 20 min. on a shift Assistance with ADLs/physical care< 20 min. on a shift Treatment Plan Meeting Phlebotomy Finger-sticks for blood glucose 30 min. checks Transport by social worker
4	Refusing Medication 15 minute checks Assessment/documentation/engagement requiring> 20 min. on a shift Supervised visits and/or phone calls Behavioral Plan in place Assistance with ADLs/physical care> 20 min. on a shift Requiring frequent redirection Behavioral Plan in place
5	Manual restraint Mechanical restraint or seclusion< 15 min. New admission during this 24 hrs. Transport by Nursing staff High Risk for Falls (by Falls Risk) Non-Emergency Involuntary Medication Frequent vital signs, neuro checks, etc.

6	Constant Observation (during any part of the 24 hrs.) Transport by Sheriffs or ambulance Mechanical restraint or seclusion> 15 min. Emergency Involuntary Medication Medical emergency Need for staff response from other units

An additional gap was identified in communications between nursing and the financial office. The current acuity model has manual information within two hours of the shift beginning on the ward or unit heading to the scheduling office; however, the lag time of the information entered doesn't return to the wards or units swiftly. An analysis is being completed to identify what new technology is needed to inform acuity in real-time.

AVERAGE DAILY STAFFING EXPENDITURES / BUDGETED STAFFING LEVELS

In December 2017, the state hospitals conducted a comprehensive financial analysis that compared three months of actual staffing expenditures to the recommended staffing levels in Table One above. State hospital fiscal staff manually categorized more than three thousand positions to align with the functional categories established by the contractor. In addition, they costed out the recommended staffing levels for each hospital.

In an effort to achieve efficiencies, the Department devoted resources to the development of an electronic financial tool designed to assist with future analysis of staffing levels within all DSHS facilities. The State Hospital Staffing Model (SHSM) application is designed to facilitate the development, analysis, and

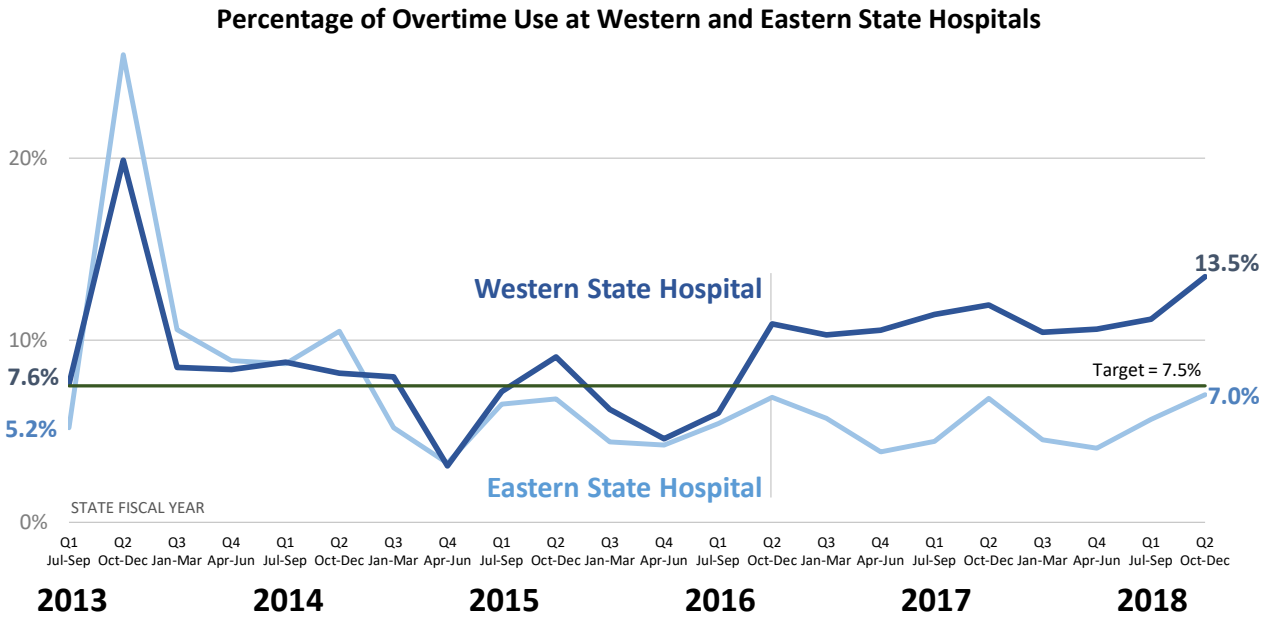
communication of large and complex staffing models. Current efforts are underway to train BHA fiscal staff to use SHSM for future modeling and analysis of current staff expenditures to recommended and budgeted levels.

The state hospitals are also on track to have ward-level allotments (i.e. budgeted amounts) in the Agency Financial Reporting System by mid-October. A comprehensive analysis of actual expenditures to budgeted amounts and recommended levels is scheduled for November/December 2018.

PERFORMANCE METRICS

Because a fully-integrated implementation of the clinical staffing tool and the hospital-wide staffing model has not yet taken place, there are no performance metrics related to and informed by the tool to share at this time. However, the following data reflect baseline information the department currently collects and reports on:

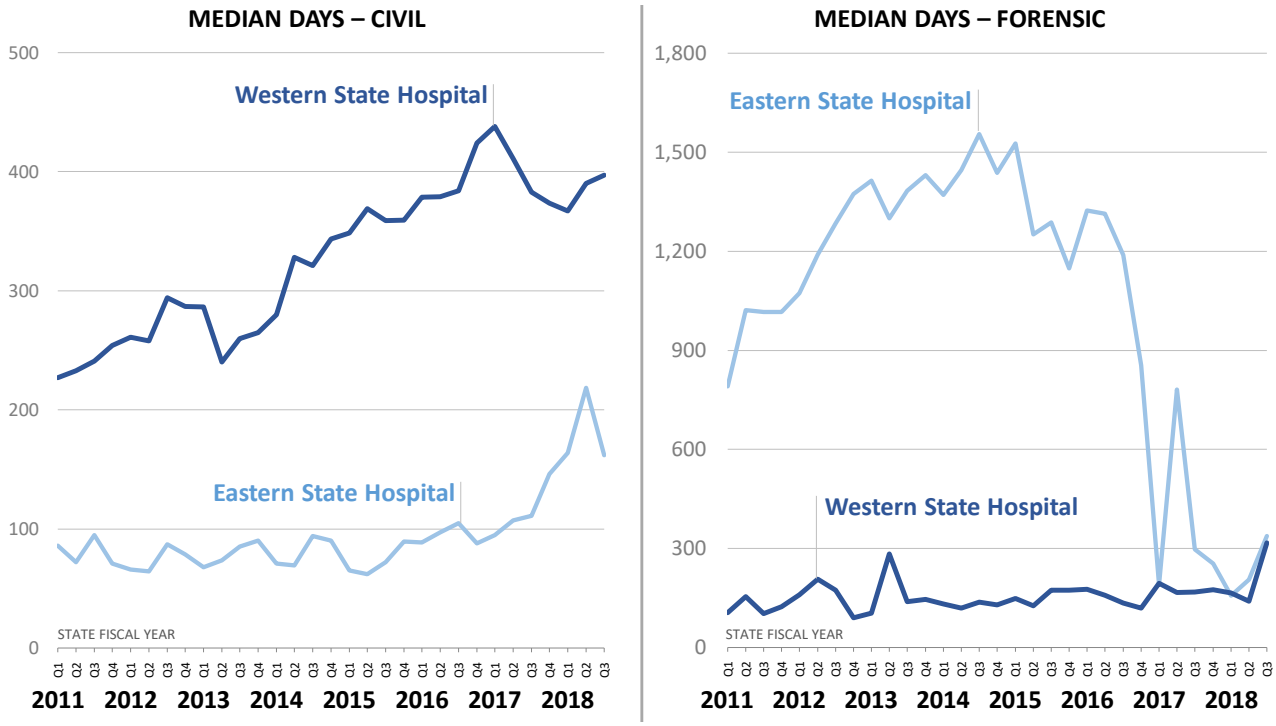
Use of Overtime and Extra Duty Pay



DATA SOURCE: Financial Services Administration's Overtime Report Summary.
MEASURE DEFINITION: Average percentage of overtime use at Western State Hospital and Eastern State Hospital.
DATA NOTES: 1 Each data point represents a quarterly percentage (e.g., SFQ 2016/4 is the sum of total overtime expenditures for SFQ 2016/4, divided by the sum of Object A (employee salary) expenditures for SFQ 2016/4). 2 Includes only Budget Units for Eastern State Hospital and Western State Hospital. 3 Negative amounts in total overtime expenditures and/or total employee salary expenditures are included in the calculation. 4 Zeros are included in the denominator. 5 Includes both disbursements and accruals.

Patient Length of Stay

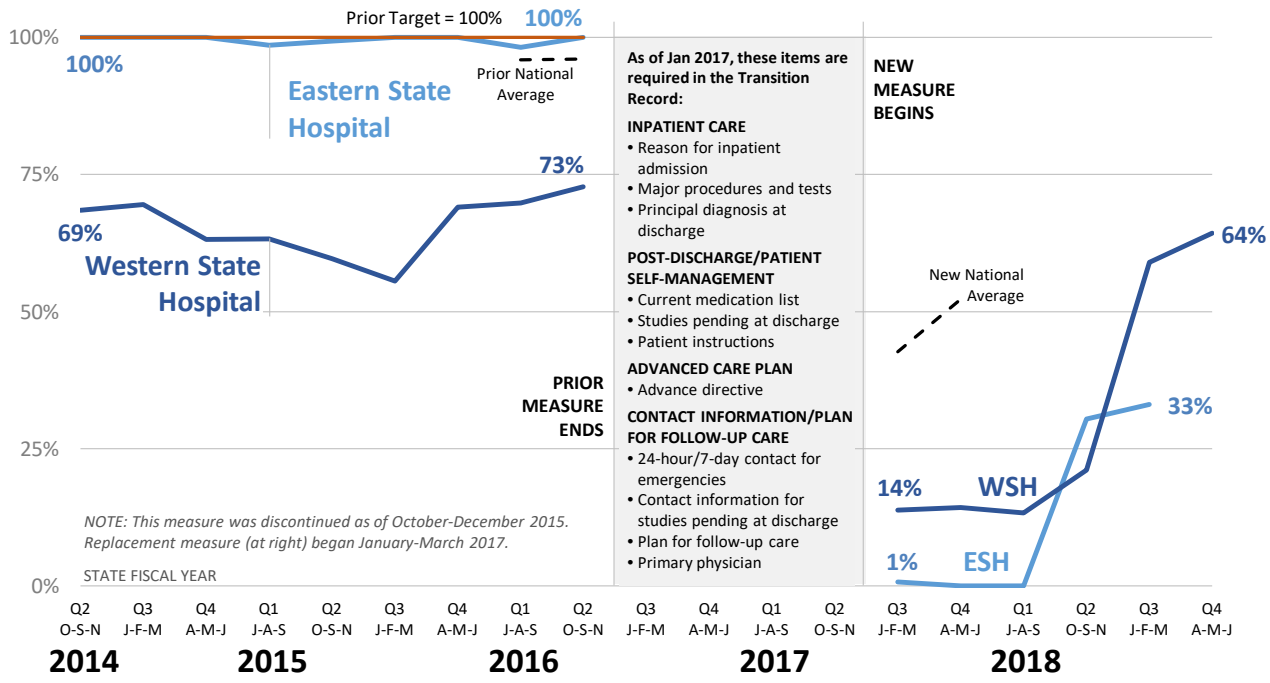
State Hospital Median Length of Stay by Fiscal Year Quarter and Legal Status
Excludes time spent in other inpatient facilities prior to admission at the hospital



DETAIL: Residential days at the hospital, since date of admission, on the first day of each fiscal quarter. No prior inpatient days at Evaluation and Treatment or Community Hospital are counted in the Length of Stay. Legal status reported for the first day of the quarter. Patients who change status (e.g. Forensic to Civil) have their LOS continued in the new status and are reported based on their legal status on the reporting date.
SOURCE: DSHS Research and Data Analysis Division, Integrated Client Databases, February 2018. BHSS SH Daily Census.

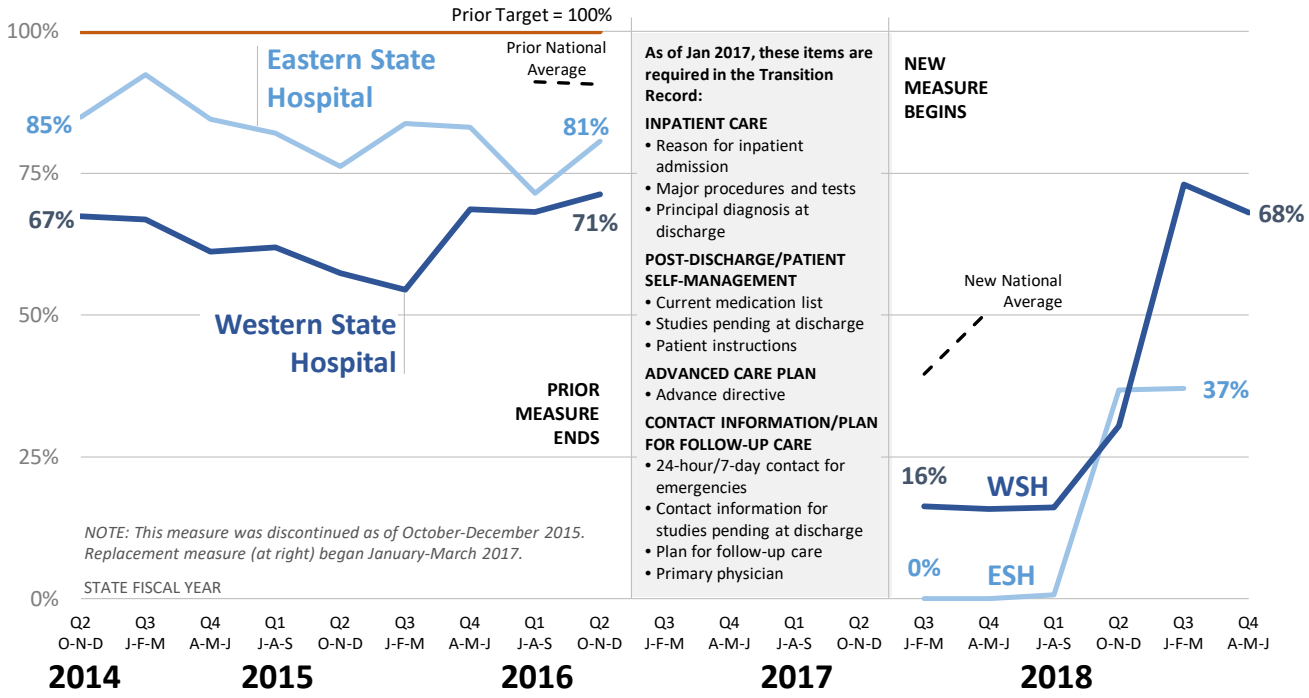
Discharge Management

Overall Rates of Post Discharge Continuing Care Plans Created at Eastern State Hospital and Western State Hospital



DATA SOURCE: Reports from Eastern State Hospital and Western State Hospital. National average from NRI's HBIPS Comparative Statistics Report (HAP and BHC).
MEASURE DEFINITION: Overall rates of post discharge continuing care plan.
DATA NOTES: 1 his measure was discontinued as a Hospital-Based Inpatient Psychiatric Services Measure in 2016. Related replacement measures is used starting January-March 2017. 2 Overall rate calculations: Numerator: Inpatients for whom the post discharge continuing care plan is created and contains all of the following: reason for hospitalization, principal discharge diagnosis, discharge medications and next level of care recommendations. Denominator: Inpatient discharges. 3 Included populations: Patients referred for next level of care with mental disorder diagnoses.

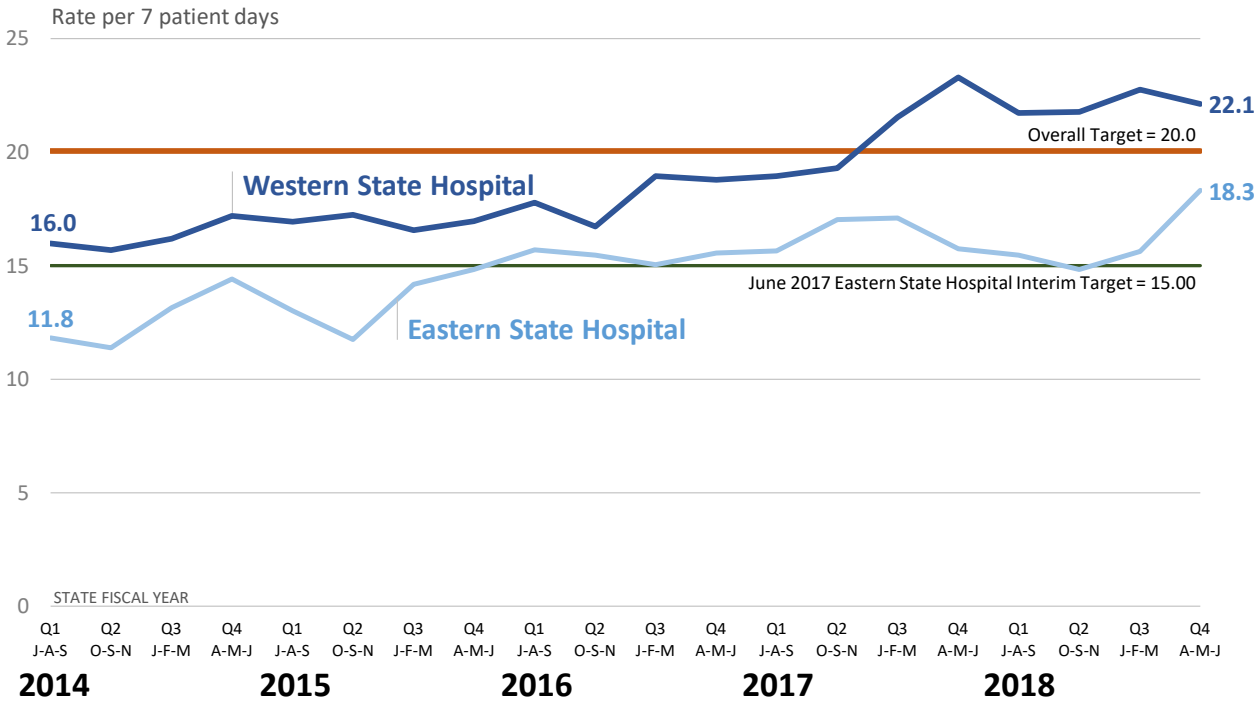
Overall Rates of Post Discharge Continuing Care Plans Transmitted to Next Level of Care Provider upon Discharge at Eastern State Hospital and Western State Hospital



DATA SOURCE: Reports from Eastern State Hospital and Western State Hospital. National average from NRI's HBIPS Comparative Statistics Report (HAP and BHC).
MEASURE DEFINITION: Overall rates of post discharge continuing care plan transmitted to next level of care provider upon discharge.
DATA NOTES: 1 This measure was discontinued as a Hospital-Based Inpatient Psychiatric Services Measure in 2016. Related replacement measures is used starting January-March 2017. 2 Overall rate calculations: Numerator: inpatients for whom the post discharge continuing care plan was transmitted to the next level of care clinician or entity. Denominator: inpatient discharges. 3 Included populations: Patients referred for next level of care with mental disorder diagnoses.

Active Treatment Planning

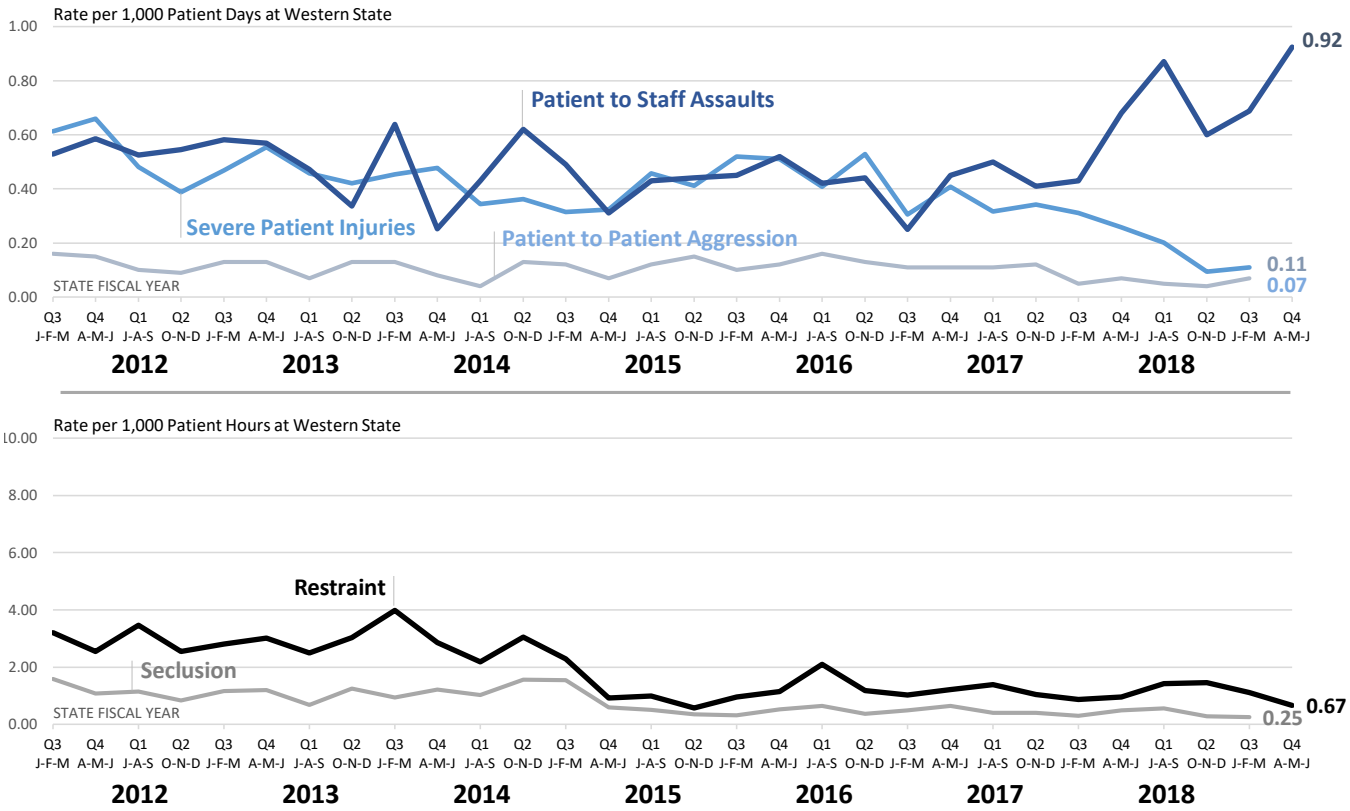
Quarterly Rates of Active Treatment Hours Delivered per 7 Patient Days at Eastern State Hospital and Western State Hospital



DATA SOURCE: Reports from Eastern State Hospital and Western State Hospital.
MEASURE DEFINITION: Active treatment hours delivered (per 7 patient days) during the reporting quarter, at each of Eastern State Hospital and Western State Hospital.
DATA NOTES: 1 The performance targets will be reached on or prior to June 30, 2017. 2 The rate is calculated by dividing the number of active treatment hours delivered in a given quarter by the number of patient days utilized by a state hospital in that quarter; and then multiplying the quotient by seven. 3 Active treatment hours are distinctly tracked for each of the state hospitals, for purposes of calculating quarterly rates by facility.

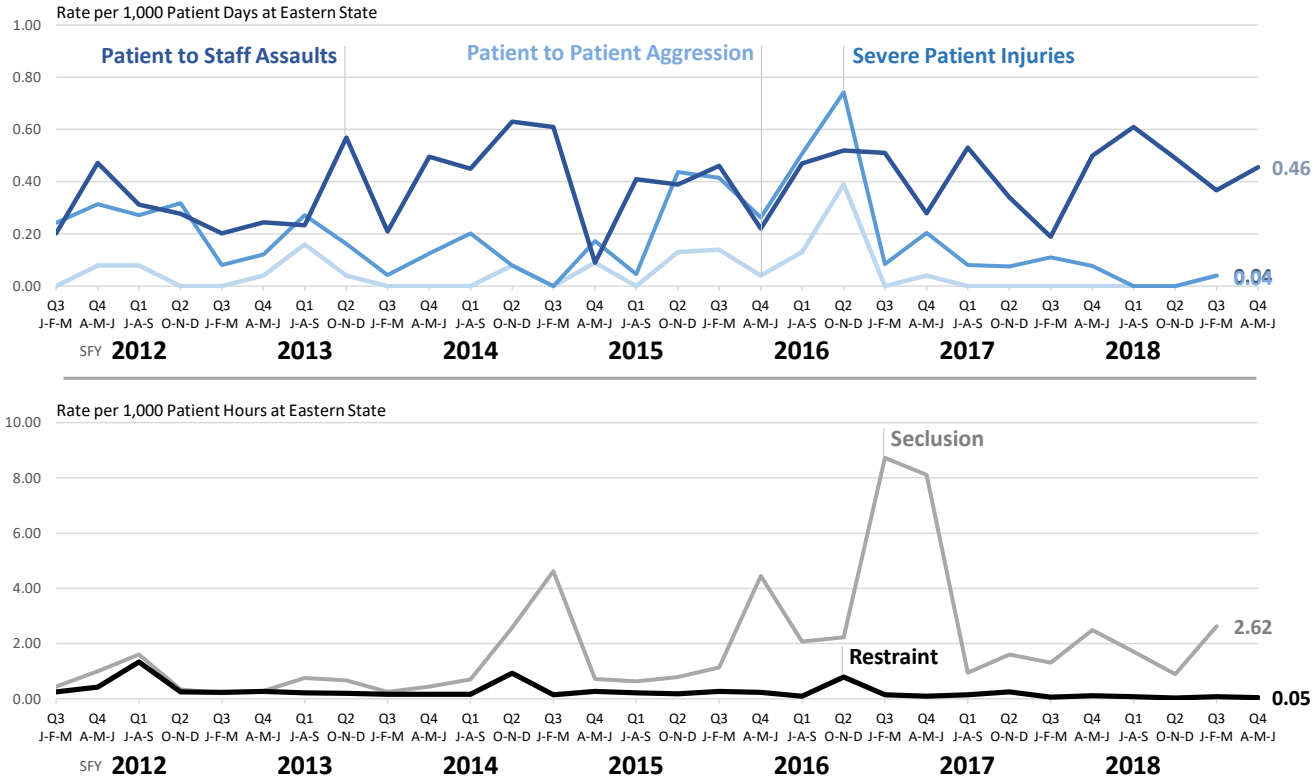
Patient and Staff Aggression

Rate of Aggression, Injury, Assault, Seclusion and Restraint at Western State Hospital



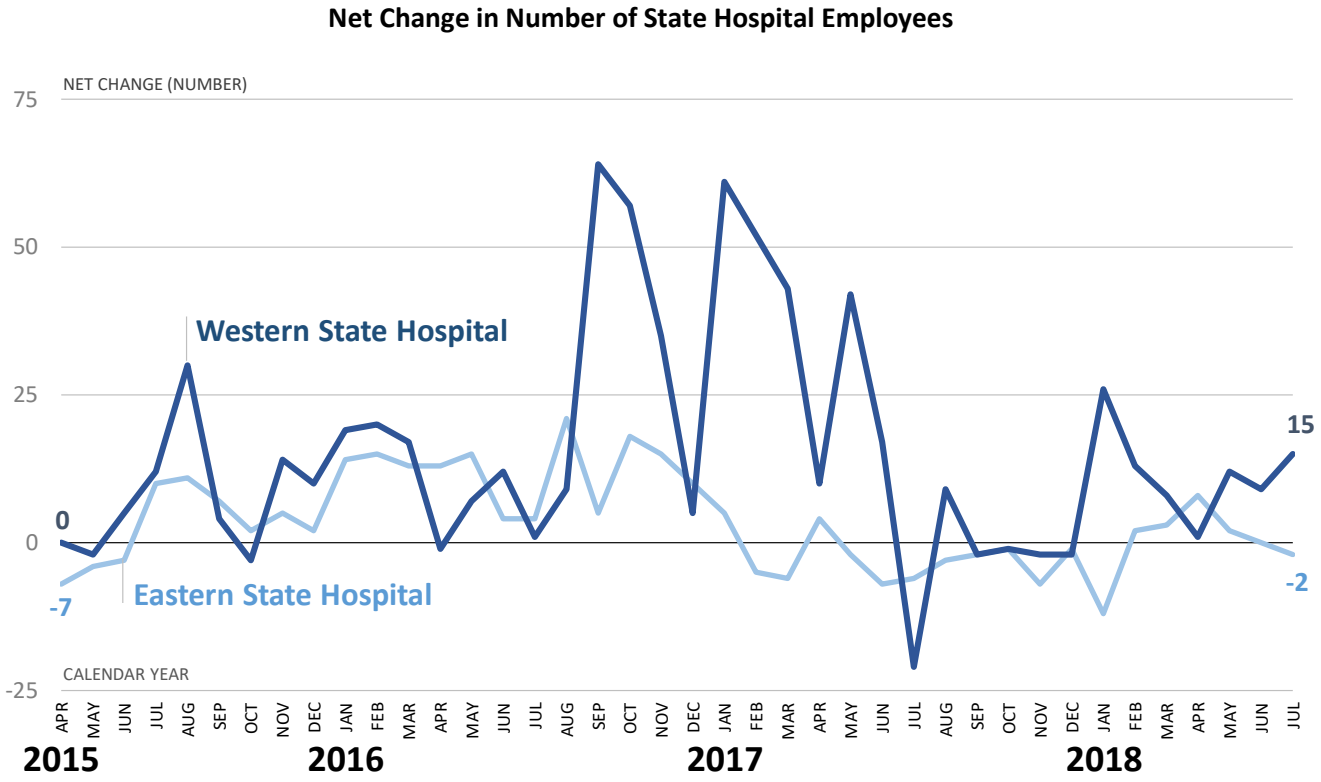
NOTE: Incidents are distinctly tracked for each of the state hospitals, for purposes of mapping rates by facility. 2 An injury occurs when a patient suffers physical harm or damage, excluding the result of a disease process. Severe patient injuries include all patient injuries with a severity level of "3" or higher (3 = medical intervention; 4 = hospitalization; 5 = death).
SOURCES: Reports from Western State Hospital.

Rate of Aggression, Injury, Assault, Seclusion and Restraint at Eastern State Hospital

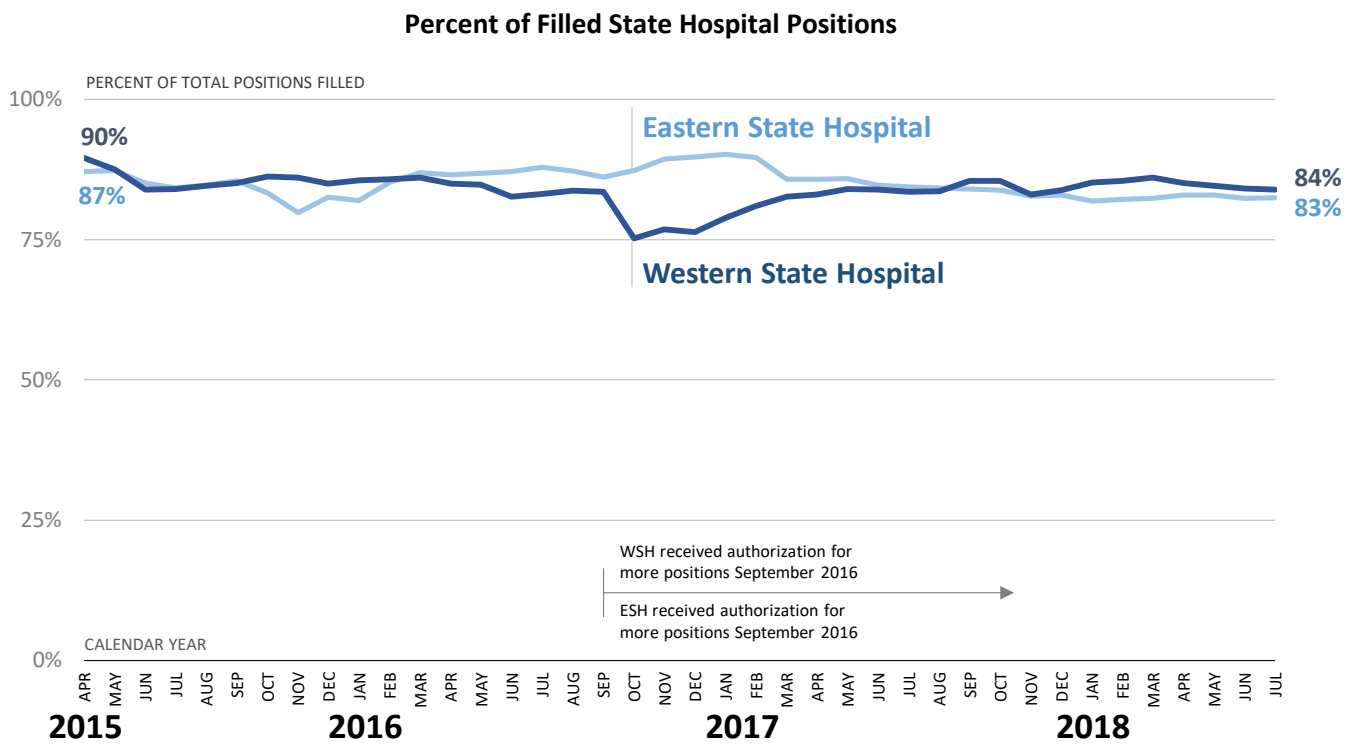


NOTE: Incidents are distinctly tracked for each of the state hospitals, for purposes of mapping rates by facility. 2 An injury occurs when a patient suffers physical harm or damage, excluding the result of a disease process. Severe patient injuries include all patient injuries with a severity level of "3" or higher (3 = medical intervention; 4 = hospitalization; 5 = death).
SOURCES: Reports from Eastern State Hospital.

Staff Recruitment and Retention



DATA SOURCE: DSHS Human Resources Division, Human Resource Management System.
MEASURE DEFINITION: Net change of employees is calculated by gains (new hires) for the month minus losses (attrition).



DATA SOURCE: DSHS Human Resources Division, Human Resource Management System.
MEASURE DEFINITION: Net change of employees is calculated by gains (new hires) for the month minus losses (attrition).

NEXT STEPS

Staffing based on patient acuity is central to ensuring quality patient outcomes, a stable nursing workforce, and financial viability. Acuity-based staffing systems valuably augment nursing knowledge and judgment, and assure accurate and safe staffing. A strategic nurse workforce plan with technology enables a new level of CNO and CFO partnership that supports delivery of the highest possible quality of care, safety and cost management. Next steps and some estimated completion dates include but are not limited to:

1. A draft policy to be completed by October 1, 2018.
2. Gap analysis to be completed by October 1, 2018.
3. Identify and pilot the best-fit technology.
4. Validate precision of the acuity data and methodology.
5. Define, plan, and implement new workflow, decision-making, and collaboration within nursing and the scheduling office by December 1, 2018.

6. Develop a program and educate nursing and scheduling on the value and the use of the acuity-based model tool.
7. A decision package for the 2019-2021 Biennium, requesting additional direct care staff, includes additional resources for a float pool to help close the gap on nursing shortages and reduce the use of overtime.

Once implemented, nurses will quickly enter the patient data into the computer, then the charge nurse or unit manager can run a report. There may be many patients with high acuity - or just the opposite (e.g. most of the patients are ready for discharge). When the report indicates that patient acuity is likely to be high on the next shift or next day, the unit manager may decide a "float nurse" is needed. The acuity system can also help the manager decide exactly where to place float nurses and others, so that the patients with the greatest needs are in the care of the most experienced nurses or those with specialized skills. This reflects the need to focus on both tasks, as well as on the cognitive skills and knowledge that are crucial to expert nursing care – patient assessments, nursing interventions, and patient advocacy, for example.