

**State Staffing Solutions Sharing Call**

**February 14, 2022**

**1:00 PM – 2:00 PM**

Participants: Jana Bitton, Mary Val Palumbo, Lanelle Weems, Kim Harper, Diane Hountz, Jane Mahowald, Tener Veneman, Sue Tedford, Rayna Letourneau, Meggin Lorino, Craig Donahue, Sofia Aragon, Lindsay Olson, Willa Fuller, Jordyn Reed, Jana Bitton, Heather O’Hara, Lori Scheidt, Pam Lauer, Matthew Clark, Marcia Proto, Lascelle Grizzle, Jenny Horn, Pam Lauer, Laura Reichhardt, Rebecca Wiseman, Linda Roberts

During this call we shared ideas related to state staffing solutions that were started through an email thread on the Forum. Snippets from the email conversation are below followed by notes from each state from the phone call.

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From Diane Evans- New Mexico:

So what if states developed their own Nurse Corps – an agency that is not-for-profit and ideally state run – where the vast majority of the nursing workforce is assigned to care clusters (critical care, peds, OB, psych, etc.).

* The State Nurse Agency would pay more than what the hospitals but would have much less overhead costs to operate. We could negotiate better benefits because we’d have the power of numbers. We could offer PENSIONS rather than 401Ks. So long as the increase cost and agency overhead remained below what the hospital already pays a nurse for salary and fringe, it would not drive up payroll costs to the hospitals.
* Hospitals would retain Unit Managers, Unit Based Educators, Charge nurses, and other key positions as facility employees to ensure CQI initiatives are met.
* Nurses would be credentialed centrally, providing maximum flexibility to meet shifting staffing needs.
* Training is inherent to the agency.
  + All grads would enter some kind of transition to practice – in both acute care and in non-hospital settings (like LTC).
  + In times of crisis, nurses whose clinics are temporarily shuttered could engage in mentored cross training so that they could be pulled to appropriate areas of need.
    - Competency in care clusters could be measured as a combination of knowledge and direct skill assessments. There could be incentives to be measured as competent in more than one work-group care cluster (critical care and med/surg as an example).
    - The agency could also help preserve nurses. Let’s say a hot-shot critical care nurse is injured to the point they can’t work adult care anymore. The state Nurse Agency could continue to pay that nurse at a lowered rate while they cross trained to another specialty – like neonatal ICU or case management. The training would be rigorous, making it so they would have the knowledge, skills, and attributes needed to pass CCNE specialty exams.
* This would allow the state’s nurses to work in their respective states, delivering culturally competent care to our own.
* It would take a lot to implement. The logistics would be daunting.
* We would absolutely need healthcare partner buy in. For something like this to work, participation by healthcare employers would likely need to be incentivized. If the State Nurse Agency received seed money from the state, that could fund set up and initial roll-out. There might be some options on state tax breaks for participation. Upon successful launch, I have no doubt CMS would be interested. Federal incentives definitely outweigh state ones.
* This would take considerable collaboration. We’d need education, employers, regulators, and legislators to be at the table at the same time, for sure. I reside in a state where this type of conversation happens a lot and I think we could get traction without too much heartache.

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From Garret Chan- California

California has had something similar to a statewide “float pool” and has also created a “centralized” staffing agency. Remember, California is very large with over 45 million people and a geography that can hold 21 New Jerseys, for example.

California’s Emergency Medical Services Authority (EMSA) created regional Medical Health Operational Area Coordinators (MHOACs).  These regional area coordinators can help find staff for their catchment areas.  Please see this [link](https://emsa.ca.gov/covid19/).  There are several sections I’d like to point out:

* Authorization of out-of-state medical personnel
  + Current statute allows EMSA to credential out-of-state personnel to come in and work within California without a California license in certain disasters.  These out-of-state licensees are not overseen by the individual health professional boards.
* Healthcare Facilities Urgent Staffing Needs
  + This section of the website has the California Department of Public Health’s All Facilities Letter (AFL) that clarifies the process for requesting staffing resources.
* Local Hospital Staffing Requests
  + This section has the MHOAC contact list.

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From Jana Bitton- Oregon

<https://www.intlnursemigration.org/2022/01/24/new-report-calls-for-global-action-plan-to-address-nursing-workforce-crisis-and-prevent-an-avoidable-healthcare-disaster/>

Maybe at the workgroup we talked about yesterday we can review this action plan. I'm interested to see if there is support for the recommendation of conducting nurse workforce impact assessments. What would that look like at a state level?

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From Patricia Moulton Burwell- North Dakota

ND proposed a centralized staffing concept at our 2021 Legislative Session last year- but it didn’t get anywhere. So not funded and not pursued in North Dakota.

Here is a link to the policy brief: <https://www.ndcenterfornursing.org/wp-content/uploads/2021/03/FInal-Draft-Revised-Center-for-Nursing-Policy-Brief.docx>

The bill itself was pretty vague. But here is a link to the bill information:  <https://www.legis.nd.gov/assembly/67-2021/bill-actions/ba2198.html>

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From Dawna Cato- Arizona

Some of you may have already seen this article by Rose Sherman, but thought I would share amongst this group….

Are There Really Enough Nurses? - Emerging Nurse Leader

<https://www.emergingrnleader.com/are-there-really-enough-nurses/>

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Notes from Sharing meeting:

* New Mexico- Started with a concern about traveling nurses- culture issues, thought about developing their own Nurse Corps – an agency that is not-for-profit and ideally state run – where the vast majority of the nursing workforce is assigned to care clusters (critical care, peds, OB, psych, etc). The State Nurse Agency would pay more than what the hospitals but would have much less overhead costs to operate. We could negotiate better benefits because we’d have the power of numbers. We could offer PENSIONS rather than 401Ks. So long as the increase cost and agency overhead remained below what the hospital already pays a nurse for salary and fringe, it would not drive-up payroll costs to the hospitals. Hospitals would retain Unit Managers, Unit Based Educators, Charge nurses, and other key positions as facility employees to ensure CQI initiatives are met. Nurses would be credentialed centrally, providing maximum flexibility to meet shifting staffing needs. All grads would enter some kind of transition to practice – in both acute care and in non-hospital settings (like LTC). In times of crisis, nurses whose clinics are temporarily shuttered could engage in mentored cross training so that they could be pulled to appropriate areas of need. Competency in care clusters could be measured as a combination of knowledge and direct skill assessments. There could be incentives to be measured as competent in more than one work-group care cluster (critical care and med/surg as an example). The agency could also help preserve nurses. Let’s say a hot-shot critical care nurse is injured to the point they can’t work adult care anymore. The state Nurse Agency could continue to pay that nurse at a lowered rate while they cross trained to another specialty – like neonatal ICU or case management. The training would be rigorous, making it so they would have the knowledge, skills, and attributes needed to pass CCNE specialty exams. The nursing shortage in NM was estimated to be 6200 before the pandemic. The nursing gap in NM is expected to grow by 9% annually over the next decade. If the healthcare providers paid a salary above their current base, while being disencumbered of the 35% fringe, that actually reduces the facility bottom line- would be a State Nurse Corps. In NM, our average nurse age increased by 5 years, suggesting that we're losing the millennial nurses... Looking at charting - crisis standards have decreased the amount of charting - I just don't see staff nurses going back to the pre-covid level of documenting.
* North Dakota- developed a policy brief to provide sustained funding to the ND Center for Nursing by creating our own travel nurse staffing model to provide for more flexible recruitment of nurses and undercut the out-of-state travel nurses.
* West Virginia- offering a $12,000 relocation bonus to West Virginia, a large hospital has bought out smaller hospitals and have a travel nurse pool, have $48 million to spend- could possibly use some of this money for something like this. WV Higher Education Policy Commission just got 48 million in nursing workforce development from CARES Act Funding. While we do have a short turn around on these funds (must be spent by September 30), there is the possibility that some of these funds might be able to be directed to this issue if there is a way to spend the money fast on an idea generated. Housing is not a significant issue in WV. We have low cost of living anyways. Rental places might be more limited in more rural areas, but they seem to have more places around where healthcare facilities are. Housing is not a significant issue in WV. We have low cost of living anyways. Rental places might be more limited in more rural areas, but they seem to have more places around where healthcare facilities are.
* Oregon/Washington- Collective bargaining units would shut this type of program down unless they were able to drive it
* Washington- need to be careful about skirting workplace safety and culture issues that are making nurses want to leave, how do you keep a nurse staying, WA State Hospital Association estimates a shortage of 4,000 staff nurses. Housing and standard of living is important. Here's a projection study looking ahead to 2030. We also knew there would be a shortage: <https://www.wcnursing.org/wp-content/uploads/documents/reports/2011-December-WCN-WA-State-RN-Supply-and-Demand-Projections-2011-2031.pdf> Here's a policy brief: <https://www.wcnursing.org/wp-content/uploads/documents/reports/2011-December-WCN-WA-State-RN-Supply-and-Demand-Projections-2011-2031-Policy-Brief.pdf>
* Hawaii- Hawaii got a list of nurses in 2020 that were available to work, and we funneled them all to one local staffing agency. It was clunky, but we didn’t have the end in mind that Diane envisioned.
* Vermont- would it work between 2 large organizations to collaborate a travel nurse pool?, I think the 50 something nurse decided this is to much, need to dust off strategies for an older nurse- would they like to travel within the network, look at flexibility in shift length etc. No rental housing available and cost of buy a home very high in VT
* North Dakota- large hospital systems have their own travel nurse pool
* Mississippi- Mississippi is down 3000 nurses in hospitals, no union, hospitals have a difficult time getting travel agency in, thinking about whether the travel agencies would try to shut it down,
* Arizona- Honor Health has a float pool for six hospitals that work together. In Mississippi, housing in the rural areas is minimal.
* Florida- The Florida Hospital Association predicts a nursing shortage of ~59,000 by 2035. That should be inherent in nursing care. Cultural competence. We can't know everything, but we should know when to ask. There are some conversations happening, a lot of the times nurses are not invited. Conversations about delegation have been happening etc. One of the recurring themes for decades is "Workplace Redesign" but I have seen very little evidence that anyone has really delved into this. The bottom line is creating and environment in which nurses feel safe and supported as well as included in the decision-making process.
* Montana- Yes, housing is a challenge in Montana from our smallest communities to our largest
* South Dakota- In South Dakota housing is very challenging in the more rural and western part of our state
* Maryland- have we stopped to think about how we could use nurses differently, or do we want to redefine what nurses bring to the table

State Impact Assessments- would states be interested in the Forum conducting this type of research? /<https://www.intlnursemigration.org/2022/01/24/new-report-calls-for-global-action-plan-to-address-nursing-workforce-crisis-and-prevent-an-avoidable-healthcare-disaster/>

These travel nurse agencies are mostly nationwide- so there may be a national role for the National Forum- there is no consideration for ensuring staffing across states.

Nursing is part of the room and board costs- Oregon, Washington is working on the value of nurses. NCSBN is creating a national nurse number that could be tied to billing.

Is anyone working with the National Governors Association/individual governor's offices? The State AARP chapters? State Chamber of Commerce? The nursing shortage is hurting businesses and communities. These groups can help with solutions and push legislators to fund solutions and workplace improvements.