2022 Research

Restoring a Safe and Thriving Healthcare Workforce

Executive Summary

Problems arising from, exacerbated by, and illuminated by the COVID-19 pandemic have caused levels of stress, burnout, and moral injury among healthcare team members that have, in turn, precipitated an exodus of healthcare professionals. Amid a nation-wide Great Resignation, healthcare team members are clamoring for safer work environments that safeguard their psychological and emotional safety, protect their physical safety, and promote health justice by declaring equity and anti-racism core components of safety and requiring focused policies and practices to advance diversity, inclusion and belonging.

And leaders are listening. In our in-depth interviews with almost 30 c-suite healthcare executives and industry experts across the country, we learned that forward-thinking health systems are investing in resources, processes, technologies, leadership changes, and culture transformations that improve team member safety and well-being. These investments address both the proactive need to shift work and work structures to be more supported and less trauma-inducing, as well as the reactive need to provide resources for recovery from the overwhelming disruption and trauma of the pandemic.

Health system leaders are also seeking acknowledgement that shared responsibility for healthcare team member well-being is needed from all stakeholders – internal and external – whose decisions, policies, and investments affect the ability to provide systemic safety.

The Current State

Healthcare team members in the US have experienced extreme challenges over the past two plus years of the pandemic. They started out in fear for their lives, faced with a novel virus whose transmission mechanisms and treatments were uncertain, in the midst of a global supply crisis of personal protective equipment. Then came a racial justice movement together with a growing recognition that the virus brought the highest mortality rates to communities of color and those who already shouldered greater burdens of poverty and pre-existing conditions. Then, there was a new surge of the virus with rising death rates and increased crowding in hospitals across the country. And all of that was just in 2020.

Since then, healthcare team members have experienced the ups and downs of political tensions, visitor restrictions, vaccine mandates, virus waves and variants, and the uncertainties of volatile labor markets that have led some to seek better pay through travel positions, while others try to hold their cultures and work environments together. Still, many others have chosen to leave the healthcare profession altogether, unable to find a feeling of safety, well-being and value in environments where some patients yell at them for requiring masks, while others complain because visitors, families, and other patients won't wear them.

The result is a workforce that is, in the words of one interviewee, "bruised." Team members and leaders alike are depleted and exhausted. They have experienced stress, trauma, and moral injury. Some can see the light at the end of the tunnel, while others are questioning the professions to which they have devoted their training, service, and souls.

Leaders across the country are looking for strategies to preserve, restore, and enhance the safety and well-being of their teams. They know that team members need time for healing, rebuilding, and reflection. And they know the issues and challenges that existed before the pandemic have been exacerbated by two-plus years of a public health emergency and now a growing staffing crisis.

In other words, leaders are working to simultaneously create conditions for recovery while building the foundations for transformation. That transformation is focused not only on the core concepts of the Quadruple

Aim (higher quality, reduced cost, better patient experience, and joy in practice), but also on creating the conditions for systemic safety and well-being: creating a healthcare system that is more likely to keep team members safe, whole, and growing than to create unhealthy levels of stress, burnout, and trauma.

Restoring a Safe and Thriving Healthcare Workforce

To understand how leading organizations are building systemic safety and well-being, we spoke with experts and executives at organizations who are part of the CEO Coalition, a group of health systems redefining team member safety to include protecting psychological and emotional well-being of team members, promoting health justice by declaring equity and anti-racism core components of safety, and preventing workplace violence, both physical and verbal.

We asked our interviewees to talk about the pandemic practices they were planning to maintain, the near-term resources they were employing to help team members recover from the trauma of the past two-and-a-half years, and their mitigation and transformation strategies they were employing to create systemic safety and well-being for all team members. In addition, we asked them to shed some light on the external factors that help or hinder their efforts to meet those goals.

This report is laid out in six categories followed by an overview of the support that hospital and health system leaders need from external stakeholders who impact their efforts. Each of the six categories of transformation includes an inventory of practices, plus a series of illustrative stories that brings more depth to key practices. The categories are:

- Talent Acquisition and Retention
- Wellness Support
- Process and Technology Improvement
- Workplace Violence Reduction
- Equity and Anti-Racism
- Human-Centered Leadership

Talent Acquisition and Retention – Inventory of Practices

Being short-staffed adds to team members' workload, stress, and cognitive and emotional burden. Leaders are exploring practices that allow them to source new talent quickly, and support team members in growing skills, solving challenges, and building meaning, purpose, and relationships. They are also re-examining benefits to ensure that team members feel supported and cared for as whole human beings.

Hiring and Sourcing Talent	• Create work pathways with community colleges, nursing schools, etc. • Invest in upskilling (e.g., IT) in under-resourced communities. • Create an in-house academy for medical assistants and other roles. • Assess job requirements, especially whether degrees are required. • Create full-time roles for talent acquisition at hospitals within multi-hospital systems and fill those roles with skilled people. • Employ predictive modeling or artificial intelligence (AI) to identify talent needs (skills, strengths, capacity); post jobs automatically (based on predictive modeling/AI) to reduce effort, resources, and time. • Hire "gig workers" who work shifts as needed/desired. • Create flexible programs to bring retired clinicians back to work with different titles, roles, responsibilities, and compensation structures. • Explore including newly licensed nurse practitioners (NPs) in the nursing coverage model rather than the provider coverage model. • Consider augmenting US recruiting staff with overseas support.
Onboarding and Skill Development	• Mix virtual and in-person orientations. • Ensure onboarding and relationship building begins before start dates. • Change orientation to be less task-focused and more about relationships and culture. • Identify key moments on the team member journey (30-60-90-120-365 days) and resource around each. • Build career paths up for all roles, including all entry-level roles. • Define a professional pathway for all nurses (skill and compensation development). • Include personal safety and well-being in skill development programs. • Build retention plans around concepts such as feeling valued (having the resources and staff needed to do the job well) and connection (having mentors to foster growth). • Maximize investments in person-aligned professional development. • Conduct pulse surveys or anniversary surveys instead of monolithic engagement surveys to create ongoing feedback/improvement mechanisms. • Create recognition and/or new role opportunities (including changes in comp, title, etc.) for experienced bedside clinicians who want to stay in the role. • Identify emerging leaders who took stretch assignments and nurture their growth. • Focus less on degrees and experiences and more on skills and capabilities. • Conduct exit interviews (all roles) to identify key areas for improvement.
Compensation and Benefits	• Assess compensation (all roles) and raise proactively to at or above market. • Re-examine compensation structures to attract team members to after-hours shifts. • Examine benefits with input from team members – including trade-off analysis (student loans, childcare, PTO rollover, etc.). • Align physician compensation structure with values (less RVU, more value-based care). • Expand mental health benefits for greater access, lower out-of-pocket costs. • Take the long view on employee experience versus well-being (e.g., team members seek overtime for near-term financial benefit, but does it support long-term well-being?). • Offer more individual choice in benefits and compensation options.

Talent Acquisition and Retention – Stories

Providence – The Four D's of Workforce Transformation

When looking at workforce transformation, Providence's EVP and Chief People Officer, Greg Till, MS, MA, and System CNO Sylvain Trepanier, DNP, RN, outlined "Four D's" to help overcome long-term staffing shortages:

- **Deconstruct**: Break down roles to their essential work components and rebuild them to improve joy in practice and accommodate new models and places of care. To accomplish this, Providence is embracing team-based care models to ensure top-of-license practice for clinicians. When non-licensed individuals can do work, it is assigned to them. As part of this work, leaders reconsider staffing models and work to identify and eliminate the 30-40% of clinician administrative time.
- **Digitize**: Simplify administrative work with automation to ease caregivers' work. To reduce friction, Providence deployed chat bots that answer simple questions. To streamline work, they built user-focused dashboards that help managers track everything from where a candidate is in the selection and onboarding process to where they may be overusing agency or overtime. And Providence is using predictive intelligence to automate nurse scheduling and "hire ahead." Their new nurse scheduling system has reduced the three-to-four hours of manual scheduling down to three minutes, while enabling the use of variable shift length and text communication. Predictive hiring software allows the organization to project staffing needs 3-6 months into future, so requisition can be opened ahead of the need.
- **Diversify**: Find new sources of talent and restructure work. Providence is creating models to make better use of gig workers, international workers, and retirees who want to continue working in different models. They have created four-, eight-, and 10-hour shifts, and shifts that focus on specialized tasks so nurses have more flexibility in when and how they work. They are also exploring virtual teams to help assign work to the best qualified team members, such as having pharmacy techs doing med reconciliation virtually with patients and family members, and virtual patient education, etc.
- **Deploy**: Use talent flexibly to quickly deploy caregivers by need and value. As Mr. Till shared, "Flexibility is the new engagement capital." They are looking at ways to move people virtually and physically across boundaries. Providence leaders support advocacy aimed at establishing cross-state licensure. They have also centralized and standardized scheduling and availability practices across the system.

SSM Health – "Stay Interviews"

Exit interviews provide insights into challenges and opportunities for improvement. But when an exit interview happens, it's too late to retain a team member or their training and expertise. To get ahead of these concerns, SSM Health is hardwiring "Stay Interviews" to proactively uncover any issues or opportunities for support. In addition, Stay Interviews allow leaders to strengthen their relationships with individual team members through purposeful conversations about future plans, sense of purpose, and joy and fulfilment in work. The goal is to identify trends and improve retention systemwide. "We've had a very positive response since implementing Stay Interviews in January," said Janet Smith-Hill, Chief Human Resources Officer at SSM Health. "We are building new leader tools, tracking systems, and learning, including opportunities to practice these critical conversations."

Wellspan Health – Easing Financial Burdens for Team Members

Part of retaining a safe and vibrant workforce is ensuring team members see a path for growth, and that they don't get derailed by financial setbacks. In addition to providing a tuition reimbursement program to help team members build skills and advance their careers, Wellspan Health introduced a program called DailyPay during the pandemic. This allows team members to access hourly pay they have already earned at any time (for a nominal fee), without waiting for their biweekly paycheck. "If team members can avoid a late fee or pay upfront for something they need, it can really help them out," said Bob Batory, MBA, SVP and Chief Human Resources Officer. And if team members experience a unique hardship, they can apply for help from the Family Help Fund to cover basic costs such as food and rent. The fund paid out more than $200,000 over the course of the pandemic.

Wellness Support – Inventory of Practices

Because of the pandemic, team members have experienced extensive fear, exhaustion and loss, as well as a tremendous weight of personal, professional, and family stress. Leaders emphasized that providing access to well-being resources is a critical baseline, but that their efforts are focused on making systemic changes that will reduce the levels of stress and trauma team members experience. They also reported a positive shift in the healthcare culture, recognizing that seeking psychological, emotional, and physical support and embedding well-being into core processes is an essential part of good healthcare practice.

Individual	• Streamline access to mental health support onsite and or virtually. Provide a mental health helpline (both immediate support, listening, and steering to ongoing resources). • Conduct brief well-being sessions – record them for access at any time. • Build an online well-being community (virtual fitness, guided meditation, yoga, etc.). • Offer resources for life (not just work) support: legal services, financial planning, childcare, eldercare, cleaning services, meal services, etc. • Upgrade EAP to the "Cadillac" version (more free sessions, lower co-pays for resources). • Experiment with therapeutic break experiences (e.g., virtual reality). • Conduct resilience skills training. • Use a validated well-being measurement tool for individual assessment, organizational benchmarking, and identification of improvement opportunities. • Train caregivers in "e-CPR" (emotional CPR) to enable them to support their colleagues. • Offer unlimited virtual mental and emotional health support.
Unit/ Department	• Bring resources such as psychologists, chaplains, therapy groups, chair yoga, massage chair programs, etc. to care units and departments; shift focus from coping to processing as appropriate. • Make spiritual support proactive (push, not pull). • Appoint wellness champions to integrate well-being practices into daily work • Deploy integrative medicine to all floors. • Ease access to resources by posting QR codes in breakrooms and on rest room doors. • Re-establish shared decision making. • Incorporate recognition and gratitude into daily work (huddles, metric boards, etc.).
System	• Appoint a system executive or committee responsible for overseeing well-being. • Create an enterprise-wide health and wellness strategy. • Create a single access point for mental health resources (intranet, help line, etc.). • Invest in peer support – across all roles. • Engage holistically trained nurses to bring their skills (healing touch, mindfulness, meditation, therapeutic communication, etc.) to team members – and pay them for it. • Implement a Code Lavender program (including support for responders). • Pursue AMA's Joy in Medicine designation. • Increase leader rounding – problem solving, communication; listen more, talk less. • Shift metrics from person-focused to cultural well-being. • Build competence among support pros to understand and respond to collective trauma. • Conduct Schwartz Rounds, incident debriefs, etc. • Incorporate personal, team, and system well-being into professional and interprofessional practice models. • Include well-being metrics in leader, organization, and board dashboards for accountability. • Hold a well-being and/or trust symposium to solicit input and learning, align on meaning, and create shared definitions and processes.

Wellness Support – Stories

ChristianaCare – Healthcare Cultural Competency for Community Mental Health Professionals

One of the reasons clinical professionals sometimes fail to find effective mental health counseling is that many mental health professionals lack training to understand the medical culture in which clinicians experience tremendous pressure, stress, and trauma. Clinicians' decisions may result in life or death, harm or healing – and these decisions occur in environments of imperfect information and sometimes insufficient time and resources.

Recognizing this, a team of clinician leaders at ChristianaCare, University of Utah, and Nemours Children's Health used grant funding from Delaware Health Services Alliance to conduct mixed-methods research that led to the creation of a two-hour training module for community mental health professionals to build cultural competency in treating clinicians. Based on surveys and in-depth interviews with nurses, physicians, and mental health professionals who specialize in clinician well-being and/or provide psychotherapy to clinicians, the module is accredited by the Delaware Psychological Association, an affiliate of the American Psychological Association.

The module assists mental health professionals in building a clinician-sensitive practice, including: 1) education to increase understanding of the culture of medicine, common experiences of clinicians beginning in training and extending throughout their career, workplace hazards, and common barriers to help-seeking, 2) logistical considerations such as adjusting your late cancellation policy, flexible scheduling; and 3) specific strategies to enhance treatment alliance and improve treatment outcomes.

ChristianaCare is currently piloting the training with mental health practices across the states of Delaware, Pennsylvania, and Utah with the goal of then expanding it across its EAP network, and, ultimately, to share it with the American Psychological Association for broader dissemination to state social work and psychological associations, EAPs/insurance panels, graduate education programs, and systems through groups such as the American Hospital Association, etc.

The Christ Hospital Network – Resilience Training Based in Sports Psychology

Resilience training is often met with skepticism or even hostility. Beleaguered team members are often unwilling to engage with tools designed to build individual competency when they see system processes, policies, and workflows undermining their well-being. Nevertheless, even well-designed and well-resourced healthcare environments expose team members to pain and loss, which can create unnecessary trauma and burnout if team members lack the tools to tools to support their emotional, psychological and physical well-being..

Leaders at The Christ Hospital Network worked with Michael Sherman, founder and owner of Mentally Tougher, a consultancy specializing in coaching resilience for soldiers, law enforcement, firefighters, and athletes. The Christ Hospital Network was the first healthcare organization to apply Mr. Sherman's sports psychology "These skills can be transformational," said Christy Miller, PhD, RN, Director Nursing Administration. "The feedback has been very positive. People are saying, 'thank you for this gift.' Someone even 'unresigned' after taking the training."

Hackensack Meridian *Health* (HMH) – Behavioral Health Navigation Program

During the pandemic, healthcare leaders added many new resources to support team members' psychological and emotional well-being. But in listening tours and leader rounds, many learned that team members often didn't know what was available, didn't know which resources were right for them, and didn't know how to access them.

To address this, HMH's Chief Wellness Officer, Amy Frieman, MD, MBA, FAAHPM, spearheaded the creation of a behavioral health navigation program. The program is staffed 24x7 by behavioral health team members and serves two purposes: First, the counselors are equipped to help manage a moment of crisis (e.g., a team member wants to vent about a difficult shift). But it is also a one-stop shop for many behavioral health services. Counselors listen to the team member's concerns, identify the services that best align with team member needs, and then facilitate a warm handoff to those resources. "This started on a voluntary basis," said Dr. Frieman, "and now it's funded. We've helped many team members who were truly in crisis. To me, that means the line pays for itself."

Process and Technology Improvement – Inventory of Practices

Well-being practices alone won't stem the tide of burnout or resignations. Leaders are examining approaches to changing the work of healthcare to support physical and emotional well-being from the get-go.

Integration of Well-being with Core Safety Processes	• Conduct root cause analysis (RCA) and provide support (e.g., peer support) for every distressing event (e.g., death of a patient), or a safety event (e.g., near miss, death of a caregiver). • Integrate team member well-being into training, concepts, processes, routines, and rituals for patient safety and operations (e.g., Lean, high reliability (HRO)). • Extend safety processes (e.g., HRO) beyond clinical teams to include housekeeping, etc. • Introduce human factors experts to improvement teams. • Employ "humane factors engineering" practices to all process redesigns. Ask: is it kind and does it align with the mission? • Focus process improvement on increasing team member empowerment and autonomy. • Make processes simple and reliable (Lean, Six Sigma, HRO). • Build trust and psychological safety explicitly into all processes, especially safety recovery and learning processes (e.g., only move onto learning when team members are fully recovered and ready to address change).
Changes to the Work	• Implement teamwork support processes such as nurse-physician daily rounding (aka "Plan of Care Daily Visit") and report compliance at tiered organizational daily huddles. • Re-examine shift lengths, remote work, etc. to create flexibility. • Examine actual time spent working (clinical plus documentation/communication) for physicians to create reasonable "full-time" working hours based on actual work. • Implement a program to "Get Rid of Stupid Stuff" (GROSS). • Examine pandemic care standards that can safely persist (e.g., having attendings attest to documentation rather than doing documentation themselves). • Streamline documentation by removing redundant and unnecessary data capture. • Employ virtual scribes to reduce documentation burden. • Examine frequency of team members skipping breaks or other well-being practices to inform work redesign. • Examine team nursing (one RN oversees a team of lower-licensed or less experienced care professionals) or other ways to extend experienced/credentialed team members. • Re-assign role responsibilities to allow clinical staff to practice at top of license (e.g., shift responsibility for managing supplies on the unit from nurses to supply chain). • Ensure that team members have the resources to work safely (e.g., lift teams and equipment, smaller linen bags to carry lighter loads). • Explore patient self-management of certain care tasks (e.g., blood sugar monitoring).
Changes to Technology	• Create a team of clinicians, human-centered design experts, and informaticists to rationalize EHR process and design; create an "EHR Flourishing Strategy." • Integrate technologies to reduce systems burden. • Optimize resources already purchased; learn about full capabilities/extensions of existing technology (beds, analytics, alarm management, etc.). • Use technology that helps reduce interruptions and alarm fatigue. • Explore technology as a "team extender" (e.g., tele-sitters). • Use analytics and decision-support to reduce cognitive burden and identify care risk/focus (e.g., skin break-down, fall-risk assessment, early sepsis identification). • Use analytics, decision support, and AI to automate as many routine tasks as possible "so doctors can be doctors and nurses can be nurses." • Invest in technology to remove hassles (e.g., upgrade ERP system).

Process and Technology Improvement – Stories

Intermountain Healthcare – Humane Factors Engineering

Mike Woodruff, MD, Chief Patient Experience Officer at Intermountain Healthcare believes that trust is at the core of both patient and team member safety – and that trust is built not only through interactions between team members and leaders, but also in all of the daily processes that team members encounter. "In all of those moving parts," said Dr. Woodruff, "if they're not really well designed to build or sustain trust, then they're going to erode trust. And without the trust of engaged, healthy teams we will not achieve sustained excellence."

Part of this work is engaging with concepts of process improvement and human factors engineering that design for efficiency and effectiveness and with a deep awareness of human strengths and limitations. But Dr. Woodruff adds another layer – what he calls "humane factors engineering" – which looks at every interaction and every process and asks, "Is it kind?" and "Does it support the mission?" This filter forces leaders to remove barriers and create kindness and connection as the foundation of work. This, in turn, creates psychological safety and engagement, and tells team members that their leaders (as proxy for the organization) really care about them. Applied to the realm of patient safety, this caring approach led to an increase in reporting and a decrease in patient harm during the pandemic, a time when many systems saw patient safety events increase.

Cleveland Clinic – Plan of Care Daily Visits

Kelly Hancock, DNP, RN, NE-BC, FAAN, Chief Caregiver Officer at the Cleveland Clinic knows from being a bedside nurse that care team coordination is essential to ensure that nurses, physicians, other clinical providers, and patients can work together toward an aligned plan of care. To facilitate coordination, Cleveland Clinic launched a program of plan of care daily visits in which the patient's primary physician and nurse round together, collaboratively establish an agenda with the patient, and jointly communicate the plan of care including clinical updates, tests and results, and discharge expectations.

"Team members work together to determine the daily scheduled time," said Dr. Hancock. "It empowers the whole team and creates efficiency when everyone understands the plan of care. Nurses don't have to circle back to clarify patient expectations, reducing pages and headaches. And it helps us provide the highest quality care."

ChristianaCare – Balancing Productivity and Well-being

ChristianaCare's Chief Wellness Officer, Heather Farley, MD, MHCDS, FACEP, is working with leaders to track metrics that define workflows as balancing productivity and well-being – a concept she calls work-life integration. Metrics capture ideas such as whether clinicians are able to finish work in the allotted time, or do they have to skip breaks and work evenings and weekends to finish documentation at "normal" productivity levels. And if those metrics are out of balance, it will be leaders' responsibility to redefine workflows ("get rid of stupid stuff") and allocate work across team members such that all team members, especially doctors and nurses, can achieve reasonable productivity in a reasonably allotted amount of time.

NYU Langone – Technology to Free Up Mental Space and Energy

Leaders at NYU Langone recognize that technology will play a crucial role in the way that healthcare work gets restructured to support team member safety and well-being. As Debra Albert, DNP, MSN, MBA, NEA-BC, SVP for Patient Care Services and Chief Nursing Officer put it, "We are using technology to reduce burden on staff, allowing them to practice at a higher level." Specifically, NYU Langone is optimizing device integration and deploying bots to automate importing end-of-life care plans from external sources into the hospital's medical records. This frees up clinician time to have better conversations with patients and families and ensure they honor their wishes. The system is similarly exploring the use of algorithms and artificial intelligence to provide clinical decision support, helping nurses identify patients who are at higher risk of skin break downs, falls, or decompensation so they can spend less time chasing risk and more time on patient education and other critical functions that make better use of their skills.

Workplace Violence Reduction – Inventory of Practices

As the greatest fears and challenges of the pandemic have ebbed, healthcare team members have faced a growing challenge of workplace violence, which was an epidemic even before COVID-19. Our interviewees almost universally reported that incidents of physical and verbal threat and assault have risen over the course of the past two years. One interviewee said, "Fuses are just shorter now. People escalate from frustrated to angry to abusive much more quickly now."

Health system leaders are doubling down on workplace violence (WPV) reduction and response strategies, and integrating them with diversity, equity, inclusion, and anti-racism work to ensure that team members, patients, and visitors are treated with dignity and respect.

Governance, Data, and Communication	• Create a WPV committee to identify threat and harm reduction strategies. • Consistently communicate how leadership is prioritizing and investing in WPV prevention and mitigation. • Hold listening sessions to understand what team members need to feel and be safe – and act on the learnings. • Examine/re-engineer response processes to ensure response impact matches intent (do team members feel heard, supported, valued, safe?). • Post 'conditions of participation' or 'behavioral expectations' for patients and team members in public spaces (e.g., "kindness matters"). • Train team members on why and how to report incidents – discuss the congruence between team member safety and trauma-informed care. • Streamline the reporting process in any way possible (e.g., dictate incident for transcription). • Capture near-misses and create improvement plans (parallel to patient safety processes). • Communicate incident data in daily location and system safety huddles. • Examine patient experience data for potential flashpoints – create improvement projects to lessen incidents (e.g., ED wait times and communication).
Protections and Resources	• Assign victim advocates to respond to both physical and verbal assaults. • Train staff on de-escalation. • Embed trained de-escalation facilitators on units – especially those with higher incidence of violence. • Expand behavioral emergency response teams – expand scope to include patients, visitors, vendors, and team members. • Limit visitor entry points to allow for screening (e.g., metal detectors, weapons detection systems) – use a visitor management system to keep track of who is coming to the hospital. • Deploy security cameras, closed-circuit TVs, lights, etc. throughout the campus, including parking lots. • Create EHR "flags" for past aggressive/violent behavior – include a review and removal process, including examining for bias. • Invest in "panic buttons" and/or voice recognition to summon help – include outpatient settings (auto-contact 911 or other community resources). • Train team members on personal safety outside the institutional walls – including social media guidelines. • Examine the impact of removing last names from team member badges. • Implement risk assessments for disruptive and violent behaviors and deploy resources accordingly (e.g., behavioral health nurses assist with care planning).

Workplace Violence Reduction – Stories

The Academy – Workplace Violence Maturity Model

In July 2022, The Health Management Academy (The Academy) released its Issue Brief on Addressing and Preventing Workplace Violence in Leading Health Systems.. The Brief, which includes interviews of CEO Coalition members and other industry experts, offers a maturity model outlining how organizations evolve in their governance, prevention, timely response, timely reporting, and aftercare for workplace violence incidents. Foundational to all efforts is a definition of workplace violence that recognizes "any act or threat of physical violence, incivility (including bullying), harassment (including racism, sexism, and bigotry), and other intimidation and disrespectful or inappropriate behavior."

In a poll of 48 nursing leaders at an Academy event, 52% reported their workplace violence maturity as foundational, and 42% as proactive and 6% as optimized. They also identified prevention and aftercare as the areas in which their organizations needed to make the most progress.

Zuckerberg San Francisco General (ZSFG) – Leveraging Patient Experience Data to Reduce Workplace Violence

ZSFG's Chief Experience Officer, Aiyana Johnson, MSW, MPH, recognizes that her team's focus has shifted during the pandemic. "My strategies from before COVID don't exist anymore," she said. "I'm not going to have my team focused on the same things." Instead, Ms. Johnson is taking a more holistic approach to team member and patient/family experience that recognizes the deep interconnection between the two.

As part of the organization's efforts to reduce workplace violence, her team is examining patient experience data and comments to look for areas of frustration that they can work to diffuse. "Wait times are the number one issue in the ED," Ms. Johnson said. "The ED also has the highest level of workplace violence events. Can we reduce wait times and thus reduce violence?" In addition to looking to process improvement to reduce wait times, the team supports de-escalation training for ED team members, and is working on ways to set expectations with patients about how triage works. "People get angry when they think someone cut them in line," said Ms. Johnson. "If we can communicate to change that perception, maybe we can lower the whole temperature in the ED."

Froedtert Hospital – Using EHR to Flags Potential Unsafe Behavior

Froedtert Hospital has designated a flag in its Epic EHR system to indicate that a patient has demonstrated violence or incivility in past interactions. "If you've exhibited unsafe behavior anywhere in the system," said Richelle Webb Dixon, MHA, FACHE, SVP and Chief Operating Officer, "we all need to know." This awareness allows team members to practice compassion and caution, apply de-escalation strategies, and possibly alert security so team members can safely interact with patients.

Importantly, the flags in the EHR are not permanent. Leaders employ set criteria for removing flags based on factors such as time since the last incident, severity of incident, whether it is isolated or consistent behavior. "We're also looking at the data for DEI purposes," said Ms. Webb Dixon. "We need to be very mindful that these flags are applied equitably."

The Queen's Health System – Using the Shaka Sign to Signal a Need for Extra Aloha

At The Queen's Health System in Hawai'i, nurses use culturally relevant symbols to identify patients who may be at risk of escalating to verbal or physical violence. They place an image of the shaka sign (a traditional pinky and thumb salute) on the doorway of patients' room to symbolize that the patient is in need of extra aloha (the Hawai'ian word for love and compassion). Nurses can then prepare to provide extra support and apply de-escalation strategies proactively with these patients and their visitors.

Equity and Anti-Racism – Inventory of Practices

Equity and anti-racism approaches are central to creating environments in which all team members can show up whole and apply their full skill and creativity to their work. Our respondents were mixed in their reporting of bias and racism, with some reporting a strong uptick in racist aggression during the pandemic, and others saying that levels are about the same as before COVID. Either way, the leaders we spoke with outlined solid dedication to building equity and anti-racism not only as a core pillar of safety, but also to integrating it into all other transformation work.

Skill Development	• Train board members on the importance of and skills for equity and inclusion. • Conduct inclusive leadership training for leaders at every level. • Create cohorts for leadership development (e.g., emerging Black leaders, Latinx leaders, etc.). • Educate leaders and team members on implicit and unconscious bias. • Include diversity, equity, inclusion, and belonging (DEI+B) training in annual Code of Conduct training (mandatory). • Hire equity coaches to help leaders and team members build skills. • Conduct self and team assessments to identify strengths and opportunities (e.g., Intercultural Development Inventory (IDI)). • Hold "Listening to Understand" sessions that promote open dialogue and communication among team members. • Recruit and train "inclusion champions" at all levels of the organization.
Governance and Integration with Other Disciplines	• Appoint an executive leader for DEI+B and social justice; align with patient health equity. • Create equity councils to identify and solve systemic challenges to equity, inclusion, and belonging. • Include equity and anti-racism in organizational values and strategic objectives. • Include DEI+B and social justice as part of the team member well-being definition. • Examine recognition programs to ensure inclusion (look beyond clinical staff). • Examine workplace violence data through an equity lens, including behavioral red-flag incidence. • Revamp graduate medical education (GME) approaches to match and interviewing to eliminate bias. • Employ rituals to strengthen awareness and mitigation of bias (e.g., "Before we meet this employment candidate, take a moment to identify your potential biases and consciously set them aside."). • Integrate bias and racism incidents into safety event reporting systems. • Institute Respect and Dignity Safety Learning Reports. • Examine all organizational data with an equity lens. • Include health equity and DEI+B on the board agenda. • Include health equity and DEI+B on key metrics, tied to executive and management pay. • Create goals to improve diverse candidate slates. • Offer a tiered benefits cost structure where lower income team members pay less for employee benefits, so health and other resources are accessible to all.

Equity and Anti-Racism – Stories

HealthPartners – Inclusive Leadership Training

HealthPartners, located in Minnesota, committed to becoming an inclusive and anti-racist organization in the wake of George Floyd's murder in May of 2020. As part of that commitment, leaders were encouraged to have conversations about race and inclusion with their team members. But when the DEI team circled back with leaders to see how things were going, leaders told them that they lacked the concrete skills and tactics to have those conversations in a way they felt would advance inclusion and belonging.

As a result, the DEI team created an Inclusive Leader training available to all formal and informal leaders that builds on the skills of a separate training on unconscious bias. Participants join a cohort of fellow leaders and take part in four one-hour training sessions (supported by a private Microsoft Teams channel for interim discussions and problem solving) that cover:

- **Conversations** (learn the skills of holding space, messing up better, and embracing conflict)
- **Coaching** (practice coaching and questions that foster diversity, equity, and inclusion)
- **Equity framework** (apply the key questions of HealthPartners' equity framework and the strategic goals of being simple and affordable):
    - For whom is this process/change simple and affordable?
    - Is there any group or population negatively impacted or left out by this process/policy/change and how?
    - What potential changes could you make to increase/improve equity and inclusion?
- **Strategic plan (**Create and choose tactics to focus on that align effort and resources towards bringing greater equity as part of the leader's strategic goals)

Children's Minnesota – Respect and Dignity Safety Learning Reports

Leaders at Children's Minnesota know that creating an environment of health justice involves changing processes and practices to support diversity, equity, inclusion, and belonging for team members, as well as pursuing health equity for patients, families, and communities. The two are interconnected: team members need inclusion and belonging to show up whole and bring their full skills, passion, and creativity to work so they can provide exceptional, inclusive care to patients and families, and they need to see an organizational commitment to equitable outcomes to know that the promises of inclusion and belonging truly extend to all people.

As described by James Burroughs, JD, SVP Government and Community Relations and Chief Equity and Inclusion Officer, and Angela Kade Goepferd, MD, Chief Education Officer and Chief of Staff at Children's Minnesota, one way to ensure a health system is moving toward an equitable environment and care, is to consider episodes of discrimination, cultural bias, and inequity as categorical harm events. To do this, leaders at Children's Minnesota augmented the system's existing reporting approach for safety events to include lapses in respect and dignity. Team members can report any incidents of emotional harm to team members or patients and families, which are then reviewed by leadership to identify the root cause and fix the system, process, or knowledge issues that led to the incident. In this way, correcting for and responding to bias and discrimination is built directly into the organization's continuous improvement approach to achieve high quality care and outcomes.

To ensure broad capture and transparency, team members have the option of reporting anonymously, reducing any perceived fear of repercussions. And as evidence of the culture of psychological safety Children's Minnesota is building around diversity, equity, inclusion, and belonging, some team members are actually reporting themselves. "Some team members tell us that they mis-named or mis-gendered a patient, or some similar lapse in respect and dignity," reported Dr. Goepferd. "They're letting us know that the systems and processes they use are not designed to support them in delivering the level of high quality and equitable care they know patients deserve."

Human-Centered Leadership – Inventory of Practices

Throughout the pandemic, leaders have been stretched to support team members while also adapting and responding to conditions that often changed throughout the course of a day. It has taken a special brand of human-centered leadership to support team members' well-being while also managing through a cascade of challenges and crises.

Often shifts in leadership are not as much about specific changes in leadership so much as how leaders show up. One interviewee described a conversation she had with a nurse manager. A talented nurse who pre-COVID had been on a leadership track had started showing up late for shifts. Instead of writing the nurse up, the nurse leader asked her what was going on – and learned that the nurse was arriving for work on time and then sitting in her car in the parking lot too anxious to come into work. The nurse manager was able to provide a different kind of support to her team member because of how she showed up as a leader.

Visibility and Communication	• Maintain pandemic communication structures (e.g., town halls, newsletters, Q&A, videos, huddles); right-size frequency and scope based on team member feedback. • Encourage leaders to model well-being behaviors (e.g., taking breaks, accessing resources). • Use storytelling (e.g., video interview with CEO and/or Wellness Officer) to highlight mental health success stories and destigmatize resource access. • Conduct "leader roving" – 4-hour shifts in which leaders visit units and departments to help with whatever is needed (clinical, storage and distribution of supplies, answering phones, running labs, etc.). • Add team member safety and workplace violence stats to c-suite dashboard.
Process, Support, and Skill Development	• Maintain the streamlined decision structures developed during the pandemic; maintain a weekly incident-command-like meeting for executive leadership for rapid decision making; create no-meeting zones to allow this (90 minutes, 3 times weekly – ideally all shifts). • Create tiered escalation huddles designed to rapidly solve hassles or stupid stuff. • Redesign support systems around leaders (especially middle managers); clearly identify priorities and streamline workflows to remove stupid stuff. • Conduct inclusive leadership training. • Train leaders in psychological first aid (identify and respond to signs of stress and distress, and help team members access resources for help) • Train leaders to work in a hybrid work environment. • Teach leaders to create the conditions for success; team members experience emotional harm when they can't succeed.

The Well-Being Five

Knowing that leaders are often overwhelmed by the variety of interventions aimed at supporting well-being, a group of experts (including from the CEO Coalition) in collaboration with the National Academy of Medicine identified the top five actions leaders should take to support team members now: The 2022 Healthcare Workforce Rescue Package. Actions include:

- These are non-normal times; adjust expectations.
- Get Rid of Stupid Stuff (GROSS).
- Get radical to shore up staffing.
- Designate a well-being executive.
- EAP is not enough! Do more.

Human-Centered Leadership – Stories

Valleywise Health – Leader Roving

At Valleywise Health, leaders sign up for unit-based, four-hour "leader roving" shifts to help out with whatever may be needed – whether supporting clinical care for those with clinical credentials, running labs, stocking linen and supplies, or answering phone calls. The added support helps the system manage through current staffing challenges. It also helps to create trust and communication between frontline team members and leaders in a way that is hard to replicate in shorter visits. And it allows leaders to observe firsthand the impact of processes that need an overhaul or how team members are managing through staffing or supply shortages.

In addition to leader roving shifts, the organization has instituted no-meeting zones from 8-9:30 am on Tuesdays, Wednesdays, and Thursdays to reserve time for leaders to round on two-to-three patients and two-to-three team members with a focus on daily problem solving. They are currently exploring how to extend the practice to evening and weekend shifts.

UChicago Medicine – Nurse Leader Immersion

Emily Chase, PhD, RN, NE-BC, FACHE started her role as CNO and SVP of Patient Care Services at UChicago Medicine in March of 2020, right at the start of the pandemic. A few months into her role, she set up a virtual town hall with the nurses of the MICU, which had been converted to the system's COVID unit. One of the nurses suggested that Dr. Chase come spend time on the unit to get first-hand exposure to the reality of what the teams were facing. The following week, Dr. Chase shared a 12-hour shift with the MICU team.

After that experience, Dr. Chase and her team set up a program in which she and her teams (which included patient experience and nursing leadership) immersed themselves with the clinical teams for full 12-hour shifts every two weeks. Team members with clinical credentials work side-by-side with clinicians. Those with administrative backgrounds aligned with support responsibilities. The teams immerse on Mondays, and the following Thursdays they debrief on what they saw, what's going well, what's not going well, and they create an action plan around improving the situation for team members. They also ask, "How did the day make you feel as a leader?"

The practice closes the invisible but sometimes substantial gap between frontline team members and leaders. It allows leaders to observe things more deeply than in a brief leader round and builds a camaraderie and trust between leaders and team members that allows for candid discussions of what works well and what needs to improve.

ChristianaCare – Support for Frontline Managers

ChristianaCare's Chief Wellness Officer, Heather Farley, MD, MHCDS, FACEP, recognizes that leaders have also experienced stress, disruption, and even overwhelm during the ups and downs of the pandemic. Leaders didn't always know how to support traumatized team members or to adapt to the ever-changing demands of the pandemic. In addition to rolling out training for all leaders in psychological first aid (skills that help leaders identify mental distress in team members, support them in the moment, and connect them to resources for ongoing support), ChristianaCare created a tiered support program for leaders. This includes self-help resources, peer support and coaching, team support resources, and professional support. And, recognizing that leaders benefit from structural changes that reduce work burden just like team members, ChristianaCare is actively working to redefine the responsibilities of frontline managers to ensure a manageable workload and "get rid of stupid stuff."

Support

Healthcare leaders cannot single-handedly enact the changes or policies that will support systemic safety and well-being for all team members over the long run. Like all business, health systems exist in an ecosystem of stakeholders who enable, constrain, or prohibit the kinds of changes that leaders would like to support. We asked our interviewees what, if any, changes they would like to see. This list constitutes a summary of key ideas and is not exhaustive, but it reflects the level of interconnectedness between internal safety and well-being efforts and external forces.

For external stakeholders, leaders expressed a desire to partner around a commitment that no healthcare team member should have to sacrifice their personal safety, health, identity, or well-being to do their jobs and care for patients. Leaders were dismayed that healthcare has become politicized and believe that collaboration could bring marked improvement to the field. They recognized the need for checks and balances and requested a spirit of non-punitive inquiry as they navigate the coming transformation.

State and National Agencies, Regulators, and Legislators	• Recognize that decisions around housing, food, safe and accessible sidewalks, childcare, transportation, etc., affect team member well-being – both as individuals and in their roles treating community members. • Reduce regulations that are well-intentioned but not operationalizable. • Protect team members from workplace violence with legislation. • Craft home health regulations and payment structures to accommodate both patient/family care needs and team member well-being needs. • Ensure mental health parity laws are operationalized and enforced. • Change how mental health is handled in licensing/credentialling. • Fund nursing and pharmacy residencies to help alleviate chronic understaffing. • Reduce outdated barriers to accelerating the development of clinicians. • Reduce outdated barriers to allowing clinicians to practice across states. • Expand the nurse licensure compact to allow team members greater employment flexibility. • Reform the litigation system to reduce unnecessary psychological and financial burden while maintaining appropriate protections.
Insurers	• Reduce or eliminate prior authorization – it creates a lot of work for little value. • End auto-denial processes. • Boost reimbursement to reflect staffing requirements and in recognition of the stress and gravity of the decisions healthcare team members have to make on a daily basis. • Expand compensation for telehealth to allow more flexibility in work hours and locations. • Support flexibility of staff locations (e.g., an in-network doctor practicing at a different location to flex around capacity should be considered in-network).
Technology Vendors	• Support interoperability standards. • Make EHR screens patient-centered, not role-centered, to support collaboration. • Make safety event reporting easier (e.g., dictation into clinical communication devices). • Partner with companies that support your health sysem's culture and mission of safety and well-being
Other	• Reduce the hierarchy in medical training to support well-being. • Align rules (e.g., timing for oversight processes) with staffing realities.

Looking Ahead

Since the start of this research in March of 2022, there have been multiple high-profile incidents of workplace violence in healthcare, including the shooting deaths of two doctors, a receptionist, and a patient in Tulsa, Oklahoma. New, immunity-dodging COVID variants, BA.4 and BA.5, have eclipsed previous omicron variants as the dominant strains in the US, causing an increase in COVID admissions from April to July, 2022. The "monkeypox" epidemic is creating pressure on immunization and treatment resources. The nursing and physician shortages are persisting at best, and too often worsening. And there have been mass shootings in multiple communities, including some that were specifically targeting people of color.

The environmental and situational trauma, and the at-work stress and moral distress continue to bear down on healthcare team members. It could be tempting, given the challenges and disruptions that have occurred since the first US-based COVID case was reported in January of 2020, to pause and seek a "return to normal." But in the words of Intermountain's Chief Patient Experience Officer, Mike Woodruff, MD, "I don't know that there's any kind of pause that would allow for effective recovery in the current state."

The challenges of stress, trauma, and moral injury in healthcare pre-date COVID. The pandemic added both strain and visibility to a system that was crying out for an overhaul. It laid bare the unsustainability of structures that too often pushed team members to the edges of human physical, emotional, cognitive, moral, and relational capacity – and beyond.

In the words of US Surgeon General Vivek Murthy, MD, MPH, "The nation's health depends on the well-being of our health workforce. Confronting the long-standing drivers of burnout among our health workers must be a top national priority." And this priority extends in all facets of support and work transformation identified by our interviewees – from greater support for team member well-being embedded in the work itself to restructuring work to create less cognitive overload and psychological trauma in an inclusive environment that welcomes and advances the strengths and talents of team members in all facets of work and life.

Building a new system that safeguards team member psychological and emotional safety, promotes health justice, and ensures physical safety is the leadership imperative embraced and espoused by the members of the CEO Coalition and their Heart of Safety Declaration of Principles. They commit to this work in partnership with external stakeholders at the local, state, and national level – not simply because it is necessary, but also because it is right.

Research conducted by:

Liz Boehm
Executive Strategist
CEO Coalition Learning Community Lead
Host of the Caring Greatly Podcast®

Gratitude

Our gratitude to the health system executives and other thought leaders who contributed their wisdom and insight to this report:

Debra Albert, DNP, MSN, MBA, NEA-BC
Senior Vice President for Patient Care Services and Chief Nursing Officer
NYU Langone Health

Robert J. Batory, MBA
Senior Vice President and Chief Human Resources Officer
WellSpan Health

Toweya Brown-Ochs, MBA
Director of Diversity and Inclusion
HealthPartners

James Burroughs, JD
SVP Government and Community Relations and Chief Equity and Inclusion Officer
Children's Minnesota

Rowena Buffett Timms, MA
Executive Vice President and Chief Administrative Officer
The Queen's Health System

Emily Chase, PhD, RN, NE-BC, FACHE
Chief Nursing Officer and Senior Vice President of Patient Care Services
University of Chicago Medicine

Lia Christiansen, MBA
Executive Vice President and Chief Administrative Officer
Valleywise Health

Kate Curley, PhD
Diversity and Inclusion Learning and Development Senior Consultant
HealthPartners

Tria Deibert, MAOL
Vice President, Culture
Hackensack Meridian *Health*

Heather Farley, MD, MHCDS, FACEP
Chief Wellness Officer
ChristianaCare

Corey Feist, JD, MBA
Co-Founder & Chief Executive Officer
Dr. Lorna Breen Heroes Foundation

Amy Frieman, MD, MBA, FAAHPM
Chief Wellness Officer
Hackensack Meridian *Health*

Angela Kade Goepferd, MD
Chief Education Officer and Chief of Staff
Children's Minnesota

Kelly Hancock, DNP, RN, NE-BC, FAAN
Chief Caregiver Officer
Cleveland Clinic

Louis Hart, III, MD
Medical Director of Health Equity
Yale-New Haven Health System

Aiyana Johnson, MSW, MPH
Chief Experience Officer
Zuckerberg San Francisco General

Julie A. Holt RN, MSN, CENP
Chief Nursing Officer, Vice President, Patient Care Services
The Christ Hospital

Kelly Johnson, PHD, RN, NEA-BC
Senior Vice President and System Chief Nursing Officer (former)
The Queen's Health System

Kate Keiper
Vice President, Human Resources
HealthPartners

Sarah Lechner, JD
Senior Vice President, Chief of Government Affairs and Advocacy
Hackensack Meridian *Health*

Christy Miller, PhD, RN
Director Nursing Administration (former)
The Christ Hospital Health Network

Alicia Pilarski, DO
Associate Professor, Emergency Medicine
Medical College of Wisconsin/Froedtert Hospital
Associate Chief Medical Officer
Froedtert Hospital

Holly Reilly
Vice President of Human Resources
Froedtert Hospital

Michael Richards, MPA
System Vice President, Government Affairs and Public Policy
SSM Health

Sunitha Sastry, MBA, CPXP
Acting Chief Experience Officer (former)
UChicago Medicine

Christine Sinsky, MD
Vice President of Professional Satisfaction
American Medical Association

Janet Smith-Hill, RN, MSN, SPHR
Chief Human Resources Officer
SSM Health

Greg Till, MS, MA
Executive Vice President and Chief People Officer
Providence

Sylvain Trepanier, DNP, RN
System Chief Nursing Officer
Providence

Deborah Visconi, MS
President and Chief Executive Officer
Bergen New Bridge Medical Center

Richelle Webb Dixon, MHA, FACHE
Senior Vice President and Chief Operating Officer
Froedtert Hospital

DeLinda Washington, JD
Chief People Officer
HealthPartners

Michael Woodruff, MD
Chief Patient Experience Officer
Intermountain Healthcare

About the CEO Coalition

The CEO Coalition, co-founded by 10 health system CEOs across the U.S., is on a mission to protect the physical safety, emotional well-being, and just treatment of all who work in healthcare. Focused on team member safety and well-being, the CEO Coalition published the Heart of Safety Declaration of Principles outlining three pillars of change needed to build a future of caring, trust, and health justice. The co-founders of the CEO Coalition have sparked a national movement and are turning the Declaration into an action plan for meaningful and sustainable change. They have since been joined by additional health system leaders who share their commitment. For more information, visit www.CEOCoalition.com.

CEO COALITION