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Unit Staffing Collaborative: Surgery

February 15, 2021

Revised: April 1, 2021

Note: One slide deck per HCS USC, calling out differences between clinics as appropriate

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Unit/ Clinic USC Members

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- Robin Kenyon, RN (Ophthalmology)
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Components of USC Project Plan Per Article 20B

- Unit profile
- Minimum staffing levels
- Analysis of time spent by nurses on nursing and non-nursing activities
- Analysis and recommendation of acuity process and/or tool
- Analysis and determination for Circulating RN(s) to enable Circulating RN(s) to facilitate meal/break coverage and assist in transfers/discharges in all critical, procedural and acute care units
- Staffing effectiveness data (see Article 20), including unit specific quality data and NDNQI RN satisfaction and Practice Environment results
- Unit-specific quality data, including unit-based improvement initiatives
- Staffing plan (grid) that includes patient care staffing of RNs and ancillary staff where appropriate
- Staffing data, including the unit budget
- Financial impact of the proposal
- Metrics to be used to measure the effectiveness of the USC Project

Timeline

- The USC Project plan must be completed and submitted to the Chief Nursing Officer of the Hospital and President the VFNHP within three (3) months of completion of project **(Inpatient: 11/20/2020; Ambulatory: 2/15/2021).** The manager will make reasonable time available for the committee to work on the written plan. Staffing plans developed under this Article 20B shall require approval by both the Chief Nursing Officer of the Hospital and President of the VFNHP. A decision on the memorandum of agreement shall be made within three (3) months of the submission of the final report **(3/31/2021)**. A failure to reject the plan or provide specific reasons for the rejection by either party within three (3) months of submission shall be considered acceptance. Where a final USC Project plan is rejected in good faith by either party, the USC committee shall reconvene and submit a new final report within three (3) months. Either party may initiate mediation following the rejection of a report.

Unit Profile

- Acute Care
  - The Clinic is open Monday thru Friday 8-5
  - Vermont's only Level I Trauma Center-and the first in the U.S. to be verified for both children and adults. Acute Care Surgery provides care to patients requiring emergent or urgent surgical intervention. We also provide Burn Care to all ages.
- CT
  - The Clinic is open Monday thru Friday 8-5
  - The University of Vermont Medical Center in Burlington, VT, offers a wide range of cardiothoracic surgery treatments for chest and heart diseases, including bypass surgery, valve replacement and repair and thoracic aortic aneurysm surgery.
- ENT
  - This practice provides otolaryngology evaluation and treatment for new and established patients. Including pre and post-operative care , coordination of care with other services and in office procedures. This practice provides audiology services as well. The hours of operation are 8:00 a.m. – 5:00 p.m. Monday, Tuesday, Wednesday, and Friday. 9:00 a.m. – 5:00 p.m. on Thursday
- ENT, Berlin
  - This practice provides otolaryngology evaluations and treatment to patients. The hours of operation are 8:00 a.m. – 5:00 p.m. Monday through Friday
- General Surgery/Bariatrics
  - This is a practice that provides pre- and post-surgical visits for general, bariatric, and colorectal patients. Visits are scheduled at UVMMC Main Campus and Williston Blair Park. General surgery patients are also seen for wound ostomy training on the inpatient floors. Monday-Friday, 40 hours by our RN wound ostomy nurse. Hours of operation are 8:00 a.m. – 5:00 p.m. Monday through Friday.
- GI
  - This practice specializes in gastrointestinal and hepatic disorders. Hours of operation are 8-5 Monday-Friday. We also complete patient calls for Endoscopy patients that are not our clinic patients that have questions or need bowel prep orders placed. We also take these same patient calls for infusion center patients. This service manages biologic infusion patients. We also see patients on the inpatient floor to perform capsule endoscopies

Unit Profile (cont.)

- IR
  - Interventional Radiology Clinic provides patient care as part of a highly specialized care team. The clinic provides consultative, diagnostic, and pre- and post-therapeutic procedure care for patients of all ages (children, adolescents, adults and/or geriatrics) who require image directed care for vascular, thoracic, neurological and metabolic pathology. Patients require a referral for care and are followed by clinic physicians as deemed appropriate for the plan of care. After completion of therapy plan, patients are referred to primary or other specialty physician directed care and followed per current standard of care for the underlying conditions. Clinic is open 8-5 Monday through Friday.
- Neurosurgery
  - Pediatric and adult neurosurgical care, treatment and services. Ages: all ages, adult and pediatrics. Hours: 8-5 Monday- Friday. Locations: primarily EP5 but our providers do see patient at clinic over at Tilley and at CVMC (for now Tilley is on hold with Covid). There is no RN coverage at those sites directly, but we do take on the patient education for those patient that end up having surgery. Services provided: our providers perform various neurologic surgeries from carpal tunnel release, spinal decompressions and fusions up to brain surgery. Nurses provide all pre-op teaching for patients as well as post-op follow up and wound care in addition to phone triage.
- Ophthalmology
  - Our patient population in ophthalmology, ranges from pediatrics to geriatrics. We have several different specialty doctors. The 2 nurses we have work with all age ranges and all providers.
- Plastics
  - This practice provides plastic surgery pre- and post- operative care, new patient consultations and in-office procedures to patients considering/undergoing plastic surgery. The hours of operation are 8:00 a.m. – 5:00 p.m. Monday through Friday
- Urology
  - The urology practice treats patients, 16 years of age and older, for urological conditions and disease processes. The practice provides medical and surgical urological consultations and interventions. The urology practice monitors for wellness and survivorship related to acute and chronic urological conditions. The hours of operation are 8:00a.m.- 5:00p.m. Monday through Friday.
- Vascular
  - This practice serves adult patients with vascular disorders. Hours of operation are 8-5, Monday- Friday. Visits are schedule at Plastic Surgery 6 times per month; RN resources from this cost center are not required for these visits. Visits are scheduled in the Berlin location two days a month; RN resources from this cost center are requires.

Meeting Dates

- 9/1- Kick off meeting
- 9/10
- 9/24
- 10/8
- 10/22
- 12/3
- 12/10
- 12/17
- 12/31
- 1/7/21
- 2/11/21

Minimum Staffing Levels: Acute Care & CT

- What are your core RN staffing levels?
  - ACS 1 ~ CT 1
- Speak to what the minimum number of RNs needed, address LPNs if applicable
  - **Acute Care Surgery ~ 1**
  - Nurse Visits
  - MyChart Messages for 10 Surgeons & 4 Midlevel's
  - Pre & Post Op Teaching
  - Discharge Follow Up Calls
  - Phone Triage
  - Wound Care
  - Ostomy Teaching/Triage (phone, outpatient & inpatient)
  - Medication refills
  - Care Coordination
  - **Cardiothoracic Surgery~ 1**
  - Nurse Visits
  - MyChart Messages for 4 Surgeons & 4 Midlevel's
  - Pre & Post Op Teaching
  - Discharge Follow Up Calls
  - Phone Triage
  - Wound Care
  - Medication refills
  - Care Coordination
- Address tactics to flex staffing up and down (i.e. sister sites, floating, per diems, resource pool)
  - A 0.5 FTE position that is cross trained between the two services
  - Resource Pool
  - Prioritization of work
  - Overtime
  - ACS & CT Surgery use Midlevel's to cover urgent triage calls
  - In event that ACS RN unavailable midlevel's or attending's can assist with care of patients

Time Spent on Nursing vs Non-Nursing Duties: Acute Care & CT

- What is the *approximate* time per week spent on non-nursing functions?
  - ACS ~ 20% CT ~ 20%
  - ACS ~ Referrals
  - Assisting with clerical support, rooming, EKG's, faxing, mailing
  - Committee Work / Certifications / CEU requirements
- Is there a recommendation on who could do the work?
  - ACS ~ SCOA could assist with clerical items
  - CT ~ once fully staffed SCOA's, not an issue
  - Helping with medical assistant support is only on occasion for both departments
- What activities do not require RNs or prevent RNs from doing core RN work (i.e. RNs can perform rooming function, but does it keep RNs from staffing triage calls)
  - Burnout
  - System inefficiencies
  - High Call Volume
  - High Census
  - Misrouted calls
  - Awaiting physician responses for clarity on patient care
- Discuss what is needed to have RNs working to top of license
  - ACS & CT are working to top of license

Recommendation for Acuity Process: Acute Care & CT

- What non-phone work drives more acute staffing needs?
  - High volume of patients requiring wound care
  - Evaluating home health orders for accuracy
  - Pre and post operative teaching with patients in clinic
  - Does in basket volume drive more acute staffing needs?
    - Yes, based on volume of discharges and post op or trauma patients that require discharge follow up calls and follow ups arranged
      - Case Management/Social Work
    - Repeat calling patients that don't return calls, minimal #'s
  - Document acuity process, what is considered/discussed
    - Smart phrases are used for discharge follow up calls.
    - Acute calls, questions/documentation based on concern
- What are the "work triggers" which cause a change in practice?
  - Clinical practice changes
    - Change, Loss or Increase in MD's
    - Change, loss of SCOA and/or Medical Assistant
  - What requires more nursing support
    - Expansion of scope of service
      - Assist with coverage with Wound Ostomy Nurse/Inpatient Care
    - Higher number of procedures which require RN
      - Increase wounds/Ostomies/Burns
      - All based on Census

AMS Benchmark Staffing Grid: Acute Care & CT

- The .5 FTE for each department could be cross trained for coverage between departments

University of Vermont Medical Center
Example of a Target Staffing Pattern
Cardiothoracic Surgery
Cost Center: 12012235

Completed Provider Visits 1,236
Average per Day 5

Skill	Description	Shift Length (hours)	Number of Staff Mon	Tue	Wed	Thur	Fri	Sat	Sun	Total Weekly Shifts	Total Weekly Req. Hrs w/o repl	Req. FTEs w/o replace	SVH Replace Ratio	Total Paid Hours	Total Paid FTEs	Hours per Indicator Worked	Paid
		A								B	C=AxB		D	E=CxD	F=E/40		
RN																	
RN		8.0	1.0	0.5	1.0					2.5	20.0	0.5	1.214	24	1	0.8414	1.0215
					Pattern Total					2.5	20.0	0.5	1.214	24	0.61	0.841	1.021

University of Vermont Medical Center
Example of a Target Staffing Pattern
Acute Care Surgery
Cost Center: 12012246

Completed Provider Visits 1,867
Average per Day 7

Skill	Description	Shift Length (hours)	Number of Staff Mon	Tue	Wed	Thur	Fri	Sat	Sun	Total Weekly Shifts	Total Weekly Req. Hrs w/o repl	Req. FTEs w/o replace	SVH Replace Ratio	Total Paid Hours	Total Paid FTEs	Hours per Indicator Worked	Paid
		A								B	C=AxB		D	E=CxD	F=E/40		
RN																	
RN		8.0	1.0	1.0		1.0	0.5			3.5	28.0	0.7	1.120	31	0.8	0.7799	0.8734
					Pattern Total					3.5	28.0	0.7	1.120	31	0.78	0.780	0.873

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Current Staffing Pattern/Schedule: Acute Care & CT

- Year to date actual at job code level
  - RNs, 1 FTE in Acute Care Surgery, 1 FTE in Cardiothoracic Surgery
  - This is what is currently budgeted
  - How is this different from AMS benchmark staffing grid and if different, why?
    - Acute Care Surgery, benchmarking shows 0.78 vs. 1 FTE not all job responsibilities were included in AMS Benchmarking
    - Cardiothoracic Surgery, benchmarking shows 0.61 vs 1 FTE, all responsibilities were included
- How do you staff M-F (weekends if applicable)?
  - 1 FTE each department Monday thru Friday
  - Closed on weekends
- How will scheduled and unscheduled CTO and unproductive time will be covered?
  - Resource Pool
  - Cross Coverage
  - Per Diems

Proposed Staffing Pattern/Schedule: Acute Care & CT

- Please add proposed RN staffing and staffing pattern
  - Propose 1.5 FTE for Acute Care Surgery and Cardiothoracic, Sharing the 1.0 FTE between departments
- Address differences from current staffing pattern/schedule and AMS benchmark (if applicable)
  - Currently without a Medical Assistant that is shared between practices
  - Decreased appointments due to COVID-19

Highlighted Changes: Acute Care & CT

- We have recommended a 0.5 to 1.0 FTE to split between Acute Care Surgery and Cardiothoracic Surgery to assist with the nursing duties and coverage for vacations/sick days or Committee work time.
- We will utilize the resource pool as required, when appropriate
- We will shift the administrative work that is done to the medical assistant when appropriate

Minimum Staffing Levels: ENT

- What are your core RN staffing levels?
  - How many people are normally scheduled?
    - ENT Burlington has 3 RN's as the core staffing levels
    - ENT Berlin has 1 RN as the core staffing level
- Speak to what the minimum number of RNs needed, address LPNs if applicable
  - What is the minimum number needed to keep clinic open?
    - ENT Burlington: 2 RN's and 2 LPN's; dependent on the # of scheduled procedures and ability to do unscheduled, add on procedures (like biopsies)
    - ENT Berlin: 1 RN
- Address tactics to flex staffing up and down (i.e. sister sites, floating, per diems, resource pool)
  - Help between Berlin and Main Campus
  - Patient schedule manipulation-moving patients to a different day or with a different provider
  - Overtime

Time Spent on Nursing vs Non-Nursing Duties: ENT

- What is the *approximate* time per week spent on non-nursing functions?
- Total hours
  - Medication prior authorization 2 hours per week
  - Sorting incoming faxes 2 hours per week
  - Calling outside facilities for lab and radiology results 3 hours per week
  - Scheduling outside radiology appointments 1 hour a week
  - Providing tech support, problem solving, equipment maintenance 3 hours per week
  - Ordering medical supplies and office supplies 1 hour a week
  - Berlin ENT is rooming patient's Tues thru Thursday 4.5 hours a week
- Is there a recommendation on who could do the work?
  - Support staff such as MA, SCOA, and tech support
- What activities do not require RNs or prevent RNs from doing core RN work:
  - Sorting faxes, calling outside facilities for radiology reports images and lab results, scheduling outside radiology appointments, ordering office supplies, and providing tech support, problem solving equipment issues, uploading and downloading images.
- Discuss what is needed to have RNs working to top of license:
  - increase support staff able to do non nursing activities

Recommendation for Acuity Process: ENT

- What non-phone work drives more acute staffing needs?
  - Providing one on one direct patient care such as In person interaction with patients. Patient's will Walk into the office with questions about their care, also some people have questions after an appointment. Nursing staff manages the DME orders and follow up. Homehealth forms are faxed to the office requiring review and signature from the provider then faxing it back to the homehealth agency. Mychart messages, electronic and fax medication refills, disability forms and FMLA paperwork. Providers will request nursing call the patient's with biopsy, lab and radiology results and follow up treatment plan. Triaging referrals. Coordinating care with multiple disciplinary teams including AeroDigestive Clinic, tumor board and cleft clinic. A need to write and revise clinic policies and protocols.
  - Does in basket volume drive more acute staffing need?
    - Yes, the in basket drives the need for more acute staffing needs. The more encounters that need to be touched the more nurses required. Tracking the encounters to make sure the patients are responded to in a timely fashion. Multiple messages being sent back and forth between the physician as well as follow to ensure the provider has reached out to the patient. Mislabeling of messages by non medical staff. Awaiting test results.
  - Document acuity process, what is considered/discussed
    - Currently this is not a part of our daily process. Future considerations could include in person pre op teaching, OR volumes, and increase in RN involvement in clinic procedures. Current process involves daily analysis of workload and required tasks.
- What are the “work triggers” which cause a change in practice?
  - Clinical practice changes: on boarding new staff MD, RN, MA, SCOA and PSS. Policy changes that require more time to complete daily work and new daily work (Covid testing), IT downtime and Committee time. New DME products, medication and in office procedures.
  - What requires more nursing support
    - Expansion of scope of service
    - New providers
    - Higher number of procedures which require RN
    - Pre and Post op education

AMS Benchmark Staffing Grid: ENT

University of Vermont Medical Center
Example of a Target Staffing Pattern
ENT
Cost Center: 12012232

																		Completed Provider Visits	19,830
																		Average per Day	79
		Shift Length	Number of Staff							Total Weekly	Total Weekly Req. Hrs	Req. FTEs w/o	SVH Replace	Total Paid	Total Paid	Hours per Indicator	
Skill	Description	(hours)	Mon	Tue	Wed	Thur	Fri	Sat	Sun	Shifts	w/o repl	replace	Ratio	Hours	FTEs	Worked	Paid
		A								B	C=AxB		D	E=CxD	F=E/40		
		RN															
RN	8a - 5p	8.0	2.0	2.0	1.0	2.0	2.0			9.0	72.0	1.8	1.170	84	2.1	0.1888	0.2209
					Pattern Total					9.0	72.0	1.8	1.170	84	2.11	0.189	0.221

University of Vermont Medical Center
Current & Target Staffing Pattern
ENT Berlin
Cost Center: 12012222

																		Completed Provider Visits	3,025
																		Average per Day	12
		Shift Length	Number of Staff							Total Weekly	Total Weekly Req. Hrs	Req. FTEs w/o	SVH Replace	Total Paid	Total Paid	Hours per Indicator	
Skill	Description	(hours)	Mon	Tue	Wed	Thur	Fri	Sat	Sun	Shifts	w/o repl	replace	Ratio	Hours	FTEs	Worked	Paid
		A								B	C=AxB		D	E=CxD	F=E/40		
		RN															
RN	8a - 5p	8.0	1.0	1.0	1.0	1.0	1.0			5.0	40.0	1.0	1.190	48	1.2	0.6876	0.8182
					Pattern Total					5.0	40.0	1.0	1.190	48	1.19	0.688	0.818

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Current Staffing Pattern/Schedule: ENT

- Year to date actual at job code level
  - As of September 2020 Burlington ENT is budgeted for 3 RN FTE, operating at 2.8 . Budgeted for 2 LPN FTE and operating at 1.9.
  - Berlin ENT is budgeted for 1 RN FTE
- How do you staff M-F ?
  - Burlington ENT: 3 RN per day
  - Berlin ENT: 1 RN per day
- What is your current staffing pattern?
  - Burlington ENT: 3 RN and 2 LPN
  - Berlin ENT: 1 RN
- How will scheduled and unscheduled CTO and unproductive time will be covered?
  - Resource Pool/Per Diem when available
  - Work short staffed

Proposed Staffing Pattern/Schedule: ENT

- The Burlington ENT proposed staffing pattern is 3 RN FTE and 2 LPN FTE as currently budgeted.
- This differs from the AMS benchmark due to additional clinic needs which do not appear to considered in the calculations.
- Berlin ENT proposed staffing pattern of 1 RN. The same as the AMS recommendation.

Highlighted Changes: ENT

Transfer non nursing functions to administrative staff to allow the current nursing staff to have the ability to spend their hours working on nursing function and improving care for our patients.

Minimum Staffing Levels: General Surgery & Bariatrics

- What are your core RN staffing levels? How many people are normally scheduled?
  - The core staffing level is four nurses Monday-Friday
  - One FTE is needed for inpatient/outpatient wound care Monday-Friday not included in clinic needs
- Speak to what the minimum number of RNs needed, address LPNs if applicable. What is the minimum number needed to keep clinic open?
  - The minimum staffing level to keep the clinic running at an appropriate level is three nurses with the ability to upstaff for higher acuity (i.e. scheduled in office procedures)
  - The minimum staffing level to keep the clinic open is two nurses with the understanding that work will be prioritized, and low-priority items will carry over
  - One additional nurse is needed for inpatient/outpatient ostomy care
- Consider infusions and procedures if applicable
  - Need to upstaff to four nurses in clinic on days there are heavy clinics requiring nurse chaperone, procedures, nurse visits, and CTO/sick days
  - One nurse is always needed for inpatient/outpatient wound care
- Address tactics to flex staffing up and down (i.e. sister sites, floating, per diems, resource pool)
  - Help staff sister clinics [Bariatrics (separate site), Wound/ostomy, GI] when clinic volumes are low (i.e. provider vacations)
  - APP assistance when nurses are out
  - Use resource pool to cover CTO and administrative duties
  - Prioritization of work
  - Overtime/adjust work hours to fit clinic schedule

Time Spent on Nursing vs Non-Nursing Duties: General Surgery & Bariatrics

- What is the *approximate* time per week spent on non-nursing functions?
  - Rooming clinic – 3 hours - MA
  - Chaperone – 5 hours - MA
  - Results monitoring and communicating results to patients – 3 hours – MA
  - EKG – 3 hours - MA
  - Assisting with office procedures – 10 hours - MA
  - Prior authorization – 1 hours – MA
  - Medication prior authorization – 1 hours – MA
  - Patient scheduling – 3 hours – MA
  - Disability and FMLA paperwork – 5 hours – MA
- Is there a recommendation on who could do the work? (goal is to identify options, not solve/implement)
  - MA
- By shifting these tasks to an MA the RN will be able to:
  - Decrease turnaround time for phone calls (within 24 hours)
  - Improved patient satisfaction:
    - Improvement in "response to concerns and questions" on Press Ganey survey to be reviewed monthly by practice and nursing supervisor.
  - Meet RN III and RN IV Requirements
    - RN IVs are able to commit 20% of FTE to non-patient care work. RN IIs and IIIs are able to maintain/advance as desired per annual evaluation. This will be evaluated at annual evaluations and improvement in responses to NDNQI survey categories "professional development access and professional development opportunities."
  - Completion of nurse triage protocols
    - GI Established unit policies and protocols will be reviewed and updated by the stated date of next review. New policies and protocols will be developed to reflect current practice. Current policies and protocols needing development or review include: H. pylori treatment protocol, Bariatric triage policy, and Bariatric medication refill policy.
- Discuss what is needed to have RNs working to top of license
  - Additional MA or PSS who would "float" to meet clinic needs
  - MA to cover when Blair Park MA is out of office or when there are two providers clinic

Recommendation for Acuity Process: General Surgery & Bariatrics

- What non-phone work drives more acute staffing needs?
  - Assigned physician in clinic, nurse visits, visit type (surgical education, EKG, drain removal, procedure), administrative duties, paperwork requests, review of provider schedule, referral review, patient education/classes
  - How does volume of nursing procedures affect acuity?
  - Nurse visits increase acuity as other nurses will need to cover urgent phone calls during this time period. The nurse involved in the procedures will then have to catch up on non-urgent calls that occurred while they were in procedures.
  - Nurse assistance with provider visits (lump and bump clinic, flex sig, hemorrhoid banding, chaperone) increases acuity significantly
  - Does in basket volume drive more acute staffing needs?
    - Requires a lot of touches
      - Case Management/Social Work
      - Ostomy care and coordination
      - Home health care coordination
      - FMLA
      - Prior authorization for urgent imaging
      - Regular wound care needs (ostomy or pilonidal cyst excision)
    - High resource utilizers
      - Cancer, new ostomy
      - Pre-/post-op questions
    - Volume/aging messages
- Document acuity process, what is considered/discussed
  - When determining staffing needs for the day, we consider physician clinic schedule, nurse visits, procedures, education needs, messages carried over in the in-basket, Wound/Ostomy needs, and CTO/sick time
- What are the "work triggers" which cause a change in practice?
  - Clinical practice changes
  - What requires more nursing support
    - Expansion of scope of service
    - New providers
    - Higher number of procedures which require RN
    - Staffing shortages in other areas (i.e. MA or PSS)
    - Yearly bariatric QI project
    - Nurse participation in NGP or other councils

AMS Benchmark Staffing Grid: General Surgery & Bariatrics

University of Vermont Medical Center

Example of a Target Staffing Pattern
General Surgery Main Campus
Cost Center: 12012240

Completed Provider Visits 8,880
Average per Day 36

Skill	Description	Shift Length (hours)	Number of Staff Mon	Tue	Wed	Thur	Fri	Sat	Sun	Total Weekly Shifts	Total Weekly Req. Hrs w/o repl	Req. FTEs w/o replace	SVH Replace Ratio	Total Paid Hours	Total Paid FTEs	Hours per Indicator Worked	Hours per Indicator Paid
		A								B	C=AxB		D	E=CxD	F=E/40		
		RN															
Nurse Clinician		8.0	1.0	1.0	1.0	1.0	1.0			5.0	40.0	1.0	1.150	46	1.15	0.2342	0.2694
RN		8.0	2.0	2.0	2.0	2.0	2.0			10.0	80.0	2.0	1.193	95	2.4	0.4685	0.5589
WOCN		8.0	1.0	1.0	1.0	1.0	1.0			5.0	40.0	1.0	1.000	40	1.0	0.2342	0.2342
					Pattern Total					20.0	160.0	4.0	1.134	181	4.54	0.937	1.062

University of Vermont Medical Center

Current and Example of a Target Staffing Pattern
General Surgery- Berlin
Cost Center: 12012229

Completed Provider Visits 2,053
Average per Day 8

Skill	Description	Shift Length (hours)	Number of Staff Mon	Tue	Wed	Thur	Fri	Sat	Sun	Total Weekly Shifts	Total Weekly Req. Hrs w/o repl	Req. FTEs w/o replace	SVH Replace Ratio	Total Paid Hours	Total Paid FTEs	Hours per Indicator Worked	Hours per Indicator Paid
		A								B	C=AxB		D	E=CxD	F=E/40		
		RN															
RN		8.0	1.0	1.0	1.0	1.0	0.5			4.5	36.0	0.9	1.142	41	1.0	0.9118	1.0413
					Pattern Total					4.5	36.0	0.9	1.142	41	1.03	0.912	1.041

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Current Staffing Pattern/Schedule: General Surgery & Bariatrics

- Year to date actual at job code level
  - Wound Ostomy Clinician – 1
  - Staff RN IV – 1
  - Staff RN III – 2
  - Staff RN II – 1
- How is this different from budget and if different, why?
  - Budgeted 5 total RNs – 0 LPNs
  - Actual number of RNs is consistent with budget
- How is this different from AMS benchmark staffing grid and if different, why?
  - AMS staffing grid recommended 3 clinic RNs and 1 WOCN RN per day.
  - Current staffing is 4 clinic RNs and 1 WOCN RN per day
  - AMS staffing grid did not consider time needed to assist in procedures, nurse visits, and high touch patient encounters
- How do you staff M-F (weekends if applicable)?
  - Five full time RNs are needed per day. One RN is full time WOCN and does not assist with clinic duties.
- What is your current staffing pattern?
  - Four 1.0 FTE in clinic Monday – Friday with coverage from 0800-1700
  - One 1.0 FTE Wound Ostomy RN Monday – Friday
- How will scheduled and unscheduled CTO and unproductive time will be covered?
  - Use resource pool
  - Other staff members assist and work is prioritized
  - PAs assist with some tasks
  - Low priority tasks carry over until staff member returns

Proposed Staffing Pattern/Schedule: General Surgery & Bariatrics

Skill	Current pattern	ACS Benchmark recommendation	Target pattern
MA	4.0 (shared between GI, GenSurg, and Bariatrics)		5.0 (add 1.0 float MA based in Bariatrics)
RN (clinic)	4.0	3.0	4.0
WOCN	1.0	1.0	1.0

- Address differences from current staffing pattern/schedule and AMS benchmark (if applicable)
  - As previously outlined, there are many hours each week spent on non-nursing duties. Adding an MA or PSS will help reduce RNs performing non-nursing duties. This will allow for greater focus on RN duties such as response time to referrals, review provider schedules, provide additional surgical education, participate in quality improvement projects, create and update policies and procedures to match current practice.
  - Four clinic RNs are proposed, instead of the AMS benchmark recommendation of three clinic RNs, in order to manage CTO/sick days, administrative duties, increased acuity and high touch patient encounters.

Highlighted Changes: General Surgery & Bariatrics

- Maintain current nursing staff level of 5.0 FTE. There is a need for 4.0 FTE in the clinic in order to meet acuity needs and cover CTO/sick days and administrative duties. 1.0 FTE is needed for inpatient and outpatient WOCN.
- Proposed addition of one MA to float between Blair Park and Main campus clinic locations. This will reduce the amount of non-nursing work currently being completed by nurses. The reduction of these tasks will allow for improved response times to telephone calls and referrals and allow nurses to improve patient education, update policies and procedures, and participate in quality improvement projects and committees.

Minimum Staffing Levels: GI

- What are your core RN staffing levels?
  - 4 RN's
- How many people are normally scheduled?
  - 3 RN's
- Speak to what the minimum number of RNs needed, address LPNs if applicable
  - 2-3 RN's
  - What is the minimum number needed to keep clinic open?
    - 2 RN's
- Address tactics to flex staffing up and down (i.e. sister sites, floating, per diems, resource pool)
  - Flex up- floats , resource pool, per diems.
  - Flex down- typically not done as time needed for RN IV administrative time, special projects, patient lists and protocol development.

Time Spent on Nursing vs Non-Nursing Duties: GI

- What is the *approximate* time per week spent on non-nursing functions?
  - 2-3 hours per day
- What non-nursing functions are consistently assigned to RNs?
  - Managing patient lists, faxing, sorting faxes and mail, managing orders, FMLA paperwork
- Is there a recommendation on who could do the work? (goal is to identify options, not solve/implement)
  - Yes- COA's, Call center staff, MA
- What activities do not require RNs or prevent RNs from doing core RN work?
  - RNs can perform rooming function but does it keep RNs from staffing triage calls
  - Rooming, EKG's, sorting paperwork, managing lists, scheduling patients Discuss what is needed to have RNs working to top of license- need to move non-RN duties

Recommendation for Acuity Process: GI

- What non-phone work drives more acute staffing needs?
  - How does volume of nursing procedures affect acuity?
    - Only a few procedures done in the office in GI (capsule endoscopy primarily)- requires one nurse on day of procedure-approx. 1 hour of time
  - Does in basket volume drive more acute staffing needs?
    - Yes- we have chronic conditions that require in depth care coordination
    - Requires a lot of touches of inbasket because dealing with long term chronic illness
      - Chasing physicians, dealing with outside labs, back and forth to multiple areas to resolve issue
    - Case Management/Social Work
    - High resource utilizers
      - Long term chronic conditions(IBD, Chronic Liver Disease)
      - Volume/aging messages- need a plan so we are proactive about this rather than reactive
        - Low priority messages do not get done in a timely fashion- high priority are dealt with on the same day.
        - Endoscopy pre/post calls are huge volume also managing infusion orders
- Document acuity process, what is considered/discussed
  - If we continually cannot get to low priority messages, we ask for help.
- What are the “work triggers” which cause a change in practice?
  - Clinical practice changes
  - What requires more nursing support
    - Expansion of scope of service- Yes- IBD Center of Excellence, Anesthesia review for procedures
    - New providers – yes- 2 new providers
    - Higher number of procedures which require RN and increase in endoscopy
    - Increased video/phone visits-this drives increased call volume

AMS Benchmark Staffing Grid: GI

- Target Staffing Pattern: 4 RN's
- Of note: GI clinic benchmark numbers revised. The recalculation was done to give us a portion of the endoscopy visits since we are doing chart review even though the patient's are not on our schedule. (It is open endoscopy), and pre and post care of these patient's by phone, as well as results review.
  - Endoscopy cases/ Infusions also drive call volume that is not included in this benchmark (these area do not take patient calls)
- Clinic: 5,040 visits. 1.13 X 5040 % 2080 = **2.73 FTE** (this does not include current volume/Dr. Roberts or next MD)

University of Vermont Medical Center

Example of a Target Staffing Pattern

Gastroenterology & Hepatology

Cost Center: 12011412

																	Completed Provider Visits		3,388
																	Average per Day		14
		Shift Length (hours)	Number of Staff							Total Weekly Shifts	Total Weekly Req. Hrs w/o repl	Req. FTEs w/o replace	SVH Replace Ratio	Total Paid Hours	Total Paid FTEs	Hours per Indicator	
Skill	Description		Mon	Tue	Wed	Thur	Fri	Sat	Sun							Worked	Paid
		A								B	C=AxB		D	E=CxD	F=E/40		
		RN															
Nurse Clinician	Clinical	8.0		1.0	1.0	1.0	1.0			4.0	32.0	0.8	1.142	37	0.9	0.4911	0.5609
Nurse Clinician	Professional Allocation	8.0	1.0							1.0	8.0	0.2	1.000	8	0.2	0.1228	0.1228
RN		8.0	1.0	1.0	1.0	1.0				4.0	32.0	0.8	1.142	37	0.9	0.4911	0.5609
					Pattern Total					9.0	72.0	1.8	1.126	81	2.03	1.105	1.245

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Current Staffing Pattern/Schedule: GI

- Year to date actual at job code level
  - How is this different from budget and if different, why? 2 new physicians, increased patient volume, increased workload
  - 2 new provider FTE's since FY 19 has more than doubled the arrived visit volumes. The GI faculty will be adding another MD this August and a 2nd MD with in FY22 with anticipated continued increase to the arrived visit volumes. We have rerun the AMS benchmark data and arrived at a 3.9FTE. Knowing we will be continuing to grow the target staffing will be 4.0 RNs (this is a 1.0FTE add)
    - 3523 FY19 up to 6216 FY20 and now FY21 projection 7175
      - (7175x1.138/2080=3.9 FTE)
  - How is this different from AMS benchmark staffing grid and if different, why?
    - 3 RN's budgeted but would like to increase to 4 RN's due to increased workload.
  - How many RN FTEs are needed per day?
    - 4 RN's M-F
    - 1 RN helping occasionally on the weekend
- What is your current staffing pattern?
  - 3 RN's
- How will scheduled and unscheduled CTO and unproductive time will be covered?
  - Leave low priority tasks undone

Proposed Staffing Pattern/Schedule: GI

- Please add proposed RN staffing and staffing pattern (LPNs if applicable)
  - 4RN's full time
- Address differences from current staffing pattern/schedule and AMS benchmark (if applicable)
  - See slide 33 outlining benchmark changes

Highlighted Changes: GI

- Request for one additional RN (current 3, need 4) because of increased volume of patient's due to 2 new Providers. Clinic patient volumes have significantly increased, thus driving increased RN workload. Frequently low priority calls go undone because of this, in addition to annual projects, goals, workflow development and protocol development, all of which are very important in providing quality patient care.

Minimum Staffing Levels: IR

- What are your core RN staffing levels?

  1 RN

- Minimum number of RNs needed

  1 RN needed

- Minimum number RNs needed to keep clinic open?
  - Volume based service clinic can remain open with 0 RN and creatively meet patient care needs
- Tactics to flex staffing up and down
  - Assistance from IR nurse in radiology (modified sister site)
  - Per diem RN coverage
  - Float assistance in rooming (could be MA)
  - APP/ attending to field patient calls
  - Float Pool coverage of some generic nursing issues

Time Spent on Nursing vs Non-Nursing Duties: IR

- What is the *approximate* time per week spent on non-nursing functions?
  - Time: 10-12 hours/week
  - Non-nursing functions consistently assigned to RN
  - Rooming patients
- Is there a recommendation on who could do the work?
  - MA could room patients, but RN workload provides
  - Downtime waiting for next triage call
- What activities do not require RNs or prevent RNs from doing core RN work?
  - None
- Discuss what is needed to have RNs working to top of license:
  - RN in this clinic works at top of license

Recommendation for Acuity Process: IR

IR clinic is staffed by a single RN as the only clinical person Who provides all aspects of patient care including triage , procedure prep Post procedure follow-up and physician support

AMS Benchmark Staffing Grid: IR

- 1 RN available for triage during clinic hours

University of Vermont Medical Center
Current & Example of a Target Staffing Pattern
Vascular IR Clinic
Cost Center: 12011346

																		Completed Provider Visits	466
																		Average per Day	2
		Shift Length	Number of Staff							Total Weekly	Total Weekly Req. Hrs	Req. FTEs w/o	SVH Replace	Total Paid	Total Paid	Hours per Indicator	
Skill	Description	(hours)	Mon	Tue	Wed	Thur	Fri	Sat	Sun	Shifts	w/o repl	replace	Ratio	Hours	FTEs	Worked	Paid
		A								B	C=AxB		D	E=CxD	F=E/40		
		RN															
RN		8.0	0.9	0.9	0.9	0.9	0.9			4.5	36.0	0.9	1.000	36	0.9	4.0172	4.0172
					Pattern Total					4.5	36.0	0.9	1.000	36	0.90	4.017	4.017

Current Staffing Pattern/Schedule: IR

IR clinic is currently staff by 1 RN

Monday – Friday coverage is with a per diem RN for scheduled time off

Staffing is more about consistent availability during clinic hours than patient volume as this is a core service

Proposed Staffing Pattern/Schedule: IR

Current, proposed and AMS benchmark staffing pattern is consistently at 0.9 RN daily Monday – Friday

Highlighted Changes: IR

- No staffing changes
- Current staffing makes RN triage available 5 days /week

Minimum Staffing Levels: Neurosurgery

- What are your core RN staffing levels?
  - How many people are normally scheduled?
    - 2 full time RNs
    - 0.4 FTE RN allocated from the pediatric neurology cost center
- Speak to what the minimum number of RNs needed, address LPNs if applicable
  - Regardless the number of arrived visit volume (phone volume can be inversely proportional to visit volume.)
    - We could probably get by with 1.5 RNs to keep clinic "open" in a pinch but it would require that we decreased some of the RN visit services that we provide day to day which would cause delays in care and increase ED visits
    - Pediatric Neurosurgery would require urgent phone coverage and clinic support so unable to drop below 0.4 FTE
- Address tactics to flex staffing up and down (i.e. sister sites, floating, per diems, resource pool)
  - For us it gets a bit tricky due the complexity of our specialty but potentially we could look at the resource pool if the staff in it was strong in neurosurgery (possible cross train pedi neurosurgery RN to adult neurosurgery).
  - –Adult Neurosurgery or pediatric general surgery would be trained to cover absences recommend training pedi ambulatory resource RN to cover as well.

Time Spent on Nursing vs Non-Nursing Duties: Neurosurgery

- What is the *approximate* time per week spent on non-nursing functions?
  - What non-nursing functions are consistently assigned to RNs?
    - Right now, we are doing a lot but that's because we are short staffed. Normally we don't do much if any non-nursing work
    - Pediatric Neurosurgery RN will need to support rooming patients and turning over rooms one day a week.
- Is there a recommendation on who could do the work? (goal is to identify options, not solve/implement)
  - The rooming and room turn over should transition to a medical assistant.
- What activities do not require RNs or prevent RNs from doing core RN work (i.e. RNs can perform rooming function, but does it keep RNs from staffing triage calls)
  - If RN is rooming and turning over rooms triage callback will be delayed.
- Discuss what is needed to have RNs working to top of license
  - Getting the providers to answer us
  - Getting buy-in from all staff members to have those that are supposed to own the task to actually own that task. We get a fair amount of push back from some staff members about changing their process and potentially taking on more/different work even if it is work that they really should own.

Recommendation for Acuity Process: Neurosurgery

- What non-phone work drives more acute staffing needs?
  - How does volume of nursing procedures affect acuity?
    - Increase in surgery patients- increases pre-op education visits and wound checks/suture & staple removal
    - MyChart messages
    - On-boarding new staff and providers
    - Education and training needs for RNs
    - Time for projects and committee work
- Does in basket volume drive more acute staffing needs?
  - Requires a lot of touches
    - Case Management/Social Work
    - High resource utilizers
    - Volume/aging messages
      - Patients that call multiple times for the same issue
      - Non- compliant patients
      - Family members and patients who have unreasonable expectations or high anxiety
  - Document acuity process, what is considered/discussed
    - Emergent neurosurgical complications which could result in loss of life of function vs non emergent symptoms or questions which can be dealt with later
- What are the "work triggers" which cause a change in practice?
  - Clinical practice changes
  - What requires more nursing support
    - Expansion of scope of service
    - New providers
    - Higher number of procedures which require RN

AMS Benchmark Staffing Grid: Neurosurgery

University of Vermont Medical Center

Example of a Target Staffing Pattern

Neurosurgery

Cost Center: 12012233

Completed Provider Visits	6,148
Average per Day	25

Skill	Description	Shift Length (hours)	Number of Staff: Mon	Tue	Wed	Thur	Fri	Sat	Sun	Total Weekly Shifts	Total Weekly Req. Hrs w/o repl	Req. FTEs w/o replace	SVH Replace Ratio	Total Paid Hours	Total Paid FTEs	Hours per Indicator: Worked	Paid
		A								B	C=AxB		D	E=CxD	F=E/40		
		RN															
RN		8.0	1.0	1.0	1.0	1.0	1.0			5.0	40.0	1.0	1.130	45	1.1	0.3383	0.3823
RN		8.0	1.0	1.0	0.5					2.5	20.0	0.5	1.130	23	0.6	0.1692	0.1912
					Pattern Total					7.5	60.0	1.5	1.130	68	1.70	0.507	0.573

Current Staffing Pattern/Schedule: Neurosurgery

- Year to date actual at job code level
  - RNs, LPNs for clinics who have LPNs

    2 RNs Adult Neurosurgery and 0.4 RN Pedi Neurosurgery (lives in neurology cost center)
  - How is this different from budget and if different, why?
    - Higher than AMS benchmark as not all job requirements were taking into consideration
  - How is this different from AMS benchmark staffing grid and if different, why?
    - AMS staffing grid does not reflect the amount of non-phone nursing work done
    - The AMS work did not encompass pediatric Neurosurgery
- How do you staff M-F (weekends if applicable)?
  - How many RN FTEs are needed per day?
  - 2.0 FTE/0.4FTE Pedi Neurosurg
- What is your current staffing pattern?
  - 2 RNs M-F
  - –0.4FTE M-F Pedi Neurosurg provided by pediatric neurology RN
- How will scheduled and unscheduled CTO and unproductive time will be covered?
  - Resource pool when up and running

Proposed Staffing Pattern/Schedule: Neurosurgery

- Please add proposed RN staffing and staffing pattern (LPNs if applicable)
  - 2.0 FTE- 2 RNS full time M-F
  - –0.4FTE M-F Pedi Neurosurg provided by pediatric neurology RN
- Address differences from current staffing pattern/schedule and AMS benchmark (if applicable)
  - Same as current staffing patter- increase from AMS benchmark to account of non-phone work that has not been included in their data. Pediatric Neurosurgery was not accounted for in the AMS work

Highlighted Changes: Neurosurgery

- No changes to current staffing pattern identified. Current pattern greater than projected benchmark. This is necessary to account for the non- phone and non-provider visit attached nursing work provided to patient's daily in addition to the phone work and provider attached nursing work done.

Minimum Staffing Levels: Ophthalmology

- What are your core RN staffing levels?
  - 2 RN's
    - 1 RN and 1 LPN could be a consideration
  - How many people are normally scheduled?
    - 2 RN
- Speak to what the minimum number of RNs needed, address LPNs if applicable:
  - What is the minimum number needed to keep clinic open?
    - 1 RN
- Address tactics to flex staffing up and down (i.e. sister sites, floating, per diems, resource pool):
  - We don't tend to staff up or down

Time Spent on Nursing vs Non-Nursing Duties: Ophthalmology

- What is the *approximate* time per week spent on non-nursing functions?
  - 5% admin work
  - What non-nursing functions are consistently assigned to RNs?
    - Letters or paperwork
- Is there a recommendation on who could do the work? (goal is to identify options, not solve/implement):
  - PSS staff, MA
- What activities do not require RNs or prevent RNs from doing core RN work
  - Admin work
- Discuss what is needed to have RNs working to top of license
  - Clerical support for the non-nursing related activities

Recommendation for Acuity Process: Ophthalmology

- What non-phone work drives more acute staffing needs? FA's, MD wants or needs
  - How does volume of nursing procedures affect acuity? The more FA's the more an RN is out of the in basket for
- Does in basket volume drive more acute staffing needs?
  - It can, vary day to day
  - Volume/aging messages-non urgent messages
  - Waiting for MD replies
- Document acuity process, what is considered/discussed
  - Urgent eye problems vs. Non urgent things that can wait or be put aside
- What are the “work triggers” which cause a change in practice?
  - Clinical practice changes: MD changes and wants
  - What requires more nursing support
    - Expansion of scope of service
    - Higher number of procedures which require RN::FA's (this varies day to day)
    - In clinic emergencies.

AMS Benchmark Staffing Grid: Ophthalmology

University of Vermont Medical Center

Example of a Target Staffing Pattern

Ophthalmology Main & Shelburne Road

Cost Center: 12012227

Completed Provider Visits 25,376

Average per Day 102

Skill	Description	Shift Length (hours)	Number of Staff: Mon	Tue	Wed	Thur	Fri	Sat	Sun	Total Weekly Shifts	Total Weekly Req. Hrs w/o repl	Req. FTEs w/o replace	SVH Replace Ratio	Total Paid Hours	Total Paid FTEs	Hours per Indicator: Worked	Hours per Indicator: Paid
		A								B	C=AxB		D	E=CxD	F=E/40		
		RN															
RN	8a - 4:30p	8.0	1.0	1.0	1.0	1.0	1.0			5.0	40.0	1.0	1.190	48	1.2	0.0820	0.0975
RN	8:30a - 5p	8.0	1.0	1.0	1.0		0.5			3.5	28.0	0.7	1.190	33	0.8	0.0574	0.0683
					Pattern Total					8.5	68.0	1.7	1.190	81	2.02	0.139	0.166

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Current Staffing Pattern/Schedule: Ophthalmology

- Year to date actual at job code level
  - RNs, LPNs for clinics who have LPNs
    - 2 RN's working at 1.0 FTE each, splitting time between main campus and Shelburne Road
  - How is this different from budget and if different, why?
    - This is the same as what is budgeted.
  - How is this different from AMS benchmark staffing grid and if different, why?
    - 2 RN FTE's are aligned with AMS benchmark
- How do you staff M-F (weekends if applicable)?
  - How many RN FTEs are needed per day?
    - 2 RN FTE's
- What is your current staffing pattern?
  - 2 FTE's
- How will scheduled and unscheduled CTO and unproductive time will be covered?
  - Per Diem RN or LPN
  - Full time MA

Proposed Staffing Pattern/Schedule: Ophthalmology

- Please add proposed RN staffing and staffing pattern (LPNs if applicable)
  - Add part time MA and Per diem RN/PLA to fill in with RN out. MA would help 4 hours a day with 2 nurses. Per diem would fill in gaps to keep 2 nurses at all times. Or have MA full time while a nurse is out. MA to help with non urgent things in the in basket: PA's, med refills, no urgent questions.
  - Currently filling second MA position that was budgeted. This is not an add.

Highlighted Changes: Ophthalmology

- Request for part time MA or Per Diem RN. This would help fill the gaps when there is an RN out. The MA would be part with nurses 5 days a week and part time in clinic 5 days a week. The MA would be asked to help out full time with the nurses if one of us is out. Or use the Per Diem RN as a second nurse when the other is out and still maintain MA part time.
- 4/6: will utilize the resource pool instead of a per diem RN

Minimum Staffing Levels: Plastics

- What are your core RN staffing levels?
  - How many people are normally scheduled?
    - 2 RN's
- Speak to what the minimum number of RNs needed, address LPNs if applicable
  - What is the minimum number needed to keep clinic open?
    - 1 to 2 RN depending on number of procedures and providers in clinic
- Address tactics to flex staffing up and down (i.e. sister sites, floating, per diems, resource pool)
    - Floating to sister site
    - Utilize float pool

Time Spent on Nursing vs Non-Nursing Duties: Plastics

- What is the *approximate* time per week spent on non-nursing functions?
  - Majority of the day is spent rooming patients, chaperoning procedures and cleaning rooms.
- Is there a recommendation on who could do the work?
  - An MA would be able to do non nursing work.
- What activities do not require RNs or prevent RNs from doing core RN work?
  - Rooming patients, chaperoning procedures, cleaning rooms, ordering supplies, stocking rooms, taking photos, transferring patients and procedure set up.
- Discuss what is needed to have RNs working to top of license.
  - In order for an RN to work at the top of their practice in this clinic would be time for patient teaching in clinic preop planning and post op care, ordering DME and following up on home health referrals. Providing support staff to do non nursing tasks.

Recommendation for Acuity Process: Plastics

- What non-phone work drives more acute staffing needs?
  - Working closely with the provider assisting with procedures, chaperoning and taking photos during the appointment. Coordination of DME orders and Homehealth referrals. Filling out disability paperwork and FMLA paperwork. Managing medication refills electronic or via fax. Mychart message management.
- Does in basket volume drive more acute staffing needs?
  - Yes, the in basket drives the need for more acute staffing needs. The more encounters that need to be touched the more nurses required. Tracking the encounters to make sure the patients are responded to in a timely fashion. Multiple messages being sent back and forth between the physician as well as follow to ensure the provider has reached out to the patient. Mislabeling of messages by non medical staff. Awaiting test results.
- Document acuity process, what is considered/discussed
  - Current process involves daily analysis of workload and required tasks.
- What are the “work triggers” which cause a change in practice?
  - Clinical practice changes: on boarding new staff MD, RN, MA, SCOA and PSS. Policy changes that require more time to complete daily work and new daily work (Covid testing), IT downtime and Committee time. New DME products, medication and in office procedures.

AMS Benchmark Staffing Grid: Plastics

University of Vermont Medical Center
Example of a Target Pattern Staffing Pattern
Plastics
Cost Center: 12012234

Completed Provider Visits	5,030
Average per Day	20

Skill	Description	Shift Length (hours)	Number of Staff Mon	Tue	Wed	Thur	Fri	Sat	Sun	Total Weekly Shifts	Total Weekly Req. Hrs w/o repl	Req. FTEs w/o replace	SVH Replace Ratio	Total Paid Hours	Total Paid FTEs	Hours per Indicator Worked	Paid
		A								B	C=AxB		D	E=CxD	F=E/40		
RN																	
RN	7a - 3:30p	8.0	1.0	1.0	1.0	1.0	1.0			5.1	40.8	1.0	1.23	50	1.3	0.4218	0.5209
RN	8:30a - 5p	8.0	1.0	1.0		1.0				3.0	24.0	0.6	1.23	30	0.7	0.2481	0.3064
	Pattern Total									8.1	64.8	1.6	1.23	80	2.00	0.670	0.827

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Current Staffing Pattern/Schedule: Plastics

- Year to date actual at job code level
  - 1 RN FTE
- How do you staff M-F (weekends if applicable)?
  - Monday- Friday 1 RN FTE supporting clinic
  - Not open on weekends
- What is your current staffing pattern?
  - 1 RN working Monday through Friday to support clinic but the clinic is budgeted for 2 RN FTE's
- How will scheduled and unscheduled CTO and unproductive time will be covered?
  - Resource Pool/Per Diem when available
  - Work short staffed

Proposed Staffing Pattern/Schedule: Plastics

- Please add proposed RN staffing and staffing pattern
  - Recruit for the open RN FTE (1.0) to match what is budgeted (2.0 RN FTE) and stop the clinic from running short staffed
- Address differences from current staffing pattern/schedule and AMS benchmark (if applicable)
  - No change

Highlighted Changes: Plastics

- Recruit an RN to fill the vacant 1.0 RN FTE in the budget. This will equal 2.0 RN FTE's in the clinic.

Minimum Staffing Levels: Urology

- What are your core RN staffing levels?
  - ACC 3.8
  - MOB 1.8
  - Middlebury 1 LPN
- Speak to what the minimum number of RNs needed, address LPNs if applicable
  - 5-6 RNs total -schedule dependent to address the following major components of care
    - Middlebury is staffed with LPN, so all Middlebury RN work is done at ACC (Triage)
    - RN only schedule requiring 8-14 hours a day
    - Physician visits linked with RN procedures
    - Clinic administered meds
    - Medication refills
    - My Chart messages for 10 physicians &1 PA
    - DME teaching, ordering, and refill
    - Phone triage volume
    - Pre- and post-operative teaching and patient preparation
    - Surgical preparation

Address tactics to flex staffing up and down

- Rotation between Urology clinic locations (all the same clinic- 3 different locations)
- Resource pool or per diem, if available
- Patient schedule manipulation- moving patients to a different day/location
- Part time RN working extra (short periods from home)
- Prioritization of work, acknowledging the work that is put off to the next day
- Overtime
- Traveler
- Flex staffing with 10-hour shifts
- Remote help from other ambulatory RN, if available
  - ***not all resources are consistently available***

Time Spent on Nursing vs Non-Nursing Duties: Urology

- What is the *approximate* time per week spent on non-nursing functions?
  - Zero except:
    - Only to maintain patient flow, when limited staff in other roles (no per diem, other staff member to fill the role)
  - What non-nursing functions are consistently assigned to RNs?
    - None
- Is there a recommendation on who could do the work?

  MA
- What activities prevent RNs from doing core RN work
  - Burnout
  - System inefficiencies (order sets, preference lists and flowsheets)
  - Unplanned / unscheduled patient visits
  - Chasing or waiting for providers to answer questions /waiting response to routed messages
  - Mis-routed calls
  - Customer service recovery
  - Inaccurate or incomplete call encounters
  - Supporting MA / schedulers staff or filing in when short staffed MA
  - Change management
  - Phone tag with patients through call center
- Discuss what is needed to have RNs working to top of license?
  - Urology is proud to have RNs consistently working at top of license
  - Increased support for other clinical staff (MAs, PSS, SCOAs)

Recommendation for Acuity Process: Urology

What non-phone work drives more acute staffing needs?

One to one direct nursing care hours. Including nursing procedure, patient teaching, and medication administration. In the urology clinics the non-phone work that drives more acute staffing needs is the number of nursing patients and the acuity of those nursing patients. The complexity of the procedure and acuity of the patient will drive the length of the time needed 30-120 minutes. Nursing also provides a lot of emotional support to our patients during invasive procedures. Dealing with patients with an acute illness or symptoms from a procedure. Not all the of nursing patient are listed on the nursing schedule, due to incomplete, unplanned or spontaneous patient needs. Multiple procedures happening at the same time or the need to cluster patients due to physician supervision. The in basket for nursing includes DME requests, home health referrals, medication refills, my chart messages, cc'd charts, staff messages from physicians, results notes from physicians, and communications from other departments. Orientation of new nursing staff will limit the ability of a nurse to function at their usual productive level. The needs of keeping registered nurses up to date with education, training, and participating in committees. Pre-operative and post-operative care and teaching for the patients. Updating patient education materials and current policies within urology.

Does in basket volume drive more acute staffing needs?

Yes the in basket drives the need for more acute staffing needs. The more encounters that need to be touched the more nurses required. Tracking the encounters to make sure the patients are responded back to in a timely fashion. Messages in the in basket that require multiple messages being sent back and forth between the physician that more time. The delay of sending messages to physicians or SCOA staff and awaiting responses. Messages within the box have to be looked at multiple times to see if no response was ever received or if the patient never called back. These message must be resent to the physicians or closed. Mis-labeling by non-medical staff of what is a high priority call and what is not a high priority call. Awaiting test results. Average 1300 encounters/week in urology.

What are the “work triggers” which cause a change in practice?

Adding nursing procedures such as Gemcitabine and the length of the procedure. Challenging policy changes that require more time to fulfill. IT downtime.

What requires more nursing support?

The onboarding of new nurses to the practice and increase number of providers. The a procedures either performed by nursing or physicians. Patient visit volume.

AMS Benchmark Staffing Grid: Urology

		AMS Benchmark Staffing				
	M	T	W	TH	F	Benchmark
ACC	3	3	1	3	3	13901
MOB	2	1	1	1	1	5817
Midd		1.2 LPN	1.2 LPN		1 LPN	
PEDI	1	1	1	1	1	

Current Staffing Pattern/Schedule: Urology

Urology is Currently staff with a combination of RNs across all locations to equal the current budget of 1.8 RN FTE-MOB , 4.8 FTE RN –ACC . and 0.7 FTE LPN in Middlebury. In-basket work is centralized, and some RNs are working from home. This is higher than the AMS benchmark staffing grid because 1 FTE of RN is allocated to Pediatric Urology and managed by the CSC to share work with Pedi General Surgery. This is consistent year to date budget. AMS benchmark staffing grids are lower than actual based on utilization of benchmark that is significantly lower that FY 20 actual completed provider visits. Adult Urology is staffed 5-6 RNs Monday – Friday totaling 5.6 FTEs. Clinic need justifies 6-7RNs/day primarily to start and complete a comprehensive plan to address specific pre-and post-operative needs of the urology patient population. Currently there is no coverage for scheduled and unscheduled CTO, but potential options are addressed in slide 16.

Proposed Staffing Pattern/Schedule: Urology

		Proposed Staffing Pattern				
	M	T	W	TH	F	Visit benchmark
ACC	5	5	5	5	5	19837
MOB	2	2	1	1	2	6000
Midd		1 LPN		1.2 LPN	1.2 LPN	
PEDI	1	1	1	1	1	
	Increase by 1 FTE based on actual completed physician visit FY 20 and new patient volume waiting access					

- Based on new volumes, recalculated FTE based on AMS benchmark
  - 5.96 RN FTE's benchmarked for ACC and MOB
  - (25830 x 0.48/2080= 5.96 FTE's)

Highlighted Changes: Urology

Increase 1 FTE RN to meet AMS benchmark given new provider volume. Increasing patient volumes, patient acuity and supporting new providers. Nursing support for new clinic therapies including Xiaflex, Gemcitabine, Testopel, Cidofovir, and Botox. Need to implement a preoperative chart review/teaching and post-operative phone assessment program to meet the standard of care and practice. Complete Referral Triage ! Nursing participation in education and committee work. Supporting urology research projects through the collection of data and implementation of study requirements.

Even though the benchmark is one RN encounter per provider visit, the inbasket volume demonstrates a minimum of two RN encounters per provider visit

Urology research: there is not funding available to support physician and cancer center research projects.

Minimum Staffing Levels: Vascular

- What are your core RN staffing levels?
  - Core staffing levels over the past several years have included 1 MA and 3 RN'S (full- time) The MA usually works 8-430 and 2 RN's work 8-430 with the third RN taking the 830 – 5 pm shift though on occasion a RN stays to complete work, late patients or patients in clinic awaiting an inpatient bed.
- Speak to what the minimum number of RNs needed, address LPNs if applicable
  - What is the minimum number needed to keep clinic open?
  - We do not have LPN'S. The current 3 RN's enables one RN to perform inpatient angiogram orders/ contact post-op patients for post-op assessment, phone triage, med refills and afford one MA and the remaining 2 RN'S to room patients /perform wound care, assist with procedures / assist with disability paperwork/ ordering of wound care supplies/ contact home health after each applicable patient visit and documentation of wound care. 1 RN assists at our off-site locations x 2 monthly.
    - Berlin: 2x/month
    - Water Tower Hill: every other Monday and every other Friday
  - Consider procedures as no infusions are performed. Performing rooming of patients, wound care, unna boots/profore/wound vac fill a large portion of our day along with patient/family teaching of dressing changes that need to be changed daily if applicable. Currently also performing regular transportation to garage and front door as greater than 50 % of our patients have mobility issues. Assisting surgeon with other procedures on an as needed basis, apligraf/puraply/pseudoaneurysm injection/sclerotherapy. We room patients as a large part of our role with only having 1 MA.
- Address tactics to flex staffing up and down (i.e. sister sites, floating, per diems, resource pool)
  - We do currently go to Berlin outreach clinic x 2 monthly requiring one RN to accompany surgeon and vascular tech. Along with our supervisor we look ahead each week to assess if we do not need any additional staff based on clinic numbers and acuity of the number for that day. If needed, we may have a float MA for a day or portion of day or as currently due to maternity leave since July we have a full time float RN . Up and down staffing is determined in advance by our patient numbers/acuity in collaboration with our supervisor
  - RN float pool
  - Per-diem MA
  - Schedule manipulation
  - APP- assist in wound care when unavailable RN

Time Spent on Nursing vs Non-Nursing Duties: Vascular

- What is the *approximate* time per week spent on non-nursing functions?
  - What non-nursing functions are consistently assigned to RNs?
    - Rooming patients, transportation, stocking of rooms
    - RN does chart prep for the outreach clinic in Berlin
- Is there a recommendation on who could do the work? (goal is to identify options, not solve/implement)
  - As of 2/11/21, we have replaced 1 MA.
  - The goal is to hire a second MA to assist with the non-nursing tasks outlined above.
- What activities do not require RNs or prevent RNs from doing core RN work?
  - RNs can perform rooming function, but does it keep RNs from staffing triage calls, some paperwork, return to work notes, etc.
- Discuss what is needed to have RNs working to top of license
  - Affording time for RN's to call post-op patients and complete EVAR /post-op data base is a goal of the division . Necessitates additional time for phone work certainly.

Recommendation for Acuity Process: Vascular

- This is a narrative
  - 1:1 nurse procedure volume
  - Patient Preparation for interventional procedures, chart review, placing orders, phone call to patient with medication instructions, documentation.
  - Patient procedures in clinic discussed in slide 8 (post-op, wound debridement's with MD, Skin substitute procedures, complex wound care)
  - Pending infusion orders to physicians and
- How does volume of nursing procedures affect acuity?
  - Ordering of skin substitutes, set –up of procedure, assist MD/np wound care and patient education after procedure, documentation EPIC/data base.
  - In office procedures have increased 10-15%
  - Does in basket volume drive more acute staffing needs?
    - Yes In Basket volume drives nursing needs. Messages that require many touches, need to consult multiple specialty
    - Low priority messages appear to be done currently within a day or early the next morning.
  - Given the nature of vascular surgery treatment plans a large majority of our patients are considered complex due to multiple co-morbidities. Patient acuity is based on multiple factors. Age of patient(large population over 85) mobility(wheelchair vs ambulatory, h/o stroke, absence of a leg (BKA vs AKA) and status post major vascular surgery, memory/cognitive issues due to age or disease process. Often need to undress and dress patient before and after exam. Ensuring patient safety in the clinic is a priority and we often also need to transport these patients to their loved ones at the front door
- What are the “work triggers” which cause a change in practice?
  - Increase skin substitute procedures requiring 1:1 And wound vacs.
  - High risk mobility patients in wheelchair requiring assist for movement.
  - What requires more nursing support
    - Expansion of scope of service
    - New providers
    - Higher number of procedures which require RN
    - Acting as transport to lobby, garage regularly

AMS Benchmark Staffing Grid: Vascular

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Example of a Target Staffing Pattern

Vascular Surgery

Cost Center: 12012242

Completed Provider Visits	5,575
Average per Day	22

			Number of Staff														
Skill	Description	Shift Length (hours)	Mon	Tue	Wed	Thur	Fri	Sat	Sun	Total Weekly Shifts	Total Weekly Req. Hrs w/o repl	Req. FTEs w/o replace	SVH Replace Ratio	Total Paid Hours	Total Paid FTEs	Hours per Indicator: Worked	Hours per Indicator: Paid
		A								B	C=AxB		D	E=CxD	F=E/40		
		RN															
RN		8.0	1.0	1.0	1.0	1.0	1.0			5.0	40.0	1.0	1.115	45	1.1	0.3731	0.4160
RN		8.0	1.0							1.0	8.0	0.2	1.115	9	0.2	0.0746	0.0832
					Pattern Total					6.0	48.0	1.2	1.115	54	1.34	0.448	0.499

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Current Staffing Pattern/Schedule: Vascular

- Year to date actual at job code level
  - 3 RN Equals budget
  - AMS 1.34 Workload is not accurately reflected
- How do you staff M-F (weekends if applicable)?
  - 3 RN daily Monday – Friday (adjusted by daily volumes)
- What is your current staffing pattern?
  - 3 RN /day
- How will scheduled and unscheduled CTO and unproductive time will be covered?
  - Covered by Float pool RN if available or not covered if census is lower for the day

Proposed Staffing Pattern/Schedule: Vascular

- Please add proposed RN staffing and staffing pattern
  - 3 RN's Monday – Friday
- Address differences from current staffing pattern/schedule and AMS benchmark (if applicable)
  - Pattern not sustainable unless Non-RN
  - Functions are reassigned to clerical staff and MA staff

Highlighted Changes: Vascular

Recommendations from our review: recommend 3 RN'S and 2 MA's.

We need to focus on nursing duties only delegating numerous activities that are non-nursing to our capable MA's. For example, rooming, printing of records, transportation, cleaning of rooms and ordering of supplies. The goal for our RN'S are to focus on wound care, phone triage, care of complex patients, wound care coordination, ordering and documentation.. Integral to our daily workflow is coordination with our skilled home health care nurses in Vermont and New York. Division EVAR data base work and multiple other vascular data bases assist us in providing care to our patients.

The RN overall goal is to work to the top of our license to provide optimal care to our complex surgical patients. Ongoing staff shortages i.e. no MA currently create extra non-nursing work and present the ongoing need to utilize our float RN pool and MA's from other divisions. Goals will be met by completion of phone calls by the end of the clinic day, communication with our community health staff nurses and improved patient satisfaction.

Staffing Data including Unit Budget

FY21 Budgeted FTEs			
Division	FY21 RNs	FY21 LPNs	Total
Gastroenterology	3	0	3
Ophthalmology	2	0	2
General Surgery	5	0	5
Surgical Oncology- included as part of Cancer Services USC	N/A	0	N/A
Otolaryngology	3	2	5
Neurosurgery	2	0	2
Plastic Surgery	2	0	2
Cardio Thoracic Surgery (CT)	1.5	0	1.5
Urology	5.6	0.7	6.3
Vascular Surgery	3	0	3
Trauma & Critical Care (ACS)	1	0	1
Total	29.4	2.7	32.1

Financial Impact of the Proposal

Service	Proposed Staffing Addition	FTE	Estimated Annual Salary	Annual Fringe (29.44%)	Financial Impact
Urology	RN	1	$ 78,166.00	$ 23,012.07	$ 101,178.07
Gen Surg/Bariatrics	MA	1	$ 35,360.00	$ 10,409.98	$ 45,769.98
GI	RN	1	$ 78,166.00	$ 23,012.07	$ 101,178.07
Vascular	MA	1	$ 35,360.00	$ 10,409.98	$ 45,769.98
Total		**4**	**$ 227,052.00**	**$ 66,844.11**	**$ 293,896.11**
Ophthalmology has 2.0 MA budgeted - just need to hire the second					

Priority:
1. Urology- FY21
2. Gen Surg/Bariatrics- FY22
3. GI- FY21 (adding new GI provider over the summer and will need additional support ASAP)
4. Vascular- FY22
5. Ophthalmology- request to hire second MA has been submitted

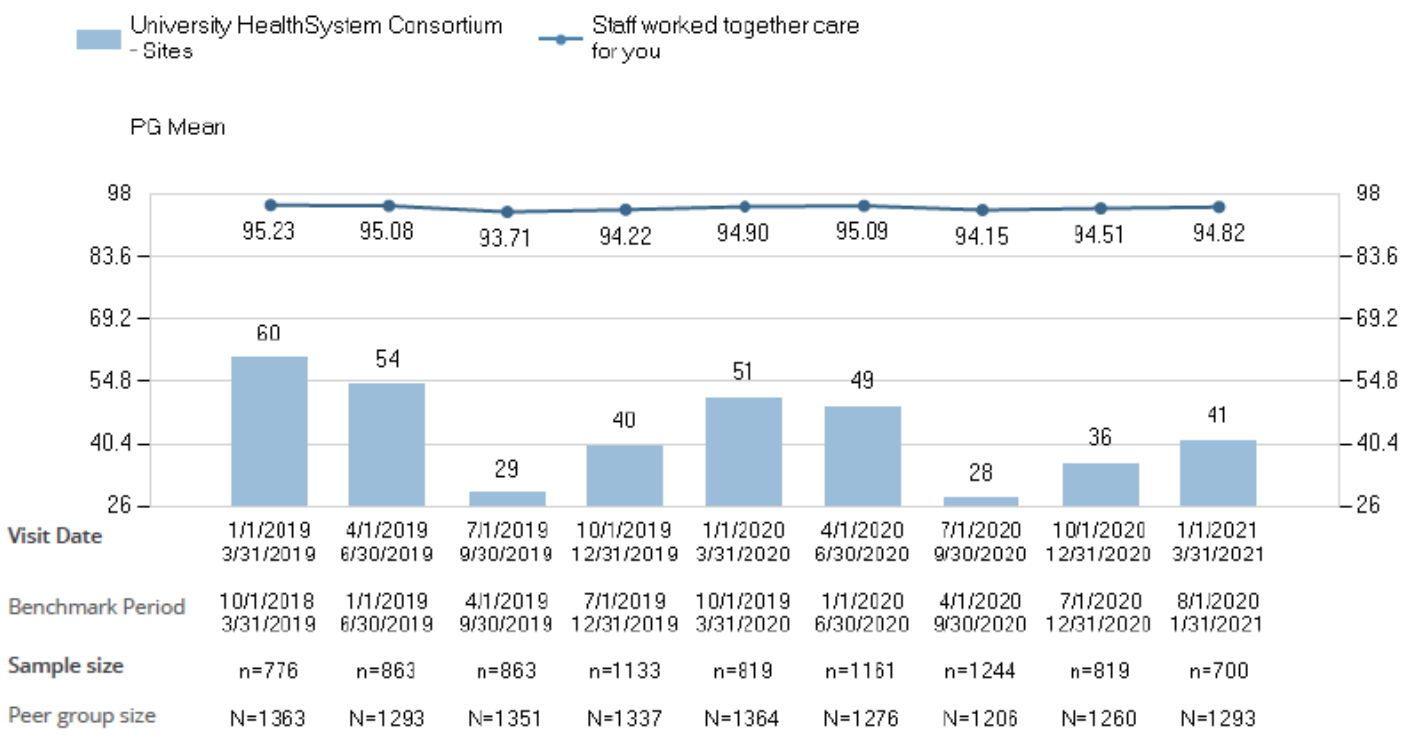
Metrics to Measure the Effectiveness of the USC Project Plan

- How will you know staffing levels are effective?
  - Decreased overtime
  - Decreased turnaround time for phone calls (within 24 hours)
    - Inbasket report
    - providing same day nursing care/visit for patient with new/evolving symptoms and/or wound issues
  - Increased employee satisfaction within division
    - NDNQI survey
  - If there are non-RN tasks, they should be phased out
    - More time to focus on RN tasks (triage, care coordination, etc.)
    - Utilization of MA
    - RN III and RN IV's are consistently able to attend committee work as needed
    - Complete nurse triage protocols
  - Improved patient satisfaction
    - Press Ganey: "responses to concerns and questions"
  - Occurrence of utilizing nursing resource pool
  - Increased # of post-op calls
    - Track use of dot phrase or chief complaint for telephone encounters
  - Utilization of a traveling nurse
  - Feedback from community partners
- Have the items you identified in the USC (i.e. non-nursing functions) been addressed
  - In progress
- This assessment will be ongoing beyond initial recommendations

Baseline Data

Press Ganey

My Sites: Total



MyChart Response Rate

	FY21
Division	**Turn Around Time**
Transplant	No Data Available
Acute Care Surgery	No Data Available
UVMMC Vascular	No Data Available
General Surgery	No Data Available
Berlin Ophthalmology	0
CT Surgery	1
Neurosurgery	2
Urology	0.8
GI	3.4
Plastics	42.9
Williston Bariatrics	36.5
Williston Vascular	1
ENT	4.9
Ophthalmology	2.6

NDNQI

Unit - Survey DESC	Measure Short Desc	Year	Srvy Unit Mean	RNSrvy_PGUnitMean
Surgery Health Care Service	Adq staff to get work done	2020	2.43	2.50

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Actionable Opportunities to Meet AMS staffing benchmarks

In process:

- Continue to transition the process of Prior authorization to the Prior Auth team especially for medications
- Develop / Cross-Train RN float Pool

Future:

- Right size MA staffing
  - Implement an MA to Physician visit staffing ratio
    - ❖ 20-23:1 in procedure-based clinic with MA assisting procedure And rooming
    - ❖ 28-30:1 in non-procedure-based clinic , MA rooming only
  - Develop /orient MA float Pool
  - As MA staffing is adjusted, transition Non-RN work to MA to include rooming, chaperoning , and assisting with procedures
- Collaborate with clinic supervisors to review and redesign workflows related to faxes, scheduling, results, supplies and other clerical tasks
- Standardize RN role across surgical specialties
- Cross train RNs to "sister sites "
- Transition work or allocate FTE to hospital departments where work is occurring and generating revenue

Time line and Deliverables

- Check in/progress update - schedule call with P. Gagne and D. Snell by **October 15, 2020**

- Final plans submission deadline:
  - **INPATIENT UNITS: November 20, 2020**
  - **AMBULATORY CLINICS: February 15, 2021**

- Submit to: CNO and President VFNHP
  - Scan as 1 document and email to Peg.Gagne@uvmhealth.org and debs@vfnhp.org

Project Plan Approval

May 3, 2021

Dear Surgery USC Team:

Thank you very much for your engagement and efforts in the Unit Staffing Collaborative (USC) project. We are pleased to let you know that your project plans and the following FTEs have been approved for FY 22. If there is an urgent need for the FTE additions to happen prior to FY 22 (10/1/2021), please follow the position review/ approval process with your leadership team:

Service	Staffing Addition	FTE
Urology	RN	1.0
Gen Surg/ Bariatrics	MA	1.0
GI	RN	1.0
Vascular	MA	1.0

If you have any questions about the USC project approvals, please let us know.

Going forward, your USC team is responsible for the implementation and ongoing monitoring of the effectiveness and progress of your staffing plan, review of any Concern Forms and submission of proposed changes/ reports to the Staffing Committee (see Article 20B).

Regards,
Peg and Deb

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