Advisory Board | Nursing Executive Center

Put an End to Nurse Manager Overload

Transform overwhelmed unit managers into high-performing and inspiring nursing leaders

RESEARCH REPORT

Look inside for best practices that help senior leaders:

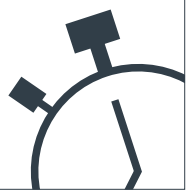
- Elevate the nurse managers' role to "sign-off"
- Better leverage in-house roles
- Filter strategic initiatives
- Spotlight and control interdisciplinary demands
- Buffer against 24/7 unit demands

TOPIC

Nurse manager **overload**

READING TIME

1.5 hr.



BEST FOR

Nurse executives and directors

LEARN HOW TO

- Describe the factors in today's environment making the nurse manager role more challenging
- Identify executive strategies to right-size nurse manager workload in your organization
- Develop a plan for revising the role to help nurse managers focus on their most important leadership responsibilities

Advisory Board | Nursing Executive Center

Put an End to Nurse Manager Overload

Transform overwhelmed unit managers into high-performing and inspiring nursing leaders

RESEARCH REPORT

Nursing Executive Center

Project Director
Anne Herleth, MPH, MSW

herletha@advisory.com
202-568-7749

Contributing Consultants
Mack Kelly

Karen Zwickel

Program Manager
Marisa Deline, MA

Managing Director
Katherine Virkstis, ND

Executive Director
Jennifer Stewart

Design Consultant
Nini Jin

LEGAL CAVEAT

Advisory Board is a division of The Advisory Board Company. Advisory Board has made efforts to verify the accuracy of the information it provides to members. This report relies on data obtained from many sources, however, and Advisory Board cannot guarantee the accuracy of the information provided or any analysis based thereon. In addition, Advisory Board is not in the business of giving legal, medical, accounting, or other professional advice, and its reports should not be construed as professional advice. In particular, members should not rely on any legal commentary in this report as a basis for action, or assume that any tactics described herein would be permitted by applicable law or appropriate for a given member's situation. Members are advised to consult with appropriate professionals concerning legal, medical, tax, or accounting issues, before implementing any of these tactics. Neither Advisory Board nor its officers, directors, trustees, employees, and agents shall be liable for any claims, liabilities, or expenses relating to (a) any errors or omissions in this report, whether caused by Advisory Board or any of its employees or agents, or sources or other third parties, (b) any recommendation or graded ranking by Advisory Board, or (c) failure of member and its employees and agents to abide by the terms set forth herein.

The Advisory Board Company and the "A" logo are registered trademarks of The Advisory Board Company in the United States and other countries. Members are not permitted to use these trademarks, or any other trademark, product name, service name, trade name, and logo of Advisory Board without prior written consent of Advisory Board. All other trademarks, product names, service names, trade names, and logos used within these pages are the property of their respective holders. Use of other company trademarks, product names, service names, trade names, and logos or images of the same does not necessarily constitute (a) an endorsement by such company of Advisory Board and its products and services, or (b) an endorsement of the company or its products or services by Advisory Board. Advisory Board is not affiliated with any such company.

IMPORTANT: Please read the following.

Advisory Board has prepared this report for the exclusive use of its members. Each member acknowledges and agrees that this report and the information contained herein (collectively, the "Report") are confidential and proprietary to Advisory Board. By accepting delivery of this Report, each member agrees to abide by the terms as stated herein, including the following:

1. Advisory Board owns all right, title, and interest in and to this Report. Except as stated herein, no right, license, permission, or interest of any kind in this Report is intended to be given, transferred to, or acquired by a member. Each member is authorized to use this Report only to the extent expressly authorized herein.
2. Each member shall not sell, license, republish, or post online or otherwise this Report, in part or in whole. Each member shall not disseminate or permit the use of, and shall take reasonable precautions to prevent such dissemination or use of, this Report by (a) any of its employees and agents (except as stated below), or (b) any third party.
3. Each member may make this Report available solely to those of its employees and agents who (a) are registered for the workshop or membership program of which this Report is a part, (b) require access to this Report in order to learn from the information described herein, and (c) agree not to disclose this Report to other employees or agents or any third party. Each member shall use, and shall ensure that its employees and agents use, this Report for its internal use only. Each member may make a limited number of copies, solely as adequate for use by its employees and agents in accordance with the terms herein.
4. Each member shall not remove from this Report any confidential markings, copyright notices, and/or other similar indicia herein.
5. Each member is responsible for any breach of its obligations as stated herein by any of its employees or agents.
6. If a member is unwilling to abide by any of the foregoing obligations, then such member shall promptly return this Report and all copies thereof to Advisory Board.

Table of Contents

©2017 Advisory Board • All Rights Reserved • 34804

Available Within Your Nursing Executive Center Membership

In recent years, the Nursing Executive Center has developed many resources for nurse managers. Select resources are shown here. All resources are available in unlimited quantities through the Nursing Executive Center.

Nurse Manager Resources

The Nurse Manager's Guide to Improving Unit Outcomes

A toolkit for nurse managers to improve unit performance

- Decide Where to Focus First
- Get to the Root of Your Problem
- Communicate Unit Priorities to Staff
- Isolate Staff Members' Best Ideas
- Avoid Rolling Out Multiple Priorities at Once

Is Nurse Manager Workload Out of Control?

An infographic outlining the five strategies to reduce nurse manager overload

- Filter Strategic Initiatives from Above
- Spotlight and Control Lateral Seepage
- Buffer Against 24/7 Unit Demands
- Elevate Manager's Role to Sign-Off
- Better Leverage In-House Support

Re-Envisioning the Nurse Unit Manager Role Toolkit

A toolkit from the Global Centre for Nursing Executive to elevate the nurse manager role

- Establish Priorities and Identify Gap to Goal
- Chart Your Course and Refocus Current Role
- Delegate Non-managerial Work and Formalize Expert Partnerships
- Enhance Real-Time Transparency and Structure Day Around Priorities
- Toolkit is available upon request

The Nurse Manager Portal

One-stop hub featuring the Nursing Executive Center's latest insights and tools for nurse managers

- Upcoming Events for Nurse Managers
- Latest Resources
- Best Practice Finder
- Implementation Resources
- Lessons from Your Peers

©2017 Advisory Board • All Rights Reserved • 34804

Executive Summary

Nurse Managers Are Overloaded—Which Hurts Managers and Their Organization

Nurse managers are finally being recognized for their outsize impact on clinical outcomes and staff performance. But this recognition comes with a high cost; they are so critical to their unit's performance that nurse managers find themselves overwhelmed by an unrelenting flood of new work.

Nurse manager overload is not only bad for nurse managers—it is even worse for their organization. Overloaded nurse managers aren't able to lead as needed. They don't have the time, energy, and resources they need to achieve key goals or hit important clinical targets.

An Executive Approach to Put an End to Nurse Manager Overload

When it comes to solving nurse manager overload, the Nursing Executive Center recommends three steps:

1. "Help managers help themselves" through training and development on topics such as prioritization, managing multiple changes at once, and reducing their own stress and burnout.
2. Alleviate "pinch points" that drag down nurse manager productivity.
3. Control the steady stream of new demands that add to the manager's workload.

This report focuses on the final two interventions. Our reasons are: it is difficult to teach training through a publication—and while training can be very powerful, it can't fix an unsustainable role.

Read the Study in Full to Learn More

Put an End to Nurse Manager Overload includes 11 best practices that help leaders:

- Elevate the nurse managers' role to "sign-off"
- Better leverage in-house roles to more effectively support managers' needs
- Filter strategic initiatives before they reach the nurse manager
- Spotlight and control interdisciplinary demands consuming nurse managers' time
- Buffer against 24/7 unit demands

©2017 Advisory Board • All Rights Reserved • 34804

Advisors to Our Work

The Nursing Executive Center is grateful to the individuals and organizations that shared their insights, analysis, and time with us. We would especially like to recognize the following individuals for being particularly generous with their time and expertise.

With Sincere Appreciation

Augusta University Health
Augusta, GA
Laura Brower
Roslyn Marshall
Patty Runyan

Baptist Memorial Health Care Corporation
Memphis, TN
Susan Arwood
Cara Beard
Denise Ferguson
Susan Ferguson
Michelle Smith

Cincinnati Children's Hospital Medical Center
Cincinnati, OH
Cheryl Hoying

Froedtert & The Medical College of Wisconsin
Milwaukee, WI
Kathy Betchel

Intermountain Healthcare
Salt Lake City, UT
Heather Brace
Janet Hintze
Ryan McClellan
Todd Neubert
Judy Williamson

Johns Hopkins Aramco Healthcare
Dhahran, Saudi Arabia
Zeina Khouri-Stevens

Presence-Resurrection Health Care System
Chicago, IL
Suzanne Lambert

St. Elizabeth Healthcare
Edgewood, KY
Lisa Blank

Texas Health Presbyterian
Dallas, TX
Cole Edmonson
Dede Scholl
Joshua Tippy

Valley Health – Winchester Medical Center
Winchester, VA
Nicole Clark
Jennifer Riggleman

Vanderbilt University Medical Center
Nashville, TN
Marilyn Dubree
Erin Tickle

Yale New Haven Hospital
New Haven, CT
Katie Arcangelo
Farah Farooqui
Sue Fitzsimons
Kathleen Kenyon
Bette Ann White

©2017 Advisory Board • All Rights Reserved • 34804

The Job Nobody Wants

©2017 Advisory Board • All Rights Reserved • 34804

©2017 Advisory Board • All Rights Reserved • 34804

The word is out: nurse managers are increasingly recognized for their impact on their unit's clinical outcomes. Studies have now captured the ability of managers to impact patient experience scores and outcomes.

In addition to clinical outcomes, nurse managers are recognized for their impact on staff performance.

Managers the Cornerstones of Clinical Excellence

Pressure Ulcers

3X More Likely

to have pressure ulcers occur on units with nurse manager turnover

Patient Complaints

43% Decrease

in patient complaints after manager led intentional rounding initiative

Overall Hospital Rating

29% Increase

in overall hospital rating after increasing nurse manager rounding

Managers are finally receiving long-deserved acknowledgment for their role in driving staff engagement, retention, and reducing absenteeism.

However, this recognition is proving to be a double-edge sword. As managers are credited as the lynchpin of unit operations, their responsibilities grow and overload them.

Managers Essential to High Staff Engagement

Staff Engagement

5X

Excellent managers are five times more likely to have engaged staff

Staff Absenteeism

57%

Excellent managers have 57% lower rate of absenteeism

Staff Turnover

36%

Excellent managers have 36% lower staff turnover

Source : I-Round for Patient Experience, *How one system turned around declining HCAHPS scores,* Washington DC: The Advisory Board Company, 2013; *Warshawsky, N. et al., "The Effect of Nurse Manager Turnover on Patient Fall and Pressure Ulcer Rates," Journal of Nursing Management, 2013, 21: 725-732;* RN.com, 2013, https://lms.rn.com/getpdf.php/1791.pdf; Advisory Board Talent Development Division; Advisory Board Employee Engagement Initiative Division; "Nurse Leadership: Being Nice Is Not Enough," Hay Group, http://www.haygroup.com/uk/downloads/details.aspx?id=2521; Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

Nurse managers are often working long hours and taking their work home on the weekends. At one large health system, almost all nurse managers are working more than 40 hours a week. And 84% are working over the weekend in order to keep up with their workload.

Nurse Managers Paying a Steep Price

> "I bring work home every night. My kid says 'I don't even know why you come home. Might as well stay at work!'"
>
> *Nurse Manager*

> "I didn't realize the stress level, and how much family time I missed until I stepped away from the role."
>
> *Nurse Manager*

98%

of nurse managers average over 40 hours per week

80%

of nurse managers average between 50-60 hours per week

84%

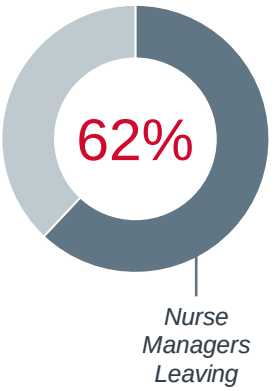
Of nurse managers take work home on weekends

Nurse managers' workload increases the risk for manager turnover. The current vacancy rate for nurse managers is 8.3%. However, between 2015 and 2020, 62% of nurse managers plan to leave their current role. While some managers are planning to retire, the vast majority are planning to leave for other reasons. Many of these reasons can be addressed by nurse executives, including the top motivation for leaving—burnout due to an overwhelming workload.

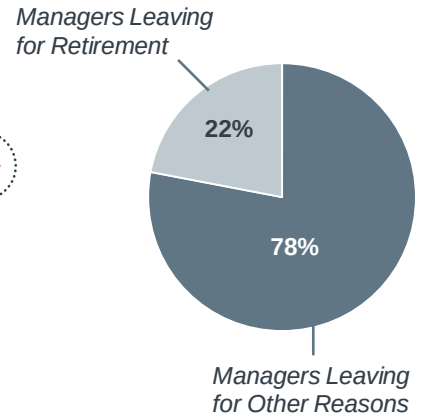
On the Verge of Hemorrhaging Management Talent

Percentage of Nurse Managers Planning to Leave Within Five Years

n=291 Nurse Managers



Reasons Managers Plan to Leave Within Five Years



Source: American Nurses Today, "Retaining Nurse Managers," 2010, https://www.americannursetoday.com/retaining-nurse-managers/ ; NCBI, "Nurse Manager Job Satisfaction and Intent to Leave," 2014, https://www.ncbi.nlm.nih.gov/pubmed/24689156; Nursing Executive Center interviews and analysis.

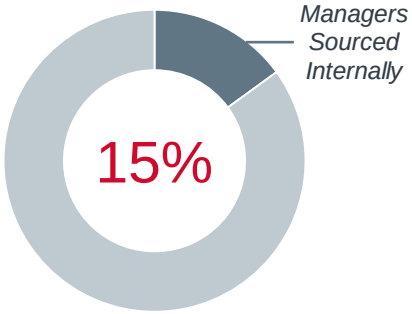
©2017 Advisory Board • All Rights Reserved • 34804

Nurse executives can't afford to let nurse manager turnover rise. Not only is turnover disruptive, it is increasingly challenging to find qualified candidates for manager positions. This is because many staff nurses are not interested in the nurse manager role. They find the role unappealing due to managers' workload and long hours.

One example is highlighted here. A prominent, Magnet organization had several nurse managers leave, and was only able to fill 15% of the open positions through internal promotions.

The Job Nobody Wants

Percentage of New Managers Promoted from Within at Addison Health[1]



Percentage Change in Manager Engagement at Addison Health

16%

Reduction in nurse manager engagement in 2016

Losing Interest in Management

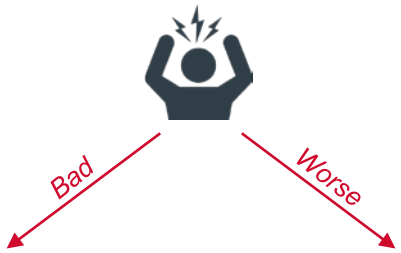
"No one wants this position. We only fill about 15% of nurse manager vacancies with internal candidates. Ideally we'd fill at least 80% internally."

Chief Nurse Executive
Addison Health

But nurse executives' goal can't be just to prevent nurse managers from departing—managers who are overwhelmed by work but remain in their role can be just as costly as those who are overwhelmed and leave. Managers who burn out and stay can create an unhealthy work environment. This can create a domino effect in which an unhealthy work environment decreases staff engagement, which increases staff turnover, decreases unit performance, and further increases manager overload and burnout.

The reason nurse managers are so overloaded is shown on the next page.

Burnout Contributes to an Unhealthy Environment



Managers Burn Out and Leave

- Difficult to backfill multiple vacancies at once
- Creates intense pressure on remaining managers to cover vacated units

Managers Burn Out and Stay

- Produces toxic work environment that affects outcomes
- Amplifies risk of driving away staff nurses

1) Pseudonym.

Source: Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

Nurse managers' workload can feel like an overflowing sink. The tap is wide open, the drain is clogged, and everything is flooding onto the floor.

There are two primary causes of the flood. The first cause is constant, new work coming in at a rapid pace. These include large health system improvement initiatives coming from senior leadership and small and less visible requests coming from other department leaders and unit staff.

The second cause is expanding unit responsibilities that take up way too much manager time. These pinch points include: hunting down and compiling data for reports and performance analyses, managing staff schedules, filling vacant shifts, and back-office work.

Can Your Nurse Managers Relate?

New Incoming Work Flowing on Full Blast

- Large health system improvement initiatives coming from senior leadership
- Small and less visible requests coming from other department leaders and unit staff

Specific Pinch Points Clogging the Drain

- Greater management demands with less support
- Expanding nursing-centric metrics and performance management

Source: Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

When it comes to solving nurse manager overload, the Nursing Executive Center recommends three distinct interventions.

The first intervention is to "unclog the drain" by identifying pinch points—the most time-consuming responsibilities dragging down manager productivity—and then alleviating them.

The second intervention is to "reduce the flow" of new work landing on the nurse manager's plate. While leaders cannot completely turn off the faucet and protect managers from new initiatives, they can reduce and rationalize the steady stream of new demands landing on manager's plates.

The third intervention is "helping managers help themselves" through training and development. Training can equip managers to prioritize, manage multiple changes at once, and reduce their own stress and burnout.

Three Necessary Interventions

"Unclog the Drain"
Alleviate pinch points that create a drag on productivity

"Reduce the Flow"
Control stream of new initiatives and unplanned work

Help Managers Help Themselves
Invest in developing skills to manage stress and burnout

Source: Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

Put an End to Nurse Manager Overload

The Nursing Executive Center identified five executive-led strategies that will put an end to nurse manager overload.

Shown on the left, there are two strategies to alleviate pinch points creating a drag on manager productivity. The first strategy is to elevate managers' role to "sign-off" (rather than "doer") by helping managers offload specific work. The second strategy is to reallocate support roles to more effectively support managers' needs.

Shown on the right, there are three strategies to control the steady stream of new demands increasing nurse managers' workloads. The first of these is to integrate or reroute strategic initiatives before they reach the nurse manager. The next strategy is to spotlight and control interdisciplinary demands consuming nurse managers' time. The final strategy is to buffer against 24/7 unit demands by redirecting requests to the manager when he/she is off shift.

To put an end to nurse manager overload, the Nursing Executive Center recommends implementing at least one best practice per strategy. The remainder of this publication describes each best practice in detail.

"Unclog the Drain"

Alleviate pinch points creating a drag on manager productivity

1 Elevate Manager's Role to Sign-Off

1. On-Demand Data Expert
2. Tiered Self-Scheduling

2 Better Leverage In-House Support

3. Back Office Backstop
4. Lateral Nurse Consultants

"Reduce the Flow"

Control the steady stream of new demands adding to nurse managers' workloads

3 Filter Strategic Initiatives from Above

5. Integrated Executive Action Plans
6. Predetermined Project Routing

4 Spotlight and Control Lateral Seepage

7. External Demand Surfacing
8. Staff-Triggered Lateral Response
9. Cross-Discipline Shared Accountability

5 Buffer Against 24/7 Unit Demands

10. Decision Escalation Plan
11. Dedicated Reflection Block

Source: Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

Executive Strategy

1

Elevate Manager's Role to Sign-Off

- Practice 1: On-Demand Data Expert
- Practice 2: Tiered Self-Scheduling

©2017 Advisory Board • All Rights Reserved • 34804

The first executive strategy to put an end to nurse manager overload is to elevate the manager's role to sign-off. It addresses the underlying challenge that managers are spending too much time hunting for data and managing staff schedules. These responsibilities are "pinch points" for managers—in other words, these are important responsibilities that consume too much manager time.

The two practices in this section will help leaders alleviate these specific pinch points by making the manager an "approver" rather than a "doer." The first practice entails dedicating experts to compile and analyze data for nurse manager reports, freeing up managers to focus on reviewing the data and problem solving. The second practice is staff self-scheduling, which will limits managers' involvement to final schedule sign-off.

Two Universal Pinch Points Bogging Managers Down

Hunting for Data

Managers spend hours compiling data needed for reports and performance analyses

Practice 1:
On-Demand Data Expert

Managing Staff Schedules

Managers build schedules, incorporate staff requests and make calls to fill vacant shifts

Practice 2:
Tiered Self-Scheduling

Source: Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

Practice 1: On-Demand Data Expert

Practice in Brief

Senior leaders assign dedicated experts to track, analyze, and translate unit-level data into a format that is easy for nurse managers to use. The goal is to free up managers from hunting for data, and instead reallocate their time to solving problems surfaced through data.

Rationale

Nurse managers often spend more time tracking and interpreting data than using it. By dedicating experts to compile and analyze data, nurse managers can save significant time.

Implementation Components

Component 1: Dedicate In-House Experts to Create Unit Reports

Leaders assign data experts to create and maintain up-to-date, high-value reports for nurse managers. Suggested reports include preliminary variance, patient census, payroll trends, sitter use, or other reports commonly requested by nurse managers.

Component 2: Create Reports That Clearly Flag Problem Areas

Experts create reports that are easy to understand and are actionable. For instance, the reports should use color coding to draw attention to problem areas.

Component 3: Provide On-Demand Consultation for Problem Solving

Nurse managers should be able to directly connect with an expert who can help them understand the report, identify root causes for problem areas, and develop solutions.

Practice Assessment

This role may require a new FTE and an up-front investment. However, there is a strong case to be made for adding this role: It may lead to improved performance and cost savings since nurse managers can spend more time problem solving.

Nursing Executive Center Grades

Practice Impact: A

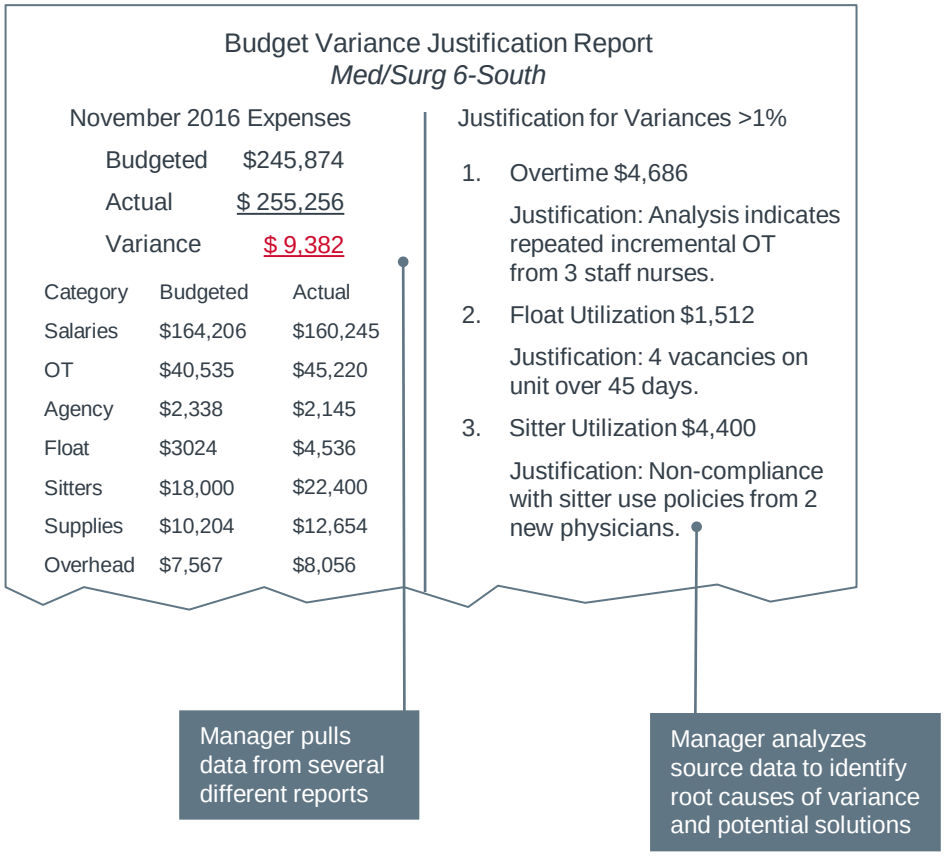
Ease of Implementation: B-

©2017 Advisory Board • All Rights Reserved • 34804

Nursing is a data-centric business and scrutiny of nurse-sensitive indicators is reaching an all-time high. This means nurse managers often spend more time tracking and interpreting data than using it to solve problems and improve unit performance. As shown in this example, nurse managers are spending their time pulling data from multiple sources and analyzing the details to identify root causes—not solving the underlying problem.

To reallocate manager time from hunting to using data, executives should dedicate experts to compile and analyze data on behalf of the managers. The key components of integrating On-Demand Data Expert into practice are described on the following pages.

Pinch Point: Hunting for Data



> "We need to tame measurement. It has gone crazy. Far from showing us our way, these searchlights training on us, they blind us."
>
> *Don Berwick*
> *Former CMS Administrator*

Source: Hospital and Health Networks, "Don Berwick Offers Health Care 9 Steps to End Era of 'Complex Incentives' and 'Excessive Measurement.'" http://www.hhnmag.com/articles/6798-don-berwick-offers-health-care-9-steps-to-end-this-era-of-greed-and-excessive-measurement; Yale New Haven Hospital, New Haven CT; Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

Component 1: Dedicate In-House Experts to Create Unit Reports

The first component of this practice is to assign data experts to create and maintain up-to-date, high-value reports for nurse managers. Suggested reports include preliminary variance, patient census, payroll trends, sitter use, or other reports commonly requested by nurse managers.

At Yale New Haven Hospital, nurse leaders partnered with the finance department to provide managers with data experts that manage nursing data and reports. As shown on the right, each service line has one part-time analyst that is funded through the finance department. While there was an up-front investment, Yale's leaders saw the expert role as an opportunity to more efficiently gather data in order to improve outcomes.

Data Experts Offer a Shortcut to Solutions

One part-time analyst per service line

Funded through the finance department

$32

Typical hourly rate for part-time data expert

0 Hours

Manager time tracking down data sources

Case in Brief: Yale New Haven Hospital (YNHH)

- 1,541-bed academic medical center; headquartered in New Haven, Connecticut
- YNHH minimizes manager time spent searching for data, assembling reports, finding problem areas, and isolating root causes; allow managers to dedicate time to solutions, rather than data hunting
- Supports managers' back-office needs using a data expert dedicated to each major service line and an Internal Consulting Group
- YNHH's Internal Consulting Group created a nursing-finance portal which populates financial reports and houses them all in one place
- The data expert helps managers translate variances from budget targets and isolate most likely root causes to allow managers to intervene more quickly and make informed decisions
- Internal Consulting Group analyzes the lowest performing units compared to benchmarks and generates a custom report with recommendations to improve performance

Source: Yale New Haven Hospital, New Haven, CT; Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

Component 2: Create Reports That Clearly Flag Problem Areas

The second component of this practice is to create reports that are easy to understand and are actionable. For instance, the reports should use color coding to draw attention to problem areas.

At Yale New Haven Hospital, the data reports are instructive as shown here. Reports include performance across similar units to allow managers to make easy comparisons, and color coding to draw attention to problem areas. In addition, most reports are linked, so managers can dig into the detailed source data by double-clicking.

Flagging Problem Areas for Managers

Medical Service Line Patient Experience Dashboard[1]

Unit	NDNQI	Budgeted Caregiver FTE Ratio	Budgeted Total FTE Ratio	Vacancy Rate	PE target FY 2016 (threshold/ target)		Oct 16	Nov 16	Dec 16	Staff Engagement	Falls	Pressure Ulcers	CAUTI	CLABSI
											Quarters Outperforming Benchmark			
1	8.21	8.89	10.2	7.7%	86	88	89	91	86	5.4	3	4	4	4
2	9.22	7.99	10.1	19%	82	82	83	85	77	5.3	3	4	2	1
3	8.11	8.59	10.2	15%	82	83	83	81	84	5.4	3	4	2	4
4	8.31	8.61	10.3	15.2%	82	85	84	84	87	5.5	4	4	3	4
5	8.28	8.26	10.2	9.8%	82	87	59	83	89	5.1	4	2	3	3
6	8.29	8.43	10.2	8.9%	82	84	84	81	89	4.8	4	3	4	4
7	8.28	8.79	10.4	8.1%	85	88	85	86	85	5.1	4	3	4	4
8	8.27	8.62	10.9	33.9%	85	88	81	85	90	4.9	1	3	2	1
9	8.33	8.39	10.1	5.1%	80	82	82	90	91	5.3	4	4	3	4
10	8.27	8.61	10.5	23%	83	86	74	85	83	5.1	3	3	4	3
11	8.78	8.49	10.6	12.1%	84	86	88	79	78	4.9	3	2	3	2
12	9.40	8.94	10.5	15%	79	82	41	70	75	4.6	1	1	2	2
13	8.55	8.69	10.5	0%	85	87	81	88	82	5.2	4	3	4	4
14	8.51	8.89	10.6	12.1%	84	85	83	85	86	5.5	4	3	4	3
			Medicine Overall		83	85	78	84	84					

Performance across similar units allows managers and analysts to single out high performers for comparative analysis

Underperforming metrics proactively flagged in red

At Yale New Haven Hospital, the finance department manages a variety of nursing reports. A partial list of these reports is shown on the right. These reports are housed in one location—the "Nursing Finance Portal" shown here. This is a one-stop shop for managers to access reports. This allows nurse managers to access up-to-date information in a few clicks.

Easy Access to the Right Set of Reports

Yale New Haven Hospital's Nursing Finance Portal

Accessible Reports in the Nursing Finance Portal

- ❑ Staffing Grid
- ❑ Preliminary Variance Report
- ❑ Travelers Report
- ❑ Sitter Report
- ❑ Payroll Trend Report
- ❑ Census Report
- ❑ Incremental Shift Report
- ❑ Vacancy Report
- ❑ Staffing Effectiveness Dashboard
- ❑ HR Predictive Tools
- ❑ Productivity Predictive Tools
- ❑ Other Dashboard Links
- ❑ Benchmarking Tools

1) Data for illustrative purposes only.

Source: Yale New Haven Hospital, New Haven, CT; Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

Component 3: Provide On-Demand Consultation for Problem Solving

The third component of this practice is to directly connect nurse managers with an expert who can help them understand the report, identify root causes for problem areas, and develop solutions. This saves manager time and can help improve unit performance.

Leaders at Yale New Haven Hospital observed the benefit of data experts, as shown in the payroll variance example on the right. With the help of a data expert, the manager identified the root cause of the variance and developed a solution, which almost immediately reduced incremental shift overtime by 12%.

Helping Managers Drill into Root Causes

Yale New Haven Hospital's Process to Fast-Track Managers from Problems to Solutions

1. Payroll trend report in the nursing finance portal flags medicine unit as over budget
2. Manager frustrated because she kept scheduled hours within budget and can't identify the root cause
3. Data expert and manager perform a deep dive analysis and find frequent 15- to 30-minute incremental shifts
4. Manager tracks down the repeat offenders and proactively moves unit payroll to green

12%

Reduction in incremental shift overtime costs

Source: Yale New Haven Hospital, New Haven, CT; Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

Practice 2: Tiered Self-Scheduling

Practice in Brief

Primary responsibility for creating a unit schedule is shifted to frontline staff—who follow a self-scheduling process with clear guidelines and a multi-level approval process. The goal is to decrease the time nurse managers spend on building and managing staff schedules.

Rationale

Scheduling is a complex and time-consuming responsibility; nurse managers often spend hours creating schedules—or in the case of self-scheduling, adjusting schedules. By using self-scheduling with a tiered approval process, nurse managers can limit their involvement to final sign-off.

Implementation Components

Component 1: Implement Self-Scheduling with Clear Guidelines

Unit leaders introduce self-scheduling with specific unit-based guidelines. The guidelines should include clear personal leave policies and minimum requirements for night and/or weekend shifts. Most importantly, staff must abide by the guidelines when selecting shifts for the upcoming schedule.

Component 2: Create a Multi-Level Process to Adjust and Approve Schedules

Once staff build a schedule, it should be reviewed by the unit scheduling committee (to ensure it meets unit guidelines). If adjustments are needed, the unit scheduling committee takes the lead. The manager only reviews the schedule once the unit scheduling committee believes it meets all guidelines.

Practice Assessment

This practice is an effective strategy for protecting nurse manager time. It elevates them from the main creator of unit schedules, to an approver. While this practice may require restructuring current scheduling procedures, it is worth considering due to its potential to save manager time and improve staff satisfaction.

Nursing Executive Center Grades

Practice Impact: B

Ease of Implementation: A-

©2017 Advisory Board • All Rights Reserved • 34804

Nurse managers often own staff scheduling, which is a complex and time-consuming responsibility. As scheduling gets more complicated due to budget constraints and staff shortages, nurse managers are spending more and more time creating schedules that meet staff and organizational demands. A selection of the complicating factors making scheduling more difficult is shown here.

Pinch Point: Managing Staff Schedules

Factors That Complicate Staff Scheduling

More Vacancies

The nursing shortage amplifies manager time spent filling vacant shifts

Budget Constraints

Manager adjusts schedule to satisfy increasingly tight budgets

Staff Preferences

Manager tries to incorporate staff member's preferred shifts into the schedule

Varied Shift Options

Manager must meet staff requests for atypical shifts and schedules

> "I would often take the schedule home and complete it over the weekend, and still it took 30 to 40 hours each month to prepare."
>
> *Nurse Manager*
> *East Coast Community Hospital*

While technology can alleviate some of the scheduling burden, self-scheduling can have its own set of challenges, as shown here. This means nurse managers often spend too much time adjusting schedules.

To decrease the time nurse managers spend on building and managing staff schedules, leaders should shift primary responsibility for scheduling to frontline staff and ask them to follow clear guidelines and a multi-level approval process. The key components of integrating Tiered Self-Scheduling into practice are described on the following pages.

Staff Self-Scheduling Typically an Imperfect Solution

Lack of Unit-Level Perspective Creates Excess Manager Follow-Up

Key Challenges Caused by Staff Self-Scheduling

Wrong Mix of Skills and Tenure

Self-scheduling without guardrails leads to imbalance of skills and experience

Staffing Gaps on Nights and Weekends

Staff avoid signing up for undesirable shifts causing gaps in the schedule

Overlapping Leave Requests

Multiple staff on the same unit schedule leave at the same time

Source: Intrigma, "Savings and Improved Patient Care Through Streamlined Nurse Scheduling," http://www.intrigma.com/wp-ontent/uploads/2015/04/nurse-scheduling-success-story.pdf; Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

Component #1: Implement Self-Scheduling with Clear Guidelines

The first component of this practice is for unit leaders to introduce self-scheduling with specific unit-based guidelines. The guidelines should include clear personal leave policies and minimum requirements for night and/or weekend shifts. Most importantly, staff must abide by the guidelines when selecting shifts for the upcoming schedule.

As shown here, leaders at Johns Hopkins Aramco developed guidelines for both staff and the schedule review committee, which is discussed on the next page.

Use Guardrails to Get Self-Scheduling Right

Guidelines for Self-Scheduling at Johns Hopkins Aramco

Staff Nurse Guidelines

- Ensure you sign up for one or two **weekend shifts** monthly, depending on unit needs
- Make sure you assign yourself **night shifts every month**
- Verify your proposed **leave time** with your manager before inputting into schedule

Scheduling Committee Guidelines

- **Double check leave requests** with leave allotment for the unit
- Confirm everyone has **appropriate distribution of nights and weekends**
- Ensure **good mixture of tenured nurses** per shift

Case in Brief: Johns Hopkins Aramco Healthcare

- 263-bed hospital in Dhahran Saudi Arabia; a joint venture between Saudi Aramco and Johns Hopkins Medicine
- Relatively remote location limits ability to keep schedule filled and fill vacant shifts on short notice
- Transformed rigid scheduling model into a more flexible and efficient tiered self-scheduling system
- Following successful pilot on two units, tiered self-scheduling rolled out house-wide with specific policies staff must follow to avoid issues resulting from the limited perspectives of individual staff
- Nurse manager investment reduced from building and managing entire schedule to quick review and sign-off
- Results include saved time for managers, better staff engagement, and lower premium labor costs

Source: Johns Hopkins Aramco Healthcare, Dhahran, Saudi Arabia; Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

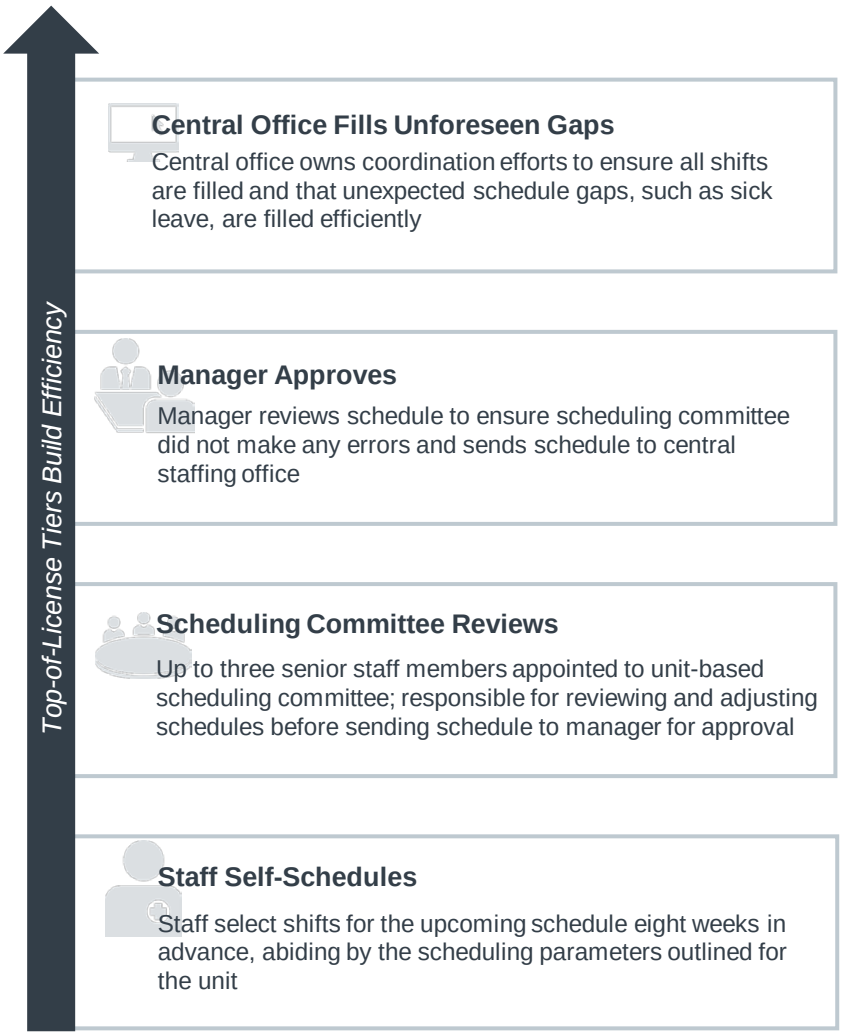
Component 2: Create a Multi-Level Process to Adjust and Approve Schedules

The second component of this practice is for the unit scheduling committee to review the schedule to ensure it meets unit guidelines. If adjustments are needed, the unit scheduling committee takes the lead. The manager only reviews the schedule once the unit scheduling committee believes it meets all guidelines.

At Johns Hopkins Aramco, leaders designed the tiered schedule approval process shown here. Staff nurses sign up for shifts six to eight weeks in advance (following the strict, unit-based guidelines). Then, the unit-based scheduling committee reviews requests and checks them against unit guidelines. This committee includes charge nurses and senior staff familiar with scheduling rules and unit needs. They adjust the proposed schedule to meet organizational targets and confirm that staff members signed up for the right number of shifts. Finally, the schedule goes to the manager for final approval.

Tiered Approvals Minimize Demands on Managers

Tiered Scheduling and Approval Process at Johns Hopkins Aramco



Source: Johns Hopkins Aramco Healthcare, Dhahran, Saudi Arabia; Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

When rolling out this practice, leaders at Johns Hopkins Aramco also proactively addressed some of the common fears around self-scheduling, which are shown here.

Addressing Common Fears About Self-Scheduling

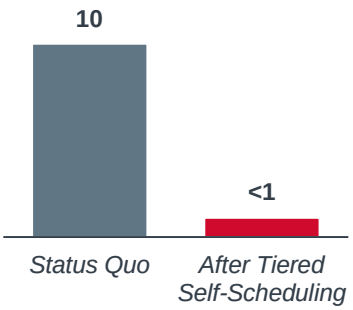
Apprehensions	Organization's Response
Leaders fear a **free-for-all** will ensue if staff are given power to self-schedule	Staff nurses given specific guidelines to follow; transition period eases staff and managers into self-scheduling
Leaders fear **gaps in care** will occur when staff avoid signing up for unwanted shifts	Unit-level guidelines for staff nurses combined with a higher level review ensure appropriate coverage
Employees fear **culture shift** required to transition to self-scheduling is **unachievable**	Pilot on two units demonstrates benefits and ease of implementation for both staff and leaders
Nurse unit managers fear **less control of schedule** and **added work** filling gaps that staff leave	Manager training highlights proven benefits of self-scheduling for unit leaders

The combination of scheduling guidelines and a tiered approval process can significantly reduce the amount of time a nurse manager spends on scheduling while meeting staff and organizational needs.

At Hopkins Aramco, managers now spend almost no time on scheduling because they only review and approve. In addition, overtime hours are down and frontline staff like having more control over their schedules.

Easier for Managers, Better for Business

Hours Spent Scheduling per Nurse Manager per Week



16-24 Overtime Hours Saved

per FTE per month in the new tiered self-scheduling model

> "The flexible schedule provides us with a greater work-life balance and enables us to get to know all the staff on the unit, not just our scheduled group."
>
> *Staff Nurse*
> *Johns Hopkins Aramco Healthcare*

Source: Johns Hopkins Aramco Healthcare, Dhahran, Saudi Arabia; Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

Better Leverage In-House Support

- Practice 3: Back Office Backstop
- Practice 4: Lateral Nurse Consultants

©2017 Advisory Board • All Rights Reserved • 34804

The second executive strategy to put an end to nurse manager overload is to better leverage in-house support. It addresses the underlying challenge that many managers have so many operational responsibilities that they feel "stuck in an office" and unable to engage with patients and staff.

The two practices in this section will help leaders leverage staff that are already available in-house to better support nurse managers. The first practice reallocates management roles to give managers more operational support and reduce span of control. The second practice reallocates non-management roles to help managers improve and sustain unit performance.

Pinch Points Requiring More In-House Support

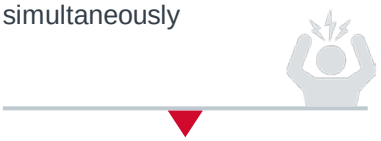
"Back Office" Work Not Easily Offloaded

Managers consumed by "back office" work, limiting facetime rounding on patients and staff

Practice 3:
Back Office Backstop

Expectations to Improve Multiple Outcomes at Once

Managers under greater scrutiny to excel on an expanding number of metrics simultaneously



Practice 4:
Lateral Nurse Consultants

Source: Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

Practice 3: Back Office Backstop

Practice in Brief

Leaders assess the current unit management structure and reallocate roles to create more "back-office" support for nurse managers. The goal is to provide operational support and reduce span of control so nurse managers can have more meaningful interactions with patients and staff.

Rationale

Nurse managers are often stuck in the "back office" with responsibilities that can't be easily off loaded to support staff, such a performance reviews and audits. These responsibilities can interfere with patient and staff facetime. Reallocating current management roles strategically spreads "back-office" responsibilities across multiple qualified owners, increasing nurse manager time with patients and staff.

Implementation Components

Component 1: Determine if Current Leadership Roles Should Be Replaced by Defined Management Positions

Nurse leaders assess unit leadership structure and decide if the current roles are meeting the unit's needs. If not, leaders swap loosely defined leadership roles, such as charge nurse and assistant nurse manager, for new, narrowly focused management positions (for example, clinical staff leaders and business managers).

Component 2: Clearly Define Responsibilities and Elevate Expectations for New Roles

Leaders define the new management roles by outlining the specific responsibilities that are in (and out) of scope. The responsibilities should target "back-office" work, such as unit operations and staff management.

Practice Assessment

Redesigning current roles can improve manager visibility among patients and staff, and can be an effective strategy for ensuring top-of-license nurse manager work. However, it can be challenging to redesign roles and potentially disruptive to staff currently in less-well-defined unit leadership roles, as some may not be prepared for the newly created positions. This practice can be budget neutral. If there are associated costs, leaders are likely to see downstream returns due to lower staff turnover and improved quality performance.

Nursing Executive Center Grades

Practice Impact: A-

Ease of Implementation: B

©2017 Advisory Board • All Rights Reserved • 34804

Nurse managers have a growing number of “back-office” responsibilities that are critical to day-to-day operations and not easily off loaded. As a result, nurse manager spend hours working in their office, leaving little time to engage with patients and staff.

To better support managers and give them more time with patients and staff, executive leaders should consider reallocating current management roles to strategically spread “back-office” responsibilities across multiple qualified owners. The key components of integrating Back Office Backstop into practice are described on the following pages.

Pinch Point: “Back Office” Work

Sample “Back Office” Management Functions that Aren’t Easily Off Loaded

- Writing 100+ staff performance evaluations
- Resolving various technical and operational problems
- Writing incident reports and other internal documentation
- Collecting, analyzing, and auditing unit performance data
- Unit representation in meetings and committees
- Disciplinary and staff dismissal paperwork
- Checking schedules against payroll for accuracy
- Reviewing stacks of resumes and interviewing candidates

Source: Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

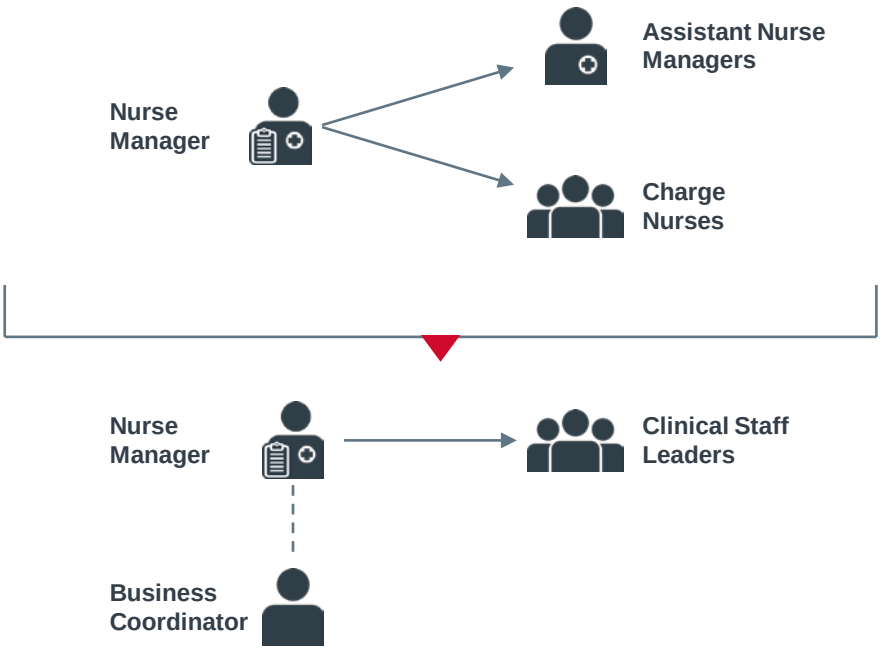
Component 1: Determine if Current Leadership Roles Should Be Replaced by Defined Management Positions

The first component of this practice is to assess unit leadership structure and decide if the current roles are meeting the unit's needs. If not, leaders should swap loosely defined leadership roles, such as charge nurse and assistant nurse manager, for new, narrowly focused management positions (for example, clinical staff leaders and business managers).

Leaders at Vanderbilt University Medical Center assessed their unit management roles and observed that the charge nurse and assistant nurse manager roles were too loosely defined and had limited management authority. To better support managers while remaining close to budget neutral, leaders swapped the assistant manager and charge nurse roles for a business coordinator and clinical staff leaders. These new roles are narrowly focused with concrete responsibilities, which are detailed on the next page.

Boosting Back Office Support at Vanderbilt

Restructuring the Support Staff Model



Economics of New Support Roles

Clinical Staff Leader (CSL)

- Replacement for assistant manager and charge nurse roles
- One CSL manages 15 to 20 staff FTEs
- Salary comparable to assistant manager, exempt from overtime
- Charge nurse function filled by a CSL during clinical time or a "Relief Staff Leader" requiring a $2.50 shift differential

Business Coordinator

- Typically one coordinator per nursing administrative director
- Added for back office support
- Salary comparable to mid-level business role

Source: Vanderbilt University Medical Center, Nashville, TN; Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

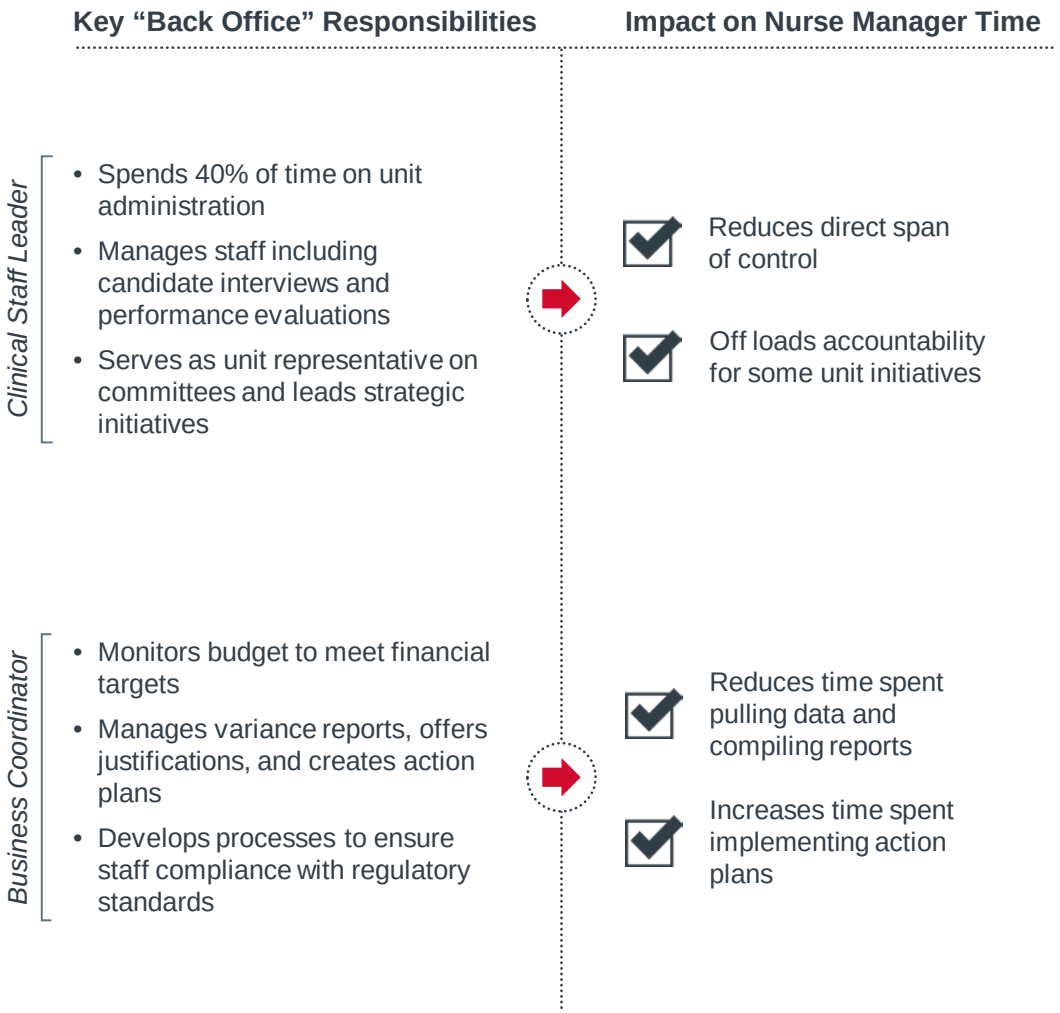
Component 2: Clearly Define Responsibilities and Elevate Expectations for New Roles

The second component of this practice is to define the new management roles by outlining the specific responsibilities that are in (and out) of scope. The responsibilities should target "back-office" work, such as unit operations and staff management.

At Vanderbilt, clinical staff leaders directly oversee 15 to 20 staff, which reduces the nurse manager's span of control. To do this, clinical staff leaders split their time: 60% clinical practice and 40% administrative work and coaching. This means, they have two 12-hour shifts as clinical leaders and two 8-hour shifts on administrative management.

In addition, the business coordinator role provides administrative support including acquiring data, monitoring budgets, and building reports and action plans to address budget variances. This allows nurse managers to spend less time in the office on operational responsibilities.

New Support Creates Space for Managers to Lead



Access Vanderbilt University Medical Center's Business Coordinator and Clinical Staff Leader Job Descriptions through the online version of this publication on advisory.com/nec.

Source: Vanderbilt University Medical Center, Nashville, TN; Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

To make sure the right people were in the newly revamped roles, Vanderbilt required everyone to apply and interview for the new roles, including former assistant nurse managers and charge nurses. Leaders at Vanderbilt looked for the specific qualities shown here to help select candidates.

Raising the Bar for Clinical Staff Leaders

Differentiators Impacting Vanderbilt's Hiring Decisions for Clinical Staff Leaders

Clinical and Strategic Expertise

Experience interpreting strategy and clinical and operational knowledge

Genuine Interest in Learning

Eager to learn both clinical and operational leadership

Relatable to Leaders at All Levels

Panel interviews with staff, nursing leaders, physicians, and non clinical leaders

Broad Staff Appeal

Solicited staff feedback on leadership skills

Case in Brief: Vanderbilt University Medical Center

- Four-hospital system headquartered in Nashville, Tennessee
- Prior to restructuring, each unit had one manager and assistant manager who were responsible for up to 120 staff; charge nurses managed patient flow and staff assignments on each shift
- In 2012, Vanderbilt eliminated the charge nurse and assistant nurse manager positions and replaced them with clinical staff leaders
- Vanderbilt also added business coordinators to provide administrative support including data acquisition, monitoring budgets, and building reports and action plans to address budget variances
- Clinical Staff Leaders oversee 15 to 20 staff, and split their time: 60% clinical practice and 40% administrative work and coaching (a critical element to secure support for initial rollout)
- Charge nurses and assistant nurse managers had to reapply for the clinical staff leader position; all were guaranteed staff nurse positions if not chosen
- Business case for redesign cites majority of funding drawn from eliminated assistant managers and charge nurse positions plus charge nurse overtime; anticipates downstream value due to lower staff turnover and better quality performance

Source: Vanderbilt University Medical Center, Nashville, TN; Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

Redesigning current roles can improve manager visibility among patients and staff, and can be an effective strategy for ensuring top-of-license nurse manager work. This can create a more positive work environment and provide staff with the hands-on support they may need.

Leaders at Vanderbilt also observed lower turnover and improved clinical quality after restructuring unit management.

A More Positive Workplace for Leaders and Staff

Staff Nurse Feedback	Clinical Staff Leader Feedback
"I love having someone do my evaluation that knows who I am and what I do"	"I feel more confident in my ability to give direct and meaningful feedback to staff"
"I love the level of accessibility to my leadership team"	"I can motivate my team differently now and recognize them individually"
"I like having a nursing leader working beside me when I care for patients"	"I see how our unit fits into the bigger picture of the medical center"

Source: Vanderbilt University Medical Center, Nashville, TN; Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

Practice 4: Lateral Nurse Consultants

Practice in Brief

Leaders assess current non-management unit roles (such as educators) and determine if they can be scoped more narrowly to focus on specific indicators or metrics. The goal is to improve unit performance on specific outcomes and sustain those outcomes over time.

Rationale

Nurse managers are under greater scrutiny to excel on an expanding number of performance outcomes at once—and it's impossible to focus on all outcomes with the same amount of effort. As a result, it's difficult to sustain performance changes over time. Reallocating current non-management unit roles to focus on specific performance metrics can improve unit outcomes and increase return on investment.

Implementation Components

Component 1: Determine if Broad, Non-management Roles Should Be Replaced by Narrowly Focused Positions

Nurse leaders assess non-management roles (such as educators) and decide if the current roles are meeting the unit's needs. If not, leaders swap loosely defined roles for new positions narrowly focused on improving unit outcomes.

Component 2: Target a Single Quality Metric That Is Underperforming

Leaders in the newly defined role select a specific unit metric that is a high priority but underperforming and improve it. Once they have improved performance on the underperforming metric they shift their focus to a new, underperforming metric. Commonly selected metrics include: CAUTI, CLABSI, falls, pressure ulcers, and patient experience.

Component 3: Focus on Improving the Selected Quality Metric

Leaders in the newly defined role own responsibility for improving the selected unit metric. These leaders should be viewed as partners for nurse managers and never reallocated to cover clinical shifts

Practice Assessment

This practice is an effective strategy for assessing existing non-management roles and deciding if they could be more effectively deployed to support nurse managers and improve unit outcomes. While redesigning roles to allow a single individual to focus on a limited number of unit outcomes can be powerful, it can be challenging to reallocate roles and potentially disruptive to existing staff. This practice can be budget neutral (but doesn't have to be).

Nursing Executive Center Grades

Practice Impact: B+

Ease of Implementation: B

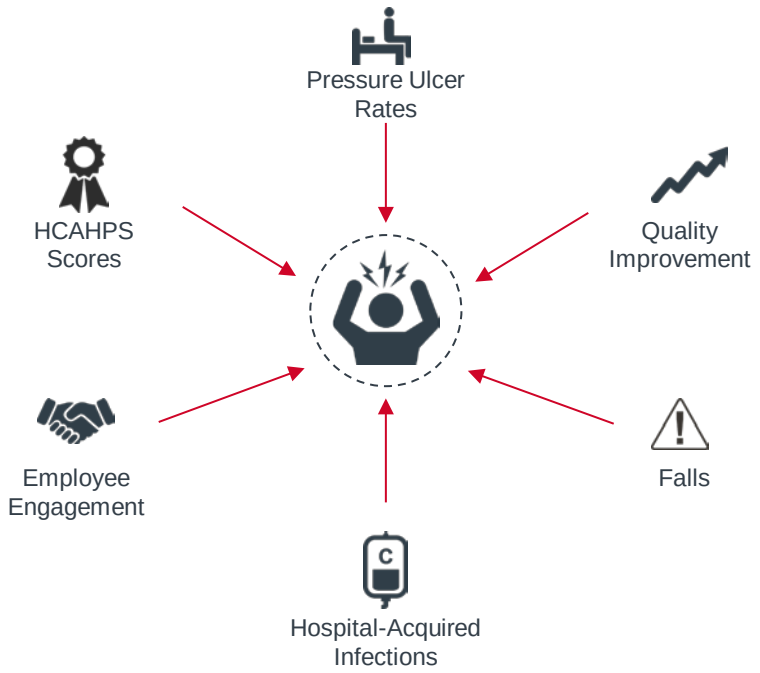
©2017 Advisory Board • All Rights Reserved • 34804

Nurse managers are under scrutiny to excel on an expanding number of performance outcomes, and it's impossible to give equal attention to every metric. As a result, managers often struggle to sustain performance changes over time.

To improve unit performance and free up manager time, leaders should consider reallocating current non-management unit roles to focus on specific performance metrics. The key components of integrating Lateral Nurse Consultants into practice are described on the following pages.

Pinch Point: Too Many Clinical Outcome Goals

Vast Volume of Quality Indicators



Too Many Metrics

"Nurse managers' priorities have shifted to managing business functions such as budgets, adequate resources, staff and patient engagement. We need someone to be laser-focused on quality metrics and the provision of care."

Laura Brower, CNO
Augusta University Health

Source: Augusta University Health, Augusta, GA; Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

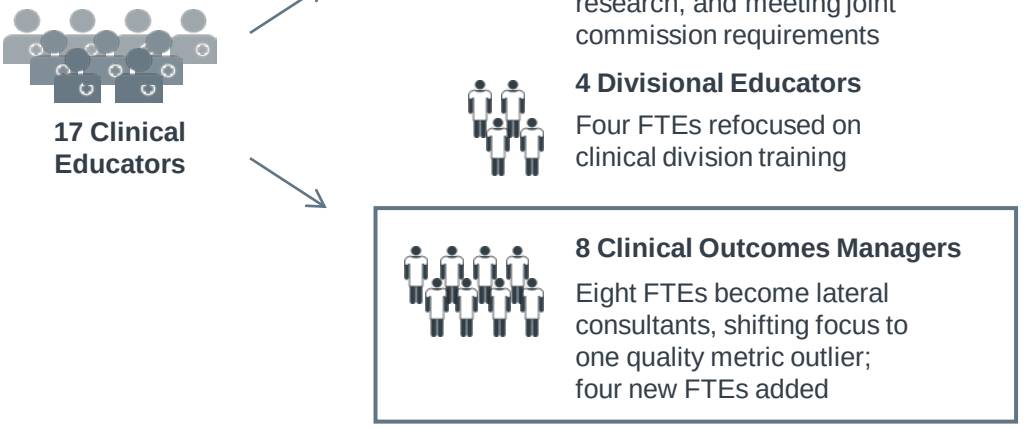
Component 1: Determine if Broad, Non-management Roles Should Be Replaced by Narrowly Focused Positions

The first component of this practice is for nurse leaders to assess non-management roles (such as educators) and decide if the current roles are meeting the unit's needs. If not, leaders swap loosely defined roles for new positions narrowly focused on improving unit outcomes. The Nursing Executive Center calls this role a "lateral nurse consultant"—a boots on the ground partner that helps managers achieve unit outcomes.

Leaders at Augusta observed that their unit-based clinical educators were spread too thin and often took bed assignments to fill vacant shifts. To fix this, leaders replaced their broad clinical educator model with a layered system that focused on clinical support, as shown here. Of the 17 educator FTEs, five became central core educators, focused on core training and orientation, and four became division-level educators. The remaining eight assumed a new role of Clinical Outcomes Manager, which was responsible for one specific clinical outcome.

Simple Scope of Practice Elevates Educator Impact

Restructuring the Clinical Educator Position at Augusta



Case in Brief: Augusta University Health

- Two-hospital health system consisting of a 478-bed medical center and a 150-bed children's hospital, headquartered in Augusta, Georgia
- In 2016, redesigned nursing unit leadership including managers, support staff, and clinical educators; goal was to simplify roles and responsibilities and focus on key results; initiative is central to Magnet Recognition Program application
- External consultants helped identify the best distribution of responsibilities among unit leaders to improve and sustain outcomes
- Existing educator model was scrapped; most educators reallocated to the new boots-on-the-ground "clinical outcomes manager" position to evaluate and improve compliance with best practices on quality measures
- Each clinical outcomes manager oversees one service line, reports to the divisional director, and provides at-the-elbow support to improve four target quality outcomes: CAUTI, CLABSI, pressure ulcers, and falls
- Remaining educators were transitioned to "core educator" positions and focus on orientation, nurse residency program, research, joint commission requirements, and diabetes education, or "divisional educator positions" that focus on clinical division training
- Pro forma model projects cost-neutral initiative; costs recouped through reallocated educators, reduced orientation costs, lower turnover, vacancies, and overtime, and projected improvements in clinical outcomes

Source: Augusta University Health, Augusta, GA; Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

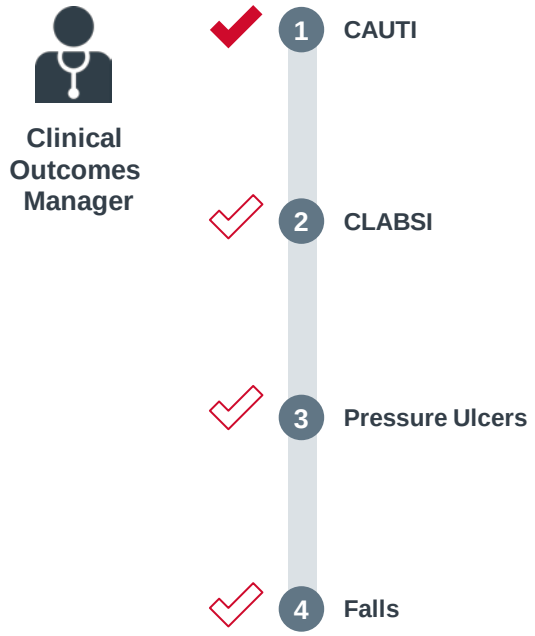
Component 2: Target a Single Quality Metric That Is Underperforming

The second component of this practice is for lateral nurse consultants to select a specific unit metric that is a high priority but underperforming and improve it. Once they have improved performance on the underperforming metric they shift their focus to a new, underperforming metric. Commonly selected metrics include: CAUTI, CLABSI, falls, pressure ulcers, and patient experience.

For example, at Augusta, the nursing division selects four target outcomes, and the Clinical Outcomes Manager prioritizes the unit's lowest performer. Once the metric is above the benchmark, the Clinical Outcomes Manager shifts focus to the next metric. Their goal is to ensure all four metrics stay above benchmark.

Separate Ownership of Key Metric Saves Time

Clinical Outcomes Manager Focuses on One Key Quality Metric at a Time



A Trusted Partner

"Managers are so grateful that they have a partner to own one huge priority on their list of concerns. Their clinical outcomes manager owns those decisions now."

Patti Runyan, Director of Professional Nursing Practice and Education
Augusta University Health

Source: Augusta University Health, Augusta, GA; Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

Component 3: Focus on Improving the Selected Quality Metric

The third component of this practice is for lateral nurse consultants to own responsibility for improving the selected unit metric. These leaders should be viewed as partners for nurse managers and never reallocated to cover clinical shifts.

At Augusta, the Clinical Outcomes Manager takes full ownership of improving the selected unit metric, and works alongside staff to observe, modify, and sustain performance. This is in contrast to the workflow before the role redesign, when the manager was responsible for behavior modification and sustaining change.

Lateral Consultant in Action at Augusta

Accountable Owner of CAUTI Improvement Initiatives

	Status Quo	Augusta University Health
Retrain Staff on Correct Protocols	Educator	Clinical Outcomes Manager
Observe Staff	Nurse Manager	Clinical Outcomes Manager
Modify Practice	Nurse Manager	Clinical Outcomes Manager
Sustain Improvements	Nurse Manager	Clinical Outcomes Manager

Source: Augusta University Health, Augusta, GA; Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

At Grey Medical Center, leaders used lateral nurse consultants to focus on another key issue: patient experience. Leaders at Grey Medical Center re-recruited two retired nurse leaders as part-time lateral consultants. Their exclusive focus is to round on patients, and troubleshoot any issues that arise, in order to improve patient experience outcomes. The key components of the role are shown here.

Calling on Retiring Leaders for Patient Rounding

Key Components of Consulting Retired Nurse Leaders at Gray Medical Center[1]

Part-Time Commitment

Two retired nurse managers work combined 40 hours per week; each covers five units

Function as Screeners

Primary responsibility is to improve quality of rounding on units and to identify and resolve patient concerns

Elevate Problems to Manager

Patient problems are evaluated; the most concerning are flagged in real time for more efficient manager intervention

Case in Brief: Grey Medical Center

- Mid-sized hospital located on the West Coast
- Retired nurse leaders brought in as lateral consultants to assist with patient rounding and meeting Joint Commission requirements
- Lateral consultants conduct patient rounds, screen for problems, and elevate cases to nurse managers in real time; current unit manager rounds on priority patient concerns to save time
- Currently two retired managers work a combined 40 hours weekly and cover daily rounds on five units; they report to the division leader
- Funding for positions absorbed by nursing administration budget; if census drops, hours may be cut to manage productivity

1) Pseudonym.

Source: Nursing Executive Center interviews and analysis.

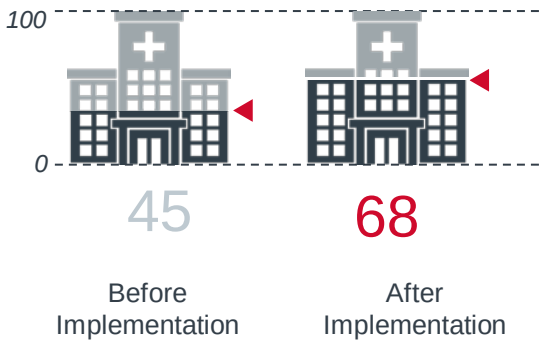
©2017 Advisory Board • All Rights Reserved • 34804

Lateral nurse consultants are an effective way to support nurse managers and improve unit outcomes.

At Grey Medical Center, they not only eased manager burden but helped improve patient experience, as shown here.

Targeted Support Improves Patient Experience

Grey Medical Center's Overall HCAHPS Score Percentile Rating



Lateral Consultants a Win-Win-Win

"This initiative eases the burden on nurse managers with conflicting priorities. The improvements in patient experience were significant."

CNO
Grey Medical Center

"Rounding is actually fun. It is not like management. I'm pleased to help a fellow manager since the job is incredibly difficult today."

Retired AVP and Lateral Consultant
Grey Medical Center

Source: Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

©2017 Advisory Board • All Rights Reserved • 34804

Filter Strategic Initiatives from Above

- Practice 5: Integrated Executive Action Plans
- Practice 6: Predetermined Project Routing

©2017 Advisory Board • All Rights Reserved • 34804

The third executive strategy to put an end to nurse manager overload is to filter strategic initiatives from above. Health system executives are developing new strategies to respond to a turbulent health care market, and the resulting challenge for managers is that each new strategy generates many next steps. And this means managers are all too often spread too thin.

The good news is that executives can limit the proliferation of initiatives landing on nurse managers' shoulders. The first practice in this section helps leaders decrease the number of action plans nurse managers oversee. It does so by helping executives identify where they can consolidate and combine managers next steps. The second practice in this section helps leaders stop over-relying on nurse managers for unit-level project implementation by routing select projects directly to unit councils lead by frontline staff.

Plethora of New Initiatives Pouring In

> "We probably had more initiatives than anyone. It got to the point that it was overwhelming."
>
> *CNO, Midwest Hospital*

320

Number of separate nursing initiatives identified at one organization

Source: Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

Practice 5: Integrated Executive Action Plans

Practice in Brief

Executives identify strategic priorities that may contain duplicative initiatives. Executives then develop integrated, action plans that can be cascaded to the manager level. The goal is to decrease the number of action plans that nurse managers oversee at the unit level and eliminate duplicative work.

Rationale

Unit managers are often responsible for advancing many strategic priorities, each with an individual action plan. When one-off initiatives overlap, managers end up frustrated and the organization doesn't achieve its strategic aims.

Implementation Components

Component 1: Identify Strategic Priorities With Duplicative Next Steps

Executives identify which strategic priorities may have similar (or overlapping) initiatives. Executives then select a sub-set of initiatives that will advance multiple strategic goals at once.

Component 2: Create a Consolidated Action Plan

Executives build an organization-wide plan with clearly defined initiatives that supports multiple goals at once. The plan is cascaded to unit managers. Senior leaders sponsor each initiative to ensure executive-level accountability.

Practice Assessment

This practice is a highly effective strategy for reducing the number of initiatives nurse managers are implementing. However, it requires significant buy-in and time across the c-suite.

Nursing Executive Center Grades

Practice Impact: A

Ease of Implementation: B-

©2017 Advisory Board • All Rights Reserved • 34804

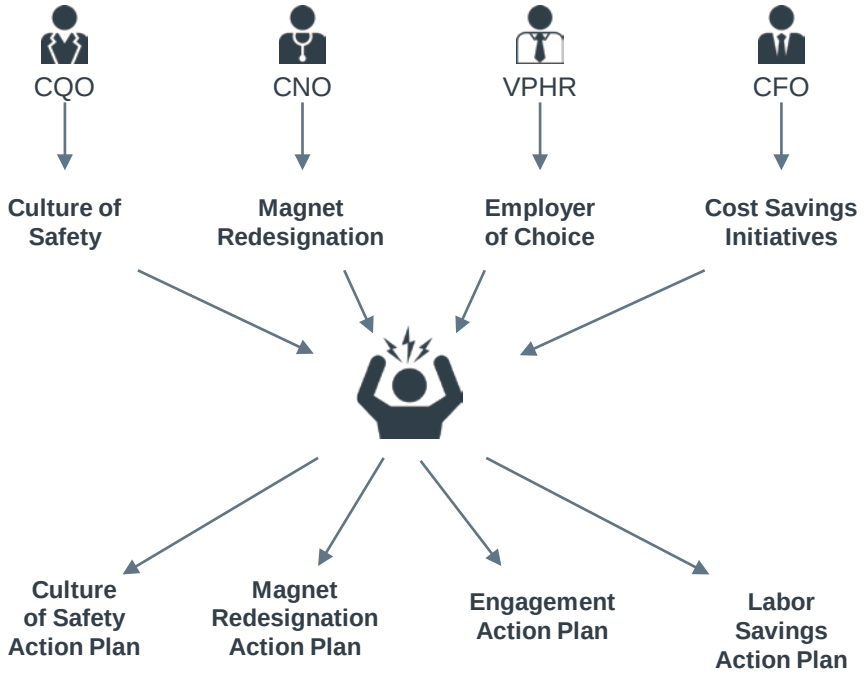
To keep up with today's changing market, executives rapidly develop new strategic priorities, each with an individual action plan. This means nurse managers often end up executing multiple actions plans and risk becoming overwhelmed, as shown on the right.

There is an opportunity for executives to avoid overwhelming nurse managers while still achieving strategic aims. In the example shown below, executives decreased the number of action plans nurse managers oversee at the unit-level by identifying areas of overlap across strategic priorities and building consolidated action plans.

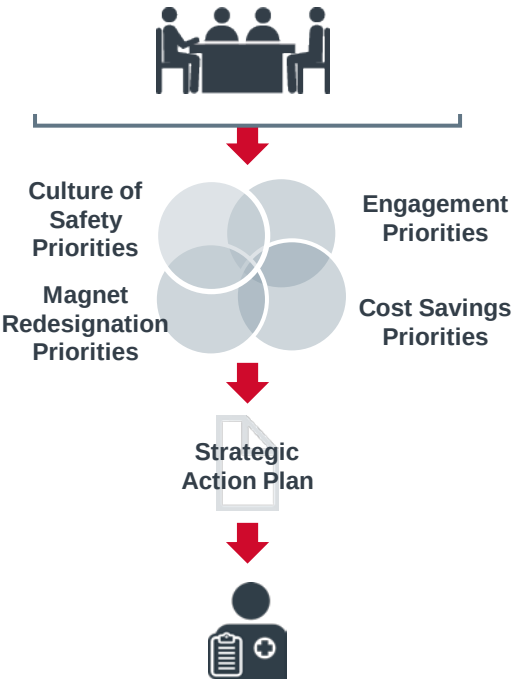
The rest of this practice shares guidance on how to integrate executive action plans.

Considering the Nurse Manager's Perspective

Status Quo



Ideal State



Source: Nursing Executive Center interviews and analysis.

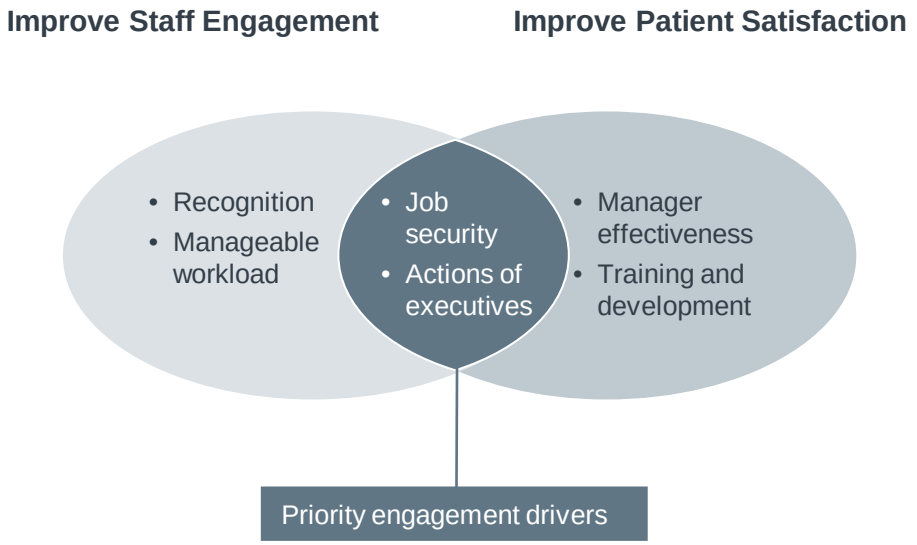
©2017 Advisory Board • All Rights Reserved • 34804

Component 1: Identify Strategic Priorities With Duplicative Next Steps

The first component of this practice is to identify which strategic priorities may contain similar (or overlapping) initiatives. Executives then select a sub-set of initiatives that will advance multiple strategic goals at once.

For example, leaders at St. Elizabeth's wanted to focus on staff engagement and patient satisfaction as strategic priorities. In order to avoid duplicative action plans for nurse managers, leaders identified two engagement drivers that also impacted patient satisfaction, as shown here.

Consolidating Executive Priorities at St. Elizabeth



Case in Brief: St. Elizabeth Healthcare

- Six-facility health system located in Northern Kentucky with more than 7,300 employees
- Faced a number of organizational challenges in 2014, including executive turnover, budget cuts, and layoffs, leading to decreases in staff engagement and patient experience
- Conducted a data analysis and identified executive actions and job security as engagement drivers that improve both staff engagement and patient experience
- Created a single action plan for implementation, assigning an executive sponsor for each initiative
- Improved job security and actions of executives in one year

Source: St. Elizabeth Healthcare, Covington, KY; Advisory Board Survey Solutions interviews and analysis; Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

Component 2: Create a Consolidated Action Plan

The second component of this practice is to build an organization-wide action plan with clearly defined initiatives that support multiple strategic priorities. The plan is then cascaded to unit managers.

Leaders at St. Elizabeth's built one, consolidated action plan to improve engagement and patient satisfaction, rather than creating two separate plans. The integrated action plan, shown here, only includes initiatives that support both strategic priorities.

Achieving Multiple Goals with a Single Action Plan

St. Elizabeth's Integrated Engagement and Patient Satisfaction Action Plan

Driver	Initiative	Description	Responsible Party	Update
Job Security	90-Day Communication Plan	All decisions with negative impact on employees will be communicated at least 90 days in advance	VPHR	HR team to determine policy guidelines and rollout plan
	Benchmarking Review	Ensure all clinical areas are appropriately staffed	VPHR	Completed
Actions of Executives	"Sacred 60" Rounding	All leaders round during same time frame each week	CEO	Implementation completed 3/31/15
	Communication Tiers	Three-tiered approach to communications depending on sensitivity of information	COO	Tiers created, first communication sent out

Shared driver identified in action plan based on survey data

Each initiative assigned an executive sponsor to drive accountability

Updates provided on a quarterly basis

Analysis in Brief

- Advisory Board Survey Solutions analyzed available data for 66 departments at St. Elizabeth's
- Analysis showed an overall correlation between engagement and patient satisfaction
- Identified job security, manager effectiveness, and training as the engagement drivers[1] that had the greatest impact on their patient satisfaction scores
- Based on data analysis and qualitative feedback, job security and actions of executives were selected as primary focus to improve both engagement and patient satisfaction

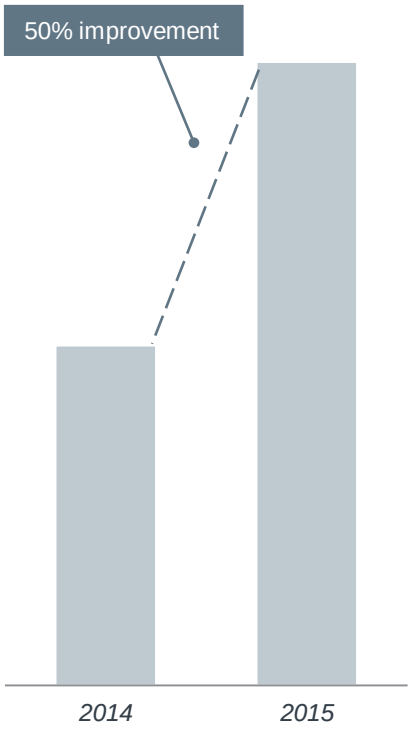
Source: St. Elizabeth Healthcare, Covington, KY; Advisory Board Survey Solutions interviews and analysis; Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

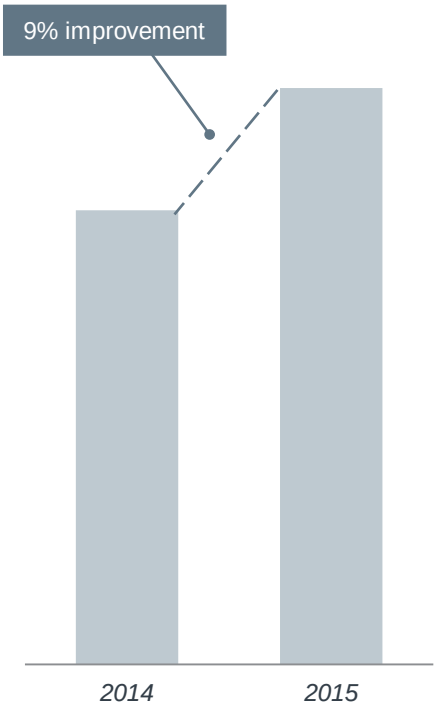
Integrated executive action plans allow nurse managers to focus on fewer initiatives and have a greater impact.
By creating an integrated executive action plan, leaders at St. Elizabeth's not only decreased competing demands on nurse managers, they also achieved their two strategic priorities. In one year, staff engagement increased by 50% and patients' likelihood to recommend increased by 9%.

Improves Staff Engagement and Patient Satisfaction

Employee Engagement



Likelihood to Recommend[1]
% Excellent Rank



> "Executive ownership of initiatives makes sure someone is driving the bus. It's not just nurse managers."
>
> *Lisa Blank*
> *System Director Employment and Development*
> *St. Elizabeth Healthcare*

1) Consumer Assessment of Healthcare Providers & Systems survey question.

Source: St. Elizabeth Healthcare, Covington, KY; Advisory Board Survey Solutions interviews and analysis; Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

Practice 6: Predetermined Project Routing

Practice in Brief

Leaders use a centralized Shared Governance Council to assign select projects directly to the unit-based councils, which are led by frontline staff. The goal is to avoid overreliance on nurse managers for unit-level project implementation.

Rationale

Most organizations assign new projects to nurse managers by default. But the ever-expanding number of projects can be overwhelming for one person. By formalizing a project assignment structure and equipping frontline staff to lead, senior leaders can strategically spread activities across multiple owners.

Implementation Components

Component 1 Create an Systematic Project Assignment Process

Senior leaders create a formal routing system that directs new projects to unit-based councils, each with an assigned frontline staff leader. Each unit has multiple councils, so new projects are routed directly to staff-led councils.

Component 2 Set Unit-Based Leaders Up for Success

Senior leaders provide frontline staff leaders with the capacity to independently execute new project work. This includes protected time dedicated to project work, additional compensation, and change management training.

Practice Assessment

This practice is a highly effective strategy for routing new projects to frontline staff leaders and reducing over-reliance on nurse managers. However, it requires considerable up front time and work for organizational leaders to establish the project routing structure. This practice is applicable to all organizations, but best suited for organizations with an existing Shared Governance structure.

Nursing Executive Center Grades

Practice Impact: A

Ease of Implementation: C

©2017 Advisory Board • All Rights Reserved • 34804

Component #1 Create an Systematic Project Assignment Process

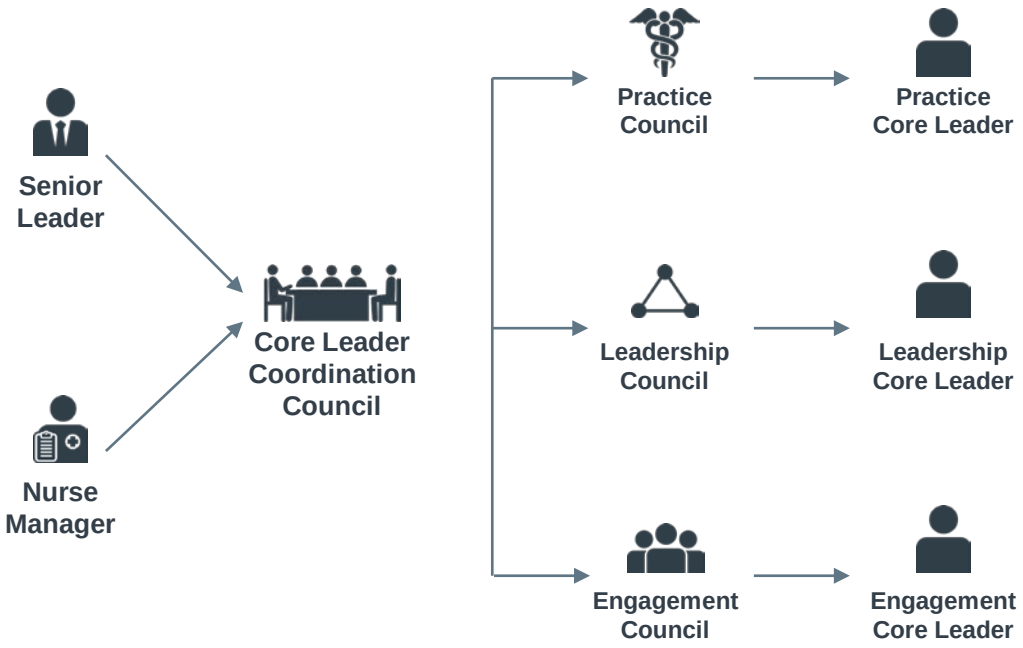
The first component of this practice is to create a formal routing system that directs new projects directly to unit-based councils. This process completely bypasses the nurse manager, meaning managers can avoid day-to-day management of certain projects.

A coordination council is in charge of assigning new projects directly to appropriate staff-led councils, as shown here. New projects can be developed by a nurse manager or senior leadership. For example, a nurse manager may review her dashboard and notices fall rates are high. In order to find out why, she can initiate a new project. The coordination council will assign the project to the practice council, which will conduct a root cause analysis and reports the results back to the manager.

This practice can be a good way to leverage an established Shared Governance program.

Bypassing the Nurse Manager

Intermountain's Project Routing Process



Case in Brief: Intermountain Healthcare

- Health system headquartered in Salt Lake City, Utah, with 39,000 employees and over 9,300 nurses
- Revamped Shared Governance model to create a standard unit structure with three councils responsible for specific types of work; council target staff engagement, clinical practice, and leadership
- The three-council structure is cascaded at the unit, hospital, region, and system levels of the organization to encourage standardization
- The councils are each led by a frontline staff "core leader" accountable for project implementation and follow-through
- New project work is automatically assigned to the appropriate council based on predetermined parameters and executed by the core leader
- Project routing bypasses the nurse manager, allowing the organization to adopt more initiatives by distributing them across core leaders rather than overwhelming nurse managers

Source: Intermountain Healthcare, Salt Lake City, UT; Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

To create their unit-based council project assignment process, Intermountain Healthcare revamped their Shared Governance model and created three standard councils per unit: practice, leadership, and engagement. These councils are responsible for specific types of projects, as shown here.

Each unit-based council has an assigned frontline staff member, called a "core leader," responsible for leading projects. This means, at Intermountain Healthcare every unit has three frontline staff leaders to oversee project work.

Predetermine Project Assignment Categories

Select Responsibilities Across Intermountain's Core Leadership Council Structure

Practice Council

- Elevate hand hygiene compliance
- Review all falls
- Analyze infection reports and teach best practices
- Revamp patient education processes

→ Core Leader
1 per unit

Leadership Council

- Maintain ongoing Joint Commission preparedness
- Manage staff utilization
- Perform physician rounding
- Oversee service recovery process for charge nurses

→ Core Leader
1 per unit

Engagement Council

- Promote the Healing Commitments
- Oversee whiteboard template for department
- Review HCAHPS reports
- Develop nurse recognition strategies

→ Core Leader
1 per unit

Source: Intermountain Healthcare, Salt Lake City, UT; Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

Component 2 Set Unit-Based Leaders Up for Success

The second component of this practice is to provide frontline staff leaders with the capacity to independently execute new project work. This allows nurse managers to step back from project work because they are confident that it will be completed efficiently and to a high standard.

Intermountain Healthcare believed they needed to invest in frontline leader time, compensation, and training in order to set-up frontline leaders to independently manage projects from start to finish.

Set Unit-Based Core Leaders Up for Success

Key Elements of Core Leader Success at Intermountain

Protected Time

Budgeted an average of 36 dedicated hours per month for 3 core leaders

Compensation

Provided 5% salary increase as an incentive to take on added leadership responsibility

Training

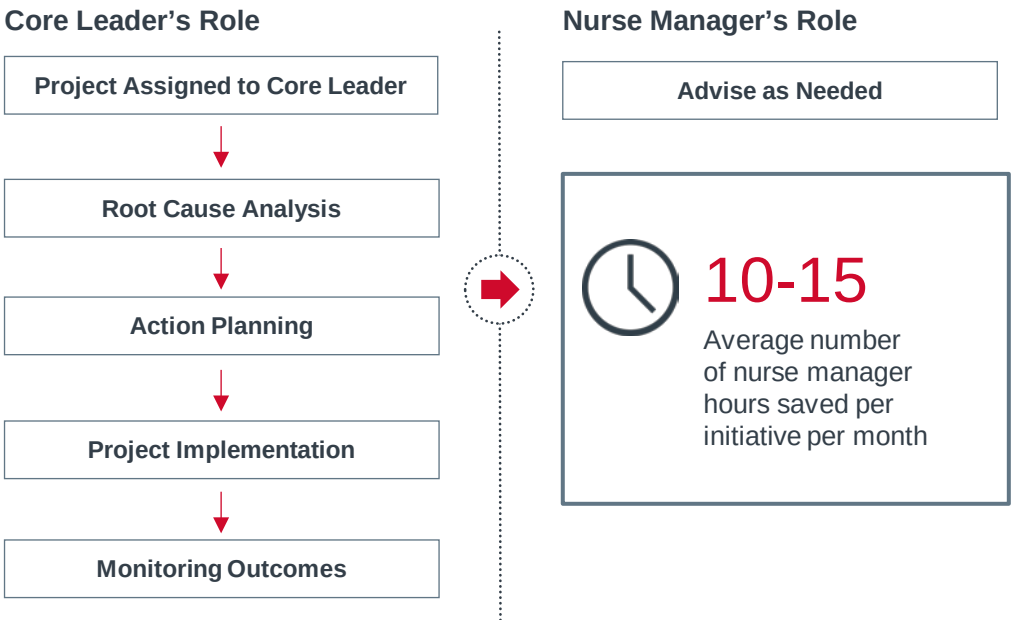
Conducted half-day leadership sessions on action planning, project management, and leading change

> "It was critical that managers ensure the right people are in the right roles in order for this model to be successful. Every great leader is a great clinician. But not every great clinician is a great leader."
>
> *Todd Neubert, CNO*
> *Homecare & Hospice*
> *Intermountain Healthcare*

Access Intermountain Healthcare's Core Leader Job Descriptions through the online version of this publication on advisory.com/nec.

The goal is for frontline staff leaders to truly own each step of the project management process, as shown on the right. While nurse managers are available for guidance as needed, frontline staff leaders handle the day-to-day project work. This includes activities like project planning, communicating changes to staff, and monitoring outcomes. At Intermountain Healthcare, this saves nurse managers lot of time, as shown on the right.

Core Leaders Equipped to Implement Independently



Source: Intermountain Healthcare, Salt Lake City, UT; Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

With predetermined project routing, nurse managers spend significantly less time on daily project work. In addition, the downstream impact, such as improved project sustainability, gives managers more time for other leadership activities (such as rounding on staff).

Across the years Intermountain has achieved strong success, as shown on the right, and credit the councils for playing a key role.

Saving Managers Time, Improving Staff Engagement

40

Approximate number of nurse manager hours saved per month

7%

Increase in overall employee engagement after adding core leaders

Project Sustainability

Improved consistency of project outcomes due to ongoing monitoring

Succession Planning

Prepares staff for vacant nurse manager positions

Initiative Engagement

Better understanding of key unit objectives and performance among staff

Source: Intermountain Healthcare, Salt Lake City, UT; Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

Executive Strategy

4

Spotlight and Control Lateral Seepage

- Practice 7: External Demand Surfacing
- Practice 8: Staff-Triggered Lateral Response
- Practice 9: Cross-Discipline Shared Accountability

©2017 Advisory Board • All Rights Reserved • 34804

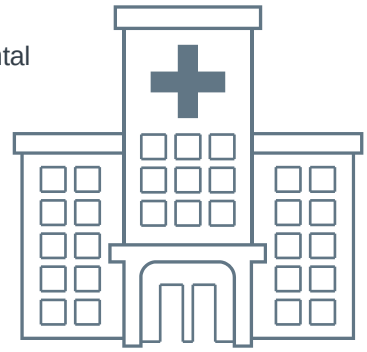
The fourth executive strategy to put an end to nurse manager overload is to spotlight and control lateral seepage—in other words, work delegated from other departments that insidiously seeps onto the manager's plate. Individually, these demands are not overwhelming. But together, they add up to a lot of nurse manager time.

Reflecting on What We Don't Hear

Representative "Off-the-Record" Comments from Nurse Managers

"I'm calling Environmental Services all day long about the trash."

"Imaging needs a change in physician documentation. Why are they coming to me?"



"Residents are always asking me to help with their projects."

"I keep calling transport to pick up that patient."

10-15

Hours per week a nurse manager spends dealing with interdisciplinary seepage

The practices in this section will help leaders spotlight and limit interdisciplinary demands on nurse manager time. The first practice helps senior leaders create an ongoing conversation with nurse managers, in which managers share new non-nursing requests that are adding to their workload.

The second practice off loads time-consuming nurse manager work by reassigning recurring, non-nursing issues to a more appropriate department. The third practice prevents seepage by aligning cross-discipline goals to ensure all leaders are working towards the same unit outcomes.

Spotlight and Control Lateral Seepage

Spotlight
Lateral Seepage

↓

Practice 7
External
Demand Surfacing

Prioritize
Recurring
Lateral Seepage

↓

Practice 8
Staff-Triggered
Lateral Response

Prevent
Lateral Seepage

↓

Practice 9
Cross-Discipline
Shared Accountability

Source: Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

Practice 7: External Demand Surfacing

Practice in Brief

A senior nursing leader creates a dedicated, safe space for nurse managers to share interdisciplinary challenges that absorb nurse manager time.

Rationale

Nurse managers can spend several hours a day responding to work from ancillary departments. Yet, senior nursing leadership is often unaware of these requests. By creating a regular dialogue with nurse managers, leaders can help identify these interdisciplinary demands and ultimately minimize the impact on nurse managers' time.

Implementation Components

Component 1: Establish A Dedicated Time For Senior Leader-Nurse Manager Workload Discussions

Routinely meet with nurse managers to discuss workload, including demands from other departments. These meetings can be monthly or quarterly, and should be closed to other leaders.

Component 2: Create A Safe Space For Managers To Share Issues

Take steps to create an environment that encourages nurse managers to openly voice their concerns about interdisciplinary workload demands. These steps can include: setting ground rules, being transparent, actively listening, and role modeling open communication.

Component 3: Steer The Conversation Towards Solutions

During meetings, use pointed questions to facilitate a solution-focused conversation with nurse managers.

Component 4: Follow Through And Communicate Candidly

Present themes from the conversations to the wider leadership team and report follow-up actions (or inactions) back to nurse managers in a timely manner.

Practice Assessment

This practice is a straightforward but effective way for executive leaders to identify insidious interdisciplinary demands that drain nurse manager time. The Nursing Executive Center highly recommends this practice for all organizations.

Nursing Executive Center Grades

Practice Impact: B

Ease of Implementation: A

©2017 Advisory Board • All Rights Reserved • 34804

Component #1: Establish A Dedicated Time For Senior Leader-Nurse Manager Workload Discussions

The first component of this practice is to routinely meet with nurse managers to discuss their workload, especially demands from other departments that nurse leaders otherwise may not know about. The goal is to create a regular dialogue between executive leadership and nurse managers, and to encourage managers to share interdisciplinary demands. These meetings can be monthly or quarterly, as long as they are predictable and attendance is voluntary.

At Texas Health Presbyterian Hospital, the CNO's quarterly meeting with nurse managers is called "Conversations with Cole." The key elements of "Conversations with Cole" are shown here.

A Forum to Spotlight Lateral Seepage

"Conversations with Cole"

- 90-minute quarterly meeting
- All nurse managers invited
- Voluntary, but encouraged attendance
- Open agenda, conversational style

Culture of Connection

"We need to authentically connect with managers and address the things that prevent them from being great leaders."

Dr. Cole Edmonson, CNO
Texas Health Presbyterian Hospital

Case in Brief: Texas Health Presbyterian Hospital Dallas

- 888-bed, acute care hospital in Dallas, Texas
- In 2012, introduced dedicated time blocks for nurse managers to share their feedback and challenges directly with the CNO on a quarterly basis; referred to meetings as "Conversations with Cole"
- Nurse managers share pain points, including interdisciplinary issues, which are aggregated and reported as themes to other senior leaders; senior leadership team develops action steps, which are reported back to the nurse manager group via existing communication channels and meetings
- Increased transparency between senior leaders and nurse managers and lead to the resolution of many pain points

Source: Texas Health Presbyterian Hospital, Dallas, TX; Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

Component 2: Create A Safe Space For Managers To Share Issues

The second component of this practice is to take steps to create an environment that encourages nurse managers to openly voice their concerns about interdisciplinary workload demands.

Leaders at Texas Health Presbyterian Hospital developed four must-dos for creating a safe space, shown here.

Create a Safe Space to Air Issues

Set Ground Rules

Keep strict confidentiality; don't track attendance or take minutes; let managers suggest other rules

Be Transparent

Be transparent about the purpose of the conversation and what nurse managers can expect from you

Exemplify Your Own Tenets

Model free and open communication and encourage the same from managers

Listen to Managers' Experiences

Encourage sharing, listen, and refrain from giving too much advice

Component 3: Steer The Conversation Towards Solutions

The third component of this practice is to use pointed questions to facilitate a solution-focused conversation. The starter questions shown here can guide the conversation to focus on solutions rather than venting.

Steer Conversation Towards Solutions

Starter Question Set

1. How much time do you spend managing cross-disciplinary issues each week?
2. What is a particular pain point caused by other departments?
3. In the last six months, is there something another department did that helped address these issues?

Source: Texas Health Presbyterian Hospital, Dallas, TX; Nursing Executive Center interviews and analysis.

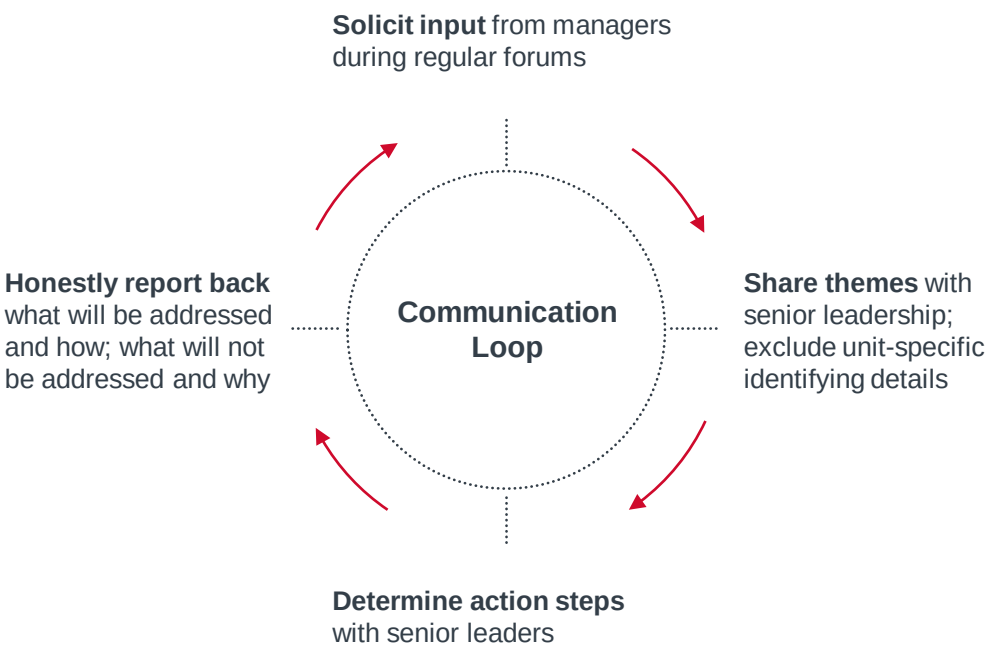
©2017 Advisory Board • All Rights Reserved • 34804

Component 4: Follow through and communicate candidly

The fourth component of this practice is to present themes from the manager conversations to a wider leadership team and report follow-up actions (or inactions) back to nurse managers in a timely manner. When nursing leadership cannot address a particular issue, it is important to honestly communicate to nurse managers what will not be addressed and why.

Texas Health Presbyterian Hospital's communication process is shown here. To save time, this process is integrated into existing meetings.

Communicate Candidly and Follow Through



Source: Texas Health Presbyterian Hospital, Dallas, TX; Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

Practice 8: Staff-Triggered Lateral Response

Practice in Brief

Unit managers identify and reassign work that can be more efficiently completed by another department. The goal is to minimize the amount of time nurse managers spend addressing issues that can be best handled by other departments.

Rationale

Nurse managers absorb responsibility for any issues that arise on their unit. However, sometimes other departments are more equipped to address these concerns. By reassigning certain reoccurring issues to the more appropriate department, nurse managers save time and the work is completed in a more efficient manner.

Implementation Components

Component 1: Identify Reoccurring, Interdisciplinary Pain Points

Leaders ask unit managers to identify reoccurring issues that could be more efficiently handled by other departments. To do this, consider implementing practice 7, External Demand Surfacing, on page 57.

Component 2: Redirect The Work To The Appropriate Department

Leaders across departments develop a new process that directly routes the issue to the correct department. The new process completely bypasses the nurse manager. For example, at one organization, nursing and security services developed a new code titled “Code Orange,” which allows staff to request immediate security support for non-urgent concerns. Security services now respond directly, rather than the nurse manager.

Component 3: Communicate The New Process To Frontline Staff

Unit managers and department leaders share details of the new process with staff during unit huddles, ensuring staff understand the rationale for the change and how it better supports them.

Practice Assessment

This practice is an effective strategy to minimize the impact of certain reoccurring issues. While this practice requires considerable interdepartmental collaboration, it can reallocate specific work to the most appropriate department, saving manager time and improving outcomes.

Nursing Executive Center Grades

Practice Impact: B+

Ease of Implementation: B

©2017 Advisory Board • All Rights Reserved • 34804

Component 1: Identify Reoccurring, Interdisciplinary Pain Points

The first component of this practice is to ask unit managers to identify reoccurring work they perform that could be more efficiently handled by other departments. Some examples of common recurring pain points that create work for nurse managers are shown here. To identify the recurring events that generate the most work for your nurse managers, consider implementing practice 7, External Demand Surfacing, on page 57.

Hardwiring a Process for Recurring Pain Points

Examples of Repetitive Lateral Seepage

Physicians

Nurse manager find physicians to correct or clarify orders

Materials Management

Nurse manager consistently calls for supply refills

Security

Nurse manager attempts to de-escalate abusive patient behavior

> "If ancillary services were more responsive in fixing issues on the unit, nurse managers would only spend 20 minutes once a day instead of 20 minutes six times a day resolving problems."
>
> *CNO, East Coast Hospital*

Case in Brief: Froedtert & Medical College of Wisconsin

- 500-bed academic medical center; part of three-hospital regional health system headquartered in Milwaukee, Wisconsin
- Experienced recurring, non-urgent patient issues that required nurse manager intervention for de-escalation
- Created "Code Orange," a call for staff members to request immediate support from security for urgent or non-urgent concerns
- Staff were encouraged to use the call liberally; resulted in a culture shift that normalized calling security
- Reduced minor injuries to staff resulting from patient or family incidents and save nurse manager time

Source: Froedtert & Medical College of Wisconsin, Froedtert Hospital, Milwaukee, WI; Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

Component 2: Redirect The Work To The Appropriate Department

The second component of this practice is to work with leaders across departments to develop a new process that directly routes the recurring issue to the correct department. The new process should completely bypass the nurse manager.

At Froedtert & Medical College of Wisconsin, leaders identified a recurring pain point on a palliative care unit: nurse managers were spending a significant amount of time de-escalating agitated patients and family members. In response, leaders from nursing and security services developed a new code titled "Code Orange," which allows staff to request immediate security support for non-urgent concerns. With "Code Orange," security services responds directly, rather than the nurse manager.

Bypassing the Nurse Manager Saves Time

Status Quo

12 people in a **patient's** room

Staff **nurse** feels threatened

Nurse manager attempts to de-escalate and then calls security

Security resolves incident

Froedtert's "Code Orange"

12 people in a **patient's** room

Staff **nurse** feels threatened

Security resolves incident

Source: Froedtert & Medical College of Wisconsin, Froedtert Hospital, Milwaukee, WI; Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

Component 3: Communicate The New Process To Frontline Staff

The third component of this practice is to share details of the new process with staff during unit huddles. It's important to ensure staff understand the rationale for the change and how it better supports them.

At Froedtert, the policy clearly states the criteria for calling "Code Orange," as shown here. In addition, unit leaders and security services reinforced the new policy by sharing success stories with staff.

Introducing "Code Orange"

Froedtert's Policy for Bypassing Nurse Managers to Directly Call Security

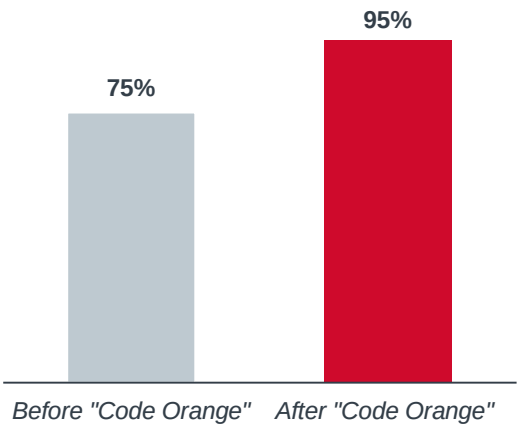
> **"Code Orange"**
>
> *Staff safety is our top priority.*
>
> **Anytime you feel unsafe**, immediately call "Code Orange" and Security Services will respond to the incident.
>
> We want all staff to have the necessary support to feel safe at work. We encourage you to use this call as often as needed.

At Froedtert, "Code Orange" saves manager time. On one unit, staff nurses call "Code Orange" two to three times a day. This means the unit manager no longer needs to de-escalate two to three incidents a day.

Leaders at Froedtert observed other important benefits for staff safety, shown here. The number of calls for non-physical violence doubled after implementing "Code Orange." In addition, the number of minor injuries to staff declined while staff-perceived safety improved.

Code Orange Increases Staff Safety, Saves Time

Staff Reported Feeling Regularly or Constantly Safe on Unit, Before and After Code Orange



Impact of Code Orange

2-3	"Code Orange" calls initiated directly by staff nurses daily on palliative care unit
2X	Doubled calls for non-physical violence
↓↓	Reduced number of minor staff injuries

Source: Froedtert & Medical College of Wisconsin, Froedtert Hospital, Milwaukee, WI; Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

Practice 9: Cross-Discipline Shared Accountability

Practice in Brief

Nursing leaders partner with non-nursing leaders to establish aligned, shared goals for nurse managers and their counterparts. The intent is to ensure all interdisciplinary leaders are working towards the same unit outcomes.

Rationale

Non-nursing departments interact with patients and staff, ultimately impacting unit performance. Despite this, nurse managers are often the only leaders held accountable for unit outcomes. Shared interdisciplinary goals guarantee that all relevant departments (and leaders) are held accountable for unit outcomes.

Implementation Components

Component 1: Set Cascading Shared Goals

Senior nursing leaders partner with other departments to define shared cross-discipline goals.

Component 2: Attach Meaningful Rewards To Goal Achievement

Senior leaders keep shared goals top of mind by routinely meeting with interdisciplinary leaders to discuss performance on their shared goals. Other methods for keeping goals top of mind can include linking goal achievement to performance appraisals and financial incentives.

Practice Assessment

This practice is an effective strategy to ensure all multidisciplinary care team members are working towards the same unit goals. It requires executive buy-in across disciplines in order to restructure and roll-out updated goals.

Nursing Executive Center Grades

Practice Impact: B+

Ease of Implementation: B-

©2017 Advisory Board • All Rights Reserved • 34804

Nurse managers are often the only leaders held accountable for unit outcomes. Yet, non-nursing departments interact with patients and staff, ultimately impacting unit performance. As a result, nurse managers are often coordinating with multiple, individual departments. This constant coordination adds up to a lot of manager time. For example, sample HCAHPS metrics that require action by non-nursing departments are shown here. In these examples, the nurse manager is responsible for unit outcomes that fall outside of nursing's control.

To save manager time, interdisciplinary leaders should ensure all departments are working towards the same unit outcomes. The key components of integrating Cross-Discipline Shared Accountability into practice are described on the following pages.

Chasing Down Interdisciplinary Partners

Sample Reasons Nurse Manager Must "Chase Down" Colleagues

HCAHPS Metric	Room and bathroom cleanliness	Physician communication	Pain management
Required Nurse Manager Action	Nurse manager calls **Environmental Services** to accelerate bed turnover time	Nurse manager consults **Medical Director** to improve **patient-physician** communication	Nurse manager coordinates **physicians, nurses, and pharmacists** to ensure pain medication is administered appropriately

Nursing Can't Do It Alone

"It feels like nursing is the catch all. For patient experience, nursing and nursing alone owns it. Nursing can't own all of it. We can't own cleanliness or physician communication."

Nurse Manager
Mid-Atlantic Hospital

Case in Brief: Yale New Haven Hospital

- 1,541-bed academic medical center headquartered in New Haven, Connecticut
- Implemented a collaborative leadership structure to encourage shared accountability for unit outcomes
- A joint leadership council made up of nursing directors and medical leaders defined cross-discipline patient outcomes that cascade to the unit level
- A unit-based partnership team of a nurse manager and physician leader developed a coordinated plan for driving the defined shared unit goals
- Selected, identical unit metrics were linked to physician and nurse manager performance appraisals
- Resulted in greater shared accountability for unit metrics among other disciplines and decreased length of stay

Source: Yale New Haven Hospital, New Haven, CT; Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

Component 1: Set Cascading Shared Goals

The first component of this practice is for nursing leaders to partner with other departments to define shared cross-discipline goals. To ensure alignment, interdisciplinary goals should use the exact same language and targets, as shown here.

Truly Aligned Goals Across Disciplines

Discipline-Specific Goals

Physician Leader Goal

Goal	Target
Reduce average length of stay (in hours) per observation case	60 hours

Nurse Manager Goal

Goal	Target
Improve discharge of patients by 11:00 a.m.	90% of patients

Truly Aligned Interdisciplinary Goal

Nurse Manager and Physician Leader Goal

Goal	Target
Reduce average length of stay (in hours) per observation case	60 hours

At Yale New Haven Hospital, leaders focused on goal alignment between physicians and nurse managers, as shown here. A joint nursing and medical leadership council defined cross-discipline goals, which cascaded down to the unit level. With identical objectives, the nurse manager and physician leader can coordinate plans that elevate performance for both disciplines.

The nurse manager and physician leader are also held accountable for unit metrics. To do this, Yale New Haven Hospital links unit metrics to nurse manager and physician leader performance appraisals.

Define Shared Goals from the Top

Yale New Haven Hospital's Process for Identifying Shared Performance Goals

Joint nursing and medical leadership council define cross-discipline outcomes that cascade to the unit level

Nurse manager and physician leader develop a coordinated plan for driving shared unit outcomes

Selected unit metrics are linked to **physician and nurse manager performance** appraisals

Source: Yale New Haven Hospital, New Haven, CT; Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

Component 2: Attach meaningful rewards to goal achievement

The second component of this practice is to keep shared goals top of mind by routinely meeting with interdisciplinary leaders to discuss performance on their shared goals. Other methods for keeping goals top of mind can include linking goal achievement to performance appraisals and financial incentives.

Leaders interested in creating meaningful performance incentives should consider the options shown here.

Use Meaningful Performance Incentives

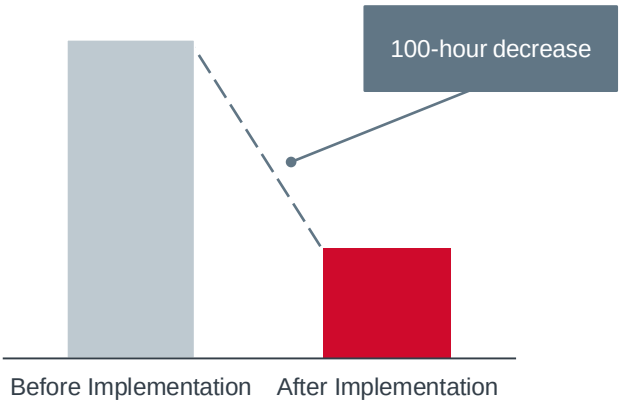
Practice	Description	Publication
Goal-Driven Performance Reviews	Hospital incorporates performance against key organization and unit goals into annual frontline nurse performance evaluations	Instilling Frontline Accountability
Principled Recognition Triggers	Unit managers and executive leaders establish clear performance criteria, tied to specific goals, that determine when staff receive special rewards or recognition.	National Prescription for Frontline Engagement

Cross-Discipline Shared Accountability can save nurse manager time by increasing accountability across disciplines. This means nurse managers are no longer the sole owner of unit outcomes.

In addition to saving manager time, leaders at Yale New Haven Hospital increased interdisciplinary collaboration, which helped decrease average length of stay, as shown here.

Benefits of Moving in Lockstep

Length of Stay in Observation Unit at Yale New Haven Hospital, Before and After Shared Accountability



Source: Yale New Haven Hospital, New Haven, CT; Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

Buffer Against 24/7 Unit Demands

- Practice 10: Decision Escalation Plan
- Practice 11: Dedicated Reflection Block

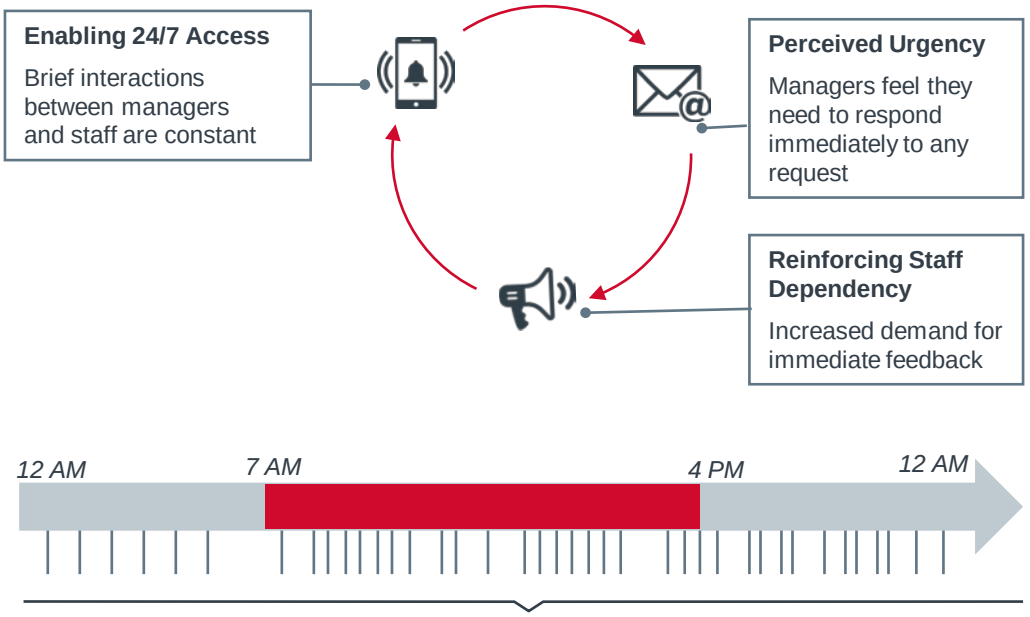
©2017 Advisory Board • All Rights Reserved • 34804

The fifth executive strategy to put an end to nurse manager overload is to buffer against 24/7 unit demands. It addresses the underlying challenge that changing technology and communication norms have transformed 24/7 *accountability* to 24/7 *accessibility*. Nurse managers are accountable for their unit 24/7. But increased availability via email, text messages, and calls means managers often feel like they have to immediately respond to staff requests. These constant staff demands add up to a significant burden on nurse managers' time, both on and off shift.

The two practices in this section will help nurse managers redirect unit and staff requests both on and off shift. The first practice in this section helps protect nurse managers from work-related communication when they are off duty by creating an after-hours communication policy. The second practice in this section creates protected time during regular working hours for nurse managers to dedicate to important but non-urgent work.

Death by 1,000 To Dos

The Downstream Impact of Today's Around the Clock Communication Norms



Individual staff requests add up to sizable burden

Source: Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

Practice 10: Decision Escalation Plan

Practice in Brief

Senior nurse leaders create an after-hours communication policy for frontline staff and assign clear points of contact (who are not the nurse managers) during off-hours. The goal is to free up nurse managers from work-related communication when they are off-duty (while still allowing frontline staff to find answers to their urgent questions).

Rationale

Technology has made nurse managers more available to frontline staff than ever before—so 24/7 responsibility often translates to 24/7 availability. This means unit managers remain available to staff via email, phone calls, and text messages, even when they are "off-duty," interfering with work-life balance. An after-hours decision escalation plan that is supported by senior leaders allows managers to disconnect from work, and decompress and refresh.

Implementation Components

Component 1: Create an After-Hours Decision Escalation Plan

Senior nurse leaders create clear guidelines for frontline staff that specify who they should contact with questions or concerns when the unit manager is off-work. The guidelines also include limited, urgent exceptions in which the nurse manager should be contacted directly. For example, urgent issues may include serious staff injury, unit evacuation, or a mass emergency.

Component 2: Empower Decision-Making Authority at Each Level

Senior leaders and unit managers empower charge nurses and supervisors to make on-the-spot decisions when the unit manager is not working. To do this, nursing leadership needs to formally give charge nurses and supervisors real decision-making authority. In addition, unit managers must respect (and not undermine) those decisions and adhere to the decision escalation policy even if staff reach out.

Practice Assessment

This practice can significantly reduce manager burnout. While it requires minimal time and resources, the practice's success hinges on the unit manager's compliance. Therefore, senior leaders need to actively encourage frontline staff *and* managers to observe the decision escalation plan, particularly when it's first rolled out.

Nursing Executive Center Grades

Practice Impact: B+

Ease of Implementation: A-

©2017 Advisory Board • All Rights Reserved • 34804

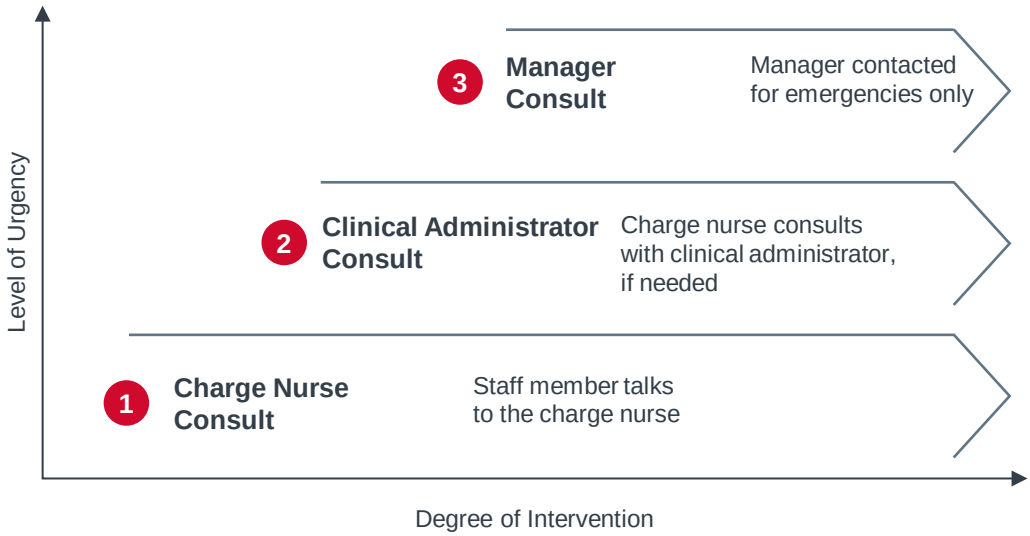
Component 1: Create an After-Hours Decision Escalation Plan

The first component in this practice is to create clear guidelines for frontline staff that specify who they should contact with questions or concerns when the unit manager is not working.

At Valley Health - Winchester Medical Center, frontline nurses follow the decision escalation plan shown here.

Mandate an After-Hours Escalation Process

Returning to a Pre-iPhone Era at Valley Health



The decision escalation plan should include staff guidelines for when to contact the nurse manager after hours, the designated chain of command, and the nurse manager's preferred phone number. In the example shown here, there are specific scenarios that warrant a direct call to the nurse manager, including a serious staff injury, unit evacuation, or mass emergency.

Clear Guidelines for Escalation

Representative Guidelines for Contacting a Nurse Manager After-Hours

Unit After-Hours Communication Policy DRAFT

Consult Charge Nurse:
- Clinical question
- Staffing change
- Technology question

Call Nurse Manager:
- Serious staff injury
- Unit evacuation
- Mass emergency

Escalation Process

Staff → Charge Nurse → Clinical Administrator

Nurse manager preferred contact number: _____

Source: Valley Health – Winchester Medical Center, Winchester, VA; Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

Component 2: Empower Decision-Making Authority at Each Level

The second component of this practice is to empower charge nurses and supervisors to make on-the-spot decisions when the unit manager is not working. To do this, nursing leadership needs to formally give charge nurses and supervisors real decision-making authority through clear guidelines.

In addition, unit managers must adhere to the decision escalation policy—especially if staff circumvent the decision escalation process and reach out to their manager directly. If nurse managers don't respect the decisions made by their charge nurses and supervisors, then they undermine their authority and the formal decision escalation process.

Help Staff Adjust to New Communication Norms

Three Components to Revamp Communication Norms at Valley Health

Clear Guidelines

Provide specific indications that warrant escalation to manager

Manager Compliance

Managers do not respond to requests outside of the established chain of command

Decision-Making Authority

Empower charge nurses and supervisors to make on-the-spot decisions

Lead by Empowering Others

"24/7 accountability is not 24/7 reachability. Let's set up operations to help unit leaders make the best decisions they can. Then, if they still need a nurse manager, be reachable through a primary contact number."

Jennifer Riggleman, Director of Acute Care
Valley Health – Winchester Medical Center

Case in Brief: Valley Health – Winchester Medical Center

- 455-bed, not-for-profit hospital in Winchester, Virginia
- Piloted a communication escalation policy for after-hours use when a nurse manager is not on the unit
- The policy empowers charge nurses to make decisions or consult with the clinical administrator by providing detailed guidelines on when independent decision making or consult is appropriate; the nurse manager is only contacted in emergencies
- The CNO gave full and immediate support of an after-hours escalation process
- Resulted in decreased number of after-hours calls, reduced stress, and improved work-life balance for nurse managers; provides signal value to all nurse leaders that work-life balance is important

Source: Valley Health – Winchester Medical Center, Winchester, VA; Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

A decision escalation plan can reduce after-hours communication and allow nurse managers to disconnect. For example, rather than calling the off-duty nurse manager, staff can discuss schedule changes or clinical questions with the charge nurse.

An added benefit of a decision escalation plan is that it doesn't just postpone work for nurse managers (by saving decisions until they return to work). It ensures work is completed in their absence by another qualified unit leader.

Immediate, Meaningful Benefit for Nurse Managers

Dual Benefits of an Escalation Process

- **Reduces number of after-hour calls** to the nurse manager
- Reduces burnout by **allowing nurse managers to disconnect**

Managers Feeling the Impact

"It's different now. I'm not sure I could have continued being a manager if the constant pressure to be available all the time continued."

Nicole Clark, Nurse Manager
Valley Health – Winchester Medical Center

Source: Valley Health – Winchester Medical Center, Winchester, VA; Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

Practice 11: Dedicated Reflection Block

Practice in Brief

Senior leaders schedule and champion protected time during regular working hours for unit managers to dedicate to leadership activities. The goal is to provide managers a set time away from unit operations to focus on important but non-urgent work.

Rationale

Unit managers feel obligated to immediately respond to staff requests, regardless of their actual urgency. These interruptions distract managers from critical leadership responsibilities. By proactively carving out a dedicated time, nurse managers can focus on important responsibilities rather than immediate requests.

Implementation Components

Component 1: Designate a Regularly Scheduled "Reflection Day"

Leaders provide a regularly scheduled, protected day for all nursing leaders to work off-site and execute important but non-urgent work. Some suggested activities include strategic planning, peer networking, and professional development.

Component 2: Create a Plan for Unit Coverage

Peer managers or assistant managers cover unit operations during a manager's "reflection day."

Practice Assessment

This practice is an effective way to protect nurse manager's time. To help generate buy-in for reflection days, executive leadership should model this practice and actively encourage nurse managers to use their day.

Nursing Executive Center Grades

Practice Impact: B

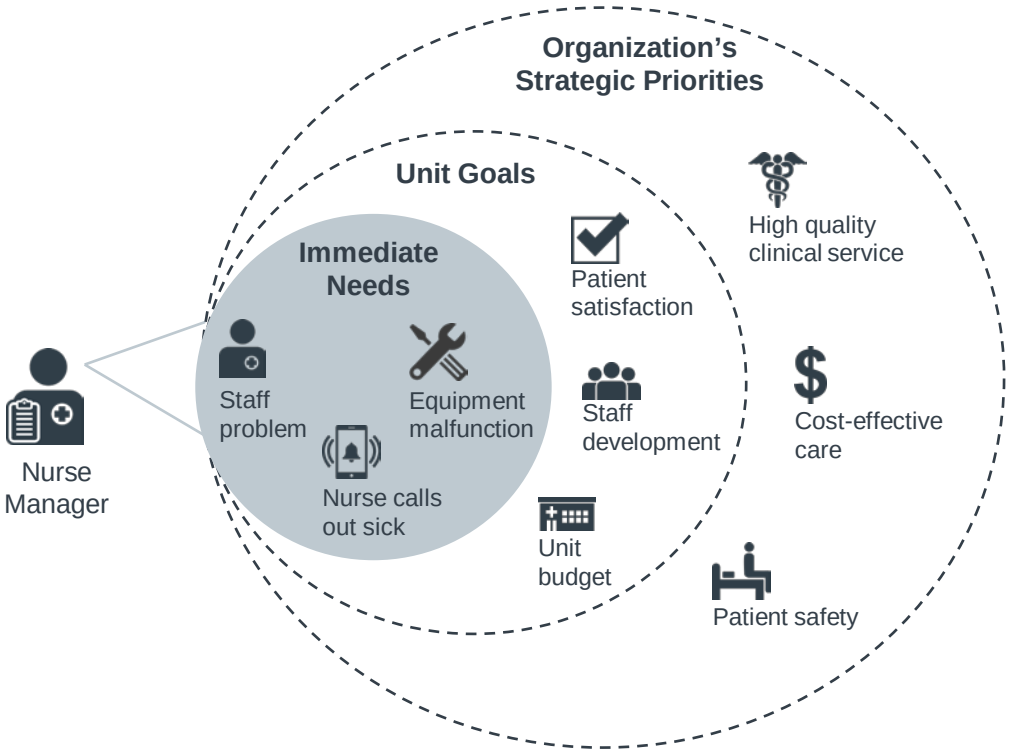
Ease of Implementation: A

©2017 Advisory Board • All Rights Reserved • 34804

Nurse managers are more available to staff than ever via email, text messages, and calls. While it's important to be available and responsive to staff, managers can feel obligated to immediately respond to staff requests regardless of the actual urgency. These immediate staff needs can distract nurse managers from focusing on important leadership work, like driving organizational and unit priorities.

One way to ensure nurse managers have uninterrupted time to focus is to carve out dedicated days to work off-site on important but non-urgent work.

Urgent Doesn't Equal Important



Case in Brief: Texas Health Presbyterian Hospital Dallas

- 888-bed acute care hospital in Dallas, Texas
- Implemented monthly "reflection day" for nursing leaders, including managers, to take dedicated time away from work devoted to leadership opportunities
- Guidance provided to help nurse leaders use their reflection time as intended, rather than catching up on email and back-office busy work
- On reflection days, units are covered by supervisors, peer nurse managers, or directors to ensure the nurse manager's time is protected
- Since introduction of reflection days, leaders observed reduced stress, increased resiliency, and greater focus on nurse manager leadership; reflection day also signals value to all nurse leaders that professional and leadership development and work-life balance are important

Source: Texas Health Presbyterian Hospital, Dallas, TX; Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

Component 1: Designate a Regularly Scheduled "Reflection Day"

The first component of this practice is to designate a regularly scheduled "reflection day." Leaders provide a regularly scheduled, protected day for all nursing leaders to work off-site and execute important but non-urgent work.

Component 2: Create a Plan for Unit Coverage

The second component of this practice is to create a plan for unit coverage. Peer managers or assistant managers cover unit operations during a manager's "reflection day." This means nurse managers are free from unit operations for the day. This allows them to focus on important, leadership priorities.

At Texas Health Presbyterian in Dallas, all nursing leaders are encouraged to take a "reflection day" once per month. Nurse leaders work off-site during their reflection day and are expected to focus on leadership activities, such as those listed here.

Empower Managers to Take an Off-Site Work Day

Key Elements of Nurse Manager Reflection Day at Texas Health Presbyterian

A Full Day
Managers take one monthly "reflection day" off of hospital grounds

Plan the Day
Managers prepare in advance how the day will be used

Unit Coverage
Peer managers or assistant managers cover unit for the day

Picklist of Leadership Activities for Reflection Days

- ☐ Strategic planning
- ☐ Peer networking
- ☐ Staff development
- ☐ Professional development
- ☐ Performance improvement
- ☐ Project planning

Source: Texas Health Presbyterian Hospital, Dallas, TX; Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

Dedicated reflection blocks remove interruptions and allow nurse managers to focus on important but non-urgent work. As a result, it decreases nurse managers' stress and burnout. At Texas Health Presbyterian, leaders observed better resilience and stronger leaders after reflection days, as shown here.

Time Well Spent

Benefits of a Reflection Day

- **Reduces stress and burnout** by removing interruptions for the day
- **Signals value** that professional development and work/life balance are important
- **Increases resilience** by providing time to reflect on leadership decisions and development

Time to Stop and Think

"The space and time to think are really valuable. After reflection days, managers have told me that they processed a stressful event or decided to move forward with nurse leader certification."

Dr. Cole Edmonson, CNO
Texas Health Presbyterian Hospital

Source: Texas Health Presbyterian Hospital, Dallas, TX; Nursing Executive Center interviews and analysis.

©2017 Advisory Board • All Rights Reserved • 34804

©2017 Advisory Board • All Rights Reserved • 34804

©2017 Advisory Board • All Rights Reserved • 34804

Want more on **nurse manager overload**?

This report is a publication of the Nursing Executive Center, a division of Advisory Board. As a member of the Nursing Executive Center, you have access to a wide variety of material, including webconferences, research reports, implementation resources, our blog, and more. Check out some of our other work on nurse manager overload.

Implementation Resource: Re-Envisioning the Nurse Unit Manager Role Toolkit

Learn four imperatives to revise and support the role and help unit managers focus on the most important aspects of their job.

Implementation Resource: The Nurse Manager's Guide to Improving Unit Outcomes

Learn how managers can prioritize among competing priorities, target opportunities for meaningful improvement, and involve staff in driving unit performance.

Infographic: Is Nurse Manager Workload Out of Control?

Learn about five executive strategies to reduce nurse manager overload.

Visit us at: **advisory.com/nec**

Email us at: **nec@advisory.com**

ADVISORY BOARD AT A GLANCE

RESEARCH AT THE CORE

A comprehensive platform to drive best practice performance at every level of your health care organization

TECHNOLOGY AND CONSULTING
TO HARDWIRE BEST PRACTICES

Deep solutions across three areas of critical importance:

- **HEALTH SYSTEM** GROWTH
- **CARE VARIATION** REDUCTION
- **REVENUE CYCLE** MANAGEMENT

Advisory Board

2445 M Street NW, Washington DC 20037
P 202.266.5600 | F 202.266.5700 | **advisory.com**