Working Paper

Maintaining a Patient Focus in the Flexible Work Environment

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Introduction

The MIT Workplace Center's spring 2003 seminar series focused on flexible work arrangements in three industries – health care, legal services, and high tech-- and looked at both the challenges and promises of creating flexibility in the workplace. This working paper was produced by Susan C. Cass from a transcript of a seminar entitled "Maintaining a Patient Focus in the Flexible Work Environment" given by Nancy Kruger and Nancy Hickey on February 25, 2003.

Nancy Kruger is Vice President, Patient Care Services and Chief Nursing Officer, Brigham and Women's Hospital. She also holds an appointment as an Instructor at Harvard Medical School and is a Senior Associate at the Institute of Nursing and Healthcare Leadership in Boston. Kruger has a long career in health care as a nurse and as an executive. She obtained her undergraduate degree from Skidmore College, a master's from New York University in parent-child health, and a doctorate from the University of Pennsylvania in clinical research. Her expertise in clinical practice is in emergency care and critical care nursing.

Before joining Brigham and Women's Hospital, she served as the Chief Nursing Officer at Hershey Medical Center in Pennsylvania for 14 years. As the Chief Nursing officer, Kruger was responsible for negotiating work schedules, recruiting staff and creating a work environment that would support the needs of a large professional work force. During that time she received a $1 million grant from the Robert Wood Johnson Foundation to study ways to strengthen hospital nursing. She continues this kind of work today, looking for ways to improve the work environment while maintaining an expert workforce dedicated to quality patient care.

Nancy Hickey is the Director of Personnel and Resource Applications at Brigham and Women's Hospital. She has an undergraduate degree in nursing from Salem State College and a master's degree in health care administration from Simmons College. She has 21 years experience at Brigham and Women's Hospital - having worked in both clinical and administrative positions.

Lotte Bailyn is the T Wilson Professor of Management at MIT's Sloan School of Management and Co-Director of the MIT Workplace Center.

Patient Care Focus

While it is important for hospitals like Brigham and Women's to have a flexible work environment and pay attention to nurses' needs so we can recruit the best and the brightest and have them work and keep us safe and healthy, we nevertheless have a social obligation to take care of sick people--our major focus is patient care. The patients are not here for our convenience; we are here to take care of and to serve patients as best we can. Our objective is to provide a safe environment for patient care. We do take into consideration the needs of the people who care for patients because we want them to come back the next day to continue caring for the patients, so we need to provide a practice environment that is provider friendly. Part of this is providing competent practitioners with the expertise that the public demands. Our physicians, nurses, and patient care assistants have to have a level of expertise that will keep the patients safe.

Continuity of care is extremely important because information about patients is passed from one person to another and from shift to shift. Patients develop relationships with their care providers and those relationships are extremely important. Patients tell their care providers very personal and private information that is critical to their care. Continuity of care is important because just like in the children's game of telephone, the story tends to get changed with each person that hears and retells it. To the degree we can have the same people taking care of our patients day after day, the more likely it is that things will not get mixed up. If I take care of a person today and I take care of them tomorrow, I have a basis for comparison. But if I take care of a person today and Jane takes care of them tomorrow and Sally takes care of them the next day, those are three people just on the day shifts that will have different impressions and will not have any personal basis for comparison, for noting how well the person is progressing. A situation like that can lead to some lapses in judgment and mix ups.

Our passion is giving extraordinary care in partnership with our patients and families.

Brigham and Women's Vision for Nursing

Our most important responsibilities are patient care, teaching, and the development of new knowledge through research. Our passion is giving extraordinary

care in partnership with our patients and families. We provide unparalleled compassionate care with unprecedented technical expertise to create a healing environment with our colleagues in patient care. This is what guides the practice of nursing at Brigham and Women's Hospital and it reflects the objectives of attending to the work environment, but make no mistake about it, the patient is first.

Much of the patient's experience is dependent on the relationship between the practitioner and the patient. We have to develop a relationship with a person very, very quickly, so that they feel safe. For example, a nurse comes into a new patient's room and is able to touch the person, look them in the eye, and can convince the patient just by his or her presence that the patient is safe and everything is going to be all right. If the patient has 15 different nurses over the course of a four-day stay, the quality of that relationship can be in jeopardy. Unfortunately, the reality is that a flexible work environment does inject more people into the patient care equation. Part of our problem is how to facilitate the quality of the relationship upon which we all depend when we are sick with a flexible work environment.

Despite this problem, for us to attract qualified practitioners we have to be prepared to offer flexible work schedules. Nursing as a discipline is in competition with many other career possibilities for women. Close to 96 percent of all people in this country who are nurses are women and although some of those numbers are beginning to change, we need to attract very bright women and men to the field. To become a nurse takes a great deal of education and experience. Qualified people need the intellectual knowledge, but also must have the intuitive skills to develop that knowledge while they take care of people. To attract these types of people to our profession we have to be flexible.

Assuring Competence and Excellence in Patient Care

At Brigham and Women's we do many things to assure competence among our nursing staff. The first is a clinical colleague program. To keep our approximately 2,500 nurses and another 400 or 500 people who work in clinical settings up to date on the most recent information, like how to work new equipment, we have developed a network of nurses whose job it is to learn these things first. They are assigned to learn new information and to teach it to 10 or 12 people on their unit. Part time schedules make this program more

problematic in that training may have to occur several times rather than once or twice to be sure that everybody is taught about new things.

We have a three-month long orientation program for newly licensed nurses with a very specific curriculum. The nurses start out on a particular unit with faculty who work with them both on the technology and the systems in place, but also on their clinical diagnostic skills and how to take care of people with particular problems.

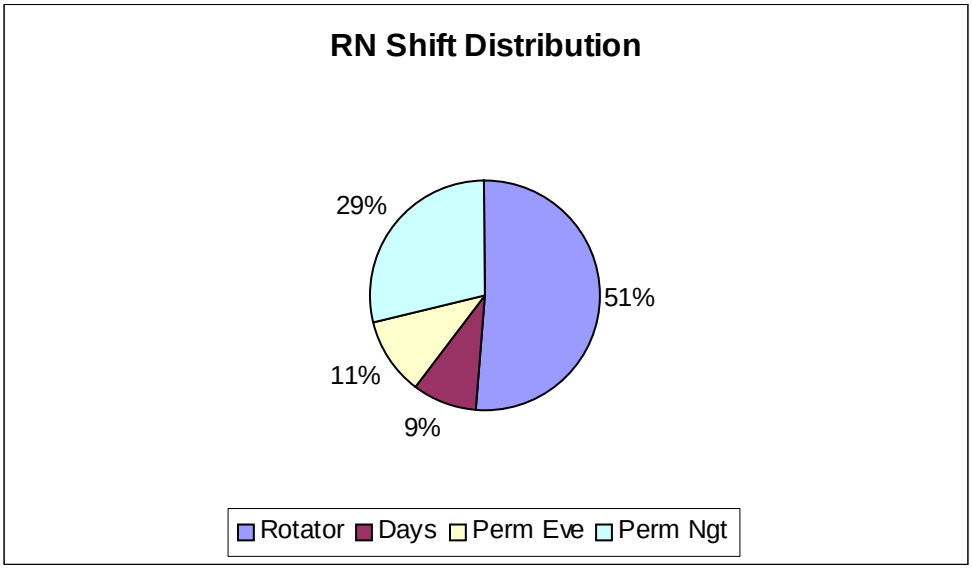
For the nurses who have been in practice for a longer period of time, we have advanced care courses. We offer these because of the constant change we experience: practice protocols and knowledge about how to care for people changes so often. These courses keep the experienced nurse actively engaged in the practice of nursing and in utilizing new knowledge. We set aside time on an ongoing basis for nurses to continue their study for intellectual stimulation and to address the hospital's needs.

Finally, we have an annual competency demonstration. We are seeing an increasing emphasis on competencies and we have to demonstrate to the public and to various agencies that certify us that we are responsible citizens and are competent to work the machinery, dispense medications, and to make appropriate judgments.

Staff Demographics and the Structure of Schedules

Chart I shows the hour and shift distribution at Brigham and Women's and the disproportionate amount of staff who rotate shifts. Rotation is when a nurse works up to 50 percent of his or her time in a four-week block on days and then either evenings or nights. Rotation lends itself to a lack of continuity.

Chart I



Twenty-nine percent of the staff works permanent night shifts and most of these people work 36-hour weeks, three 12-hour night shifts. Most of them are in their 30s and 40s and have children. There is a very small amount, 9 percent, who work permanent days. Brigham and Women's is a contract hospital which means a nurse has to have a certain seniority, usually about 10 years, before he or she can take a day position. Finally, 11 percent work permanent evenings. In our last contract negotiations, one of our goals was to increase the proportion of permanent evening staff, hoping that if we were able to attract them by larger shift differential, it would allow more continuity for patients: they would see the same staff or the same cluster of staff in the evening as they do on nights. Unfortunately, the union did not agree with this new idea. Traditionally the union likes increases across the board in shift differential, looking at it as a reward for not working on days. We plan to re-strategize for the next negotiations.

Chart II

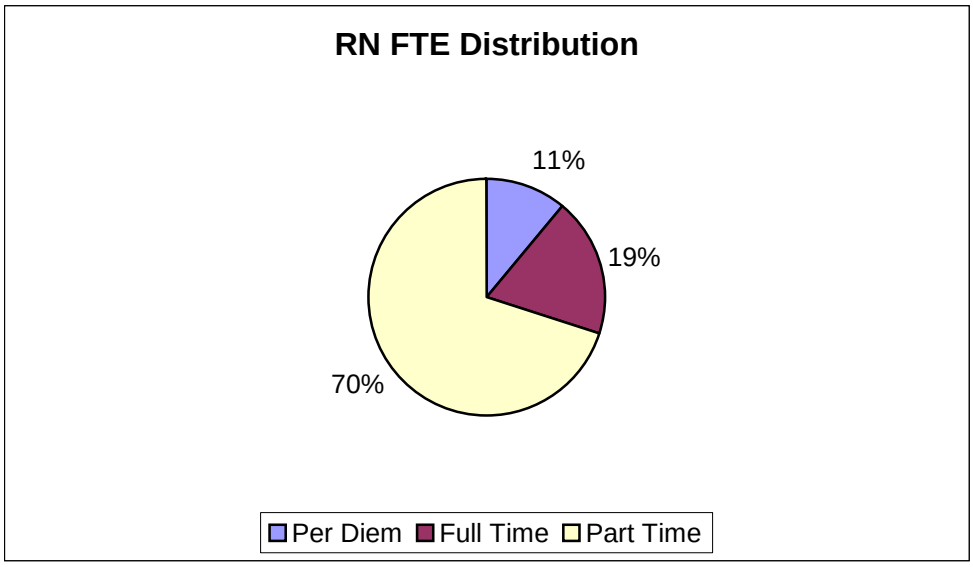


Chart II shows that 70 percent of RNs work part time. Part time is defined as less than 40 hours, so nurses who work 36 hours a week are considered part time. It is important to show the 36-hour group in this figure because they are not there five days a week. Most nurses work three times a week or less.

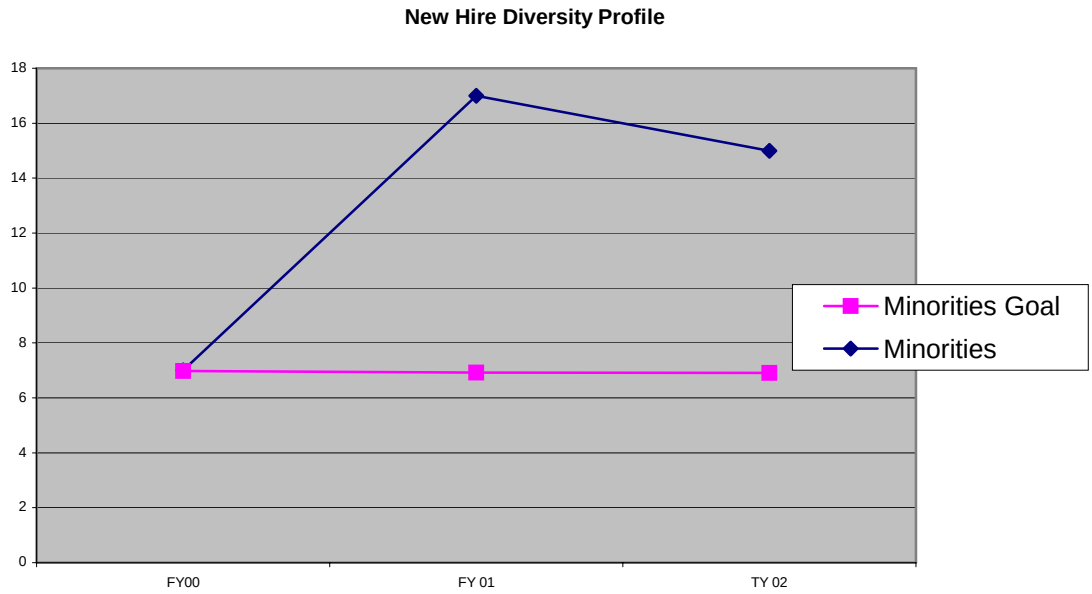
Who are the full time people? Nineteen percent of Brigham and Women's nurses work full time. They are often new, young nurses, 22 or 23 years old. They are the rotators who do not want to work nights or evenings because they usually have very active social lives. Typically, as they earn more money by staying, they will also want to reduce their hours and work three 12-hour shifts, so they become part of our 70 percent part time staff.

Eleven percent of our staff is per diem, which means they must work at least four shifts a month, but can pick up additional shifts that are vacant. These nurses are typically women who have had their second child. The traditional progression is: the full time workers move into the part-time when they have their first child. When they have their second or third child, they move into per diem work. They are not necessarily interested in committing to a full-time position any longer and it is hard to recapture that group back into the full-time workforce. The reason? They can work four shifts a month or one 16-hour shift a week, and do some overtime and they can make quite a bit of money. They typically get paid time-and-a-half and double-time, so they can do quite well even working a very limited amount of hours.

Diversity Hiring

Brigham and Women's Hospital tries to hire a diverse group of nurses because it helps us meet the needs of our diverse patient population. Our minority hiring goal has been approximately seven percent and we have exceeded that each year. In FY01 it was 17 percent and FY02 it was 15 percent. What does not show in Chart III is the sex diversity amongst the young nurses, as more men enter the nursing workforce. An interesting element of this is many men who work in nursing tend to work full time.

Chart III



Recruitment

In planning for recruitment and retention, we look at the number of nurses and nurses aides that we need to recruit and at some of the challenges age and lifestyle present to us. We have found that nurses who work in a contract hospital like ours reduce their hours as they earn more money. A contract hospital is a unionized hospital where seniority plays a part in scheduling. A nurse who is working 24 hours a week is probably making a salary he or she feels very comfortable with and so chooses not to work 40 hours.

We look at the age distribution of current staff and project out over a 10-year period of time. Relative to where we are in FY02, there is an equal distribution of staff that would be in the 40 years of age or less category and if we were not to replace those staff, in 10

years we would have a large number of staff who would be ready to retire. So we developed a long-term strategic plan to prepare for when those staff would be leaving or reducing their hours.

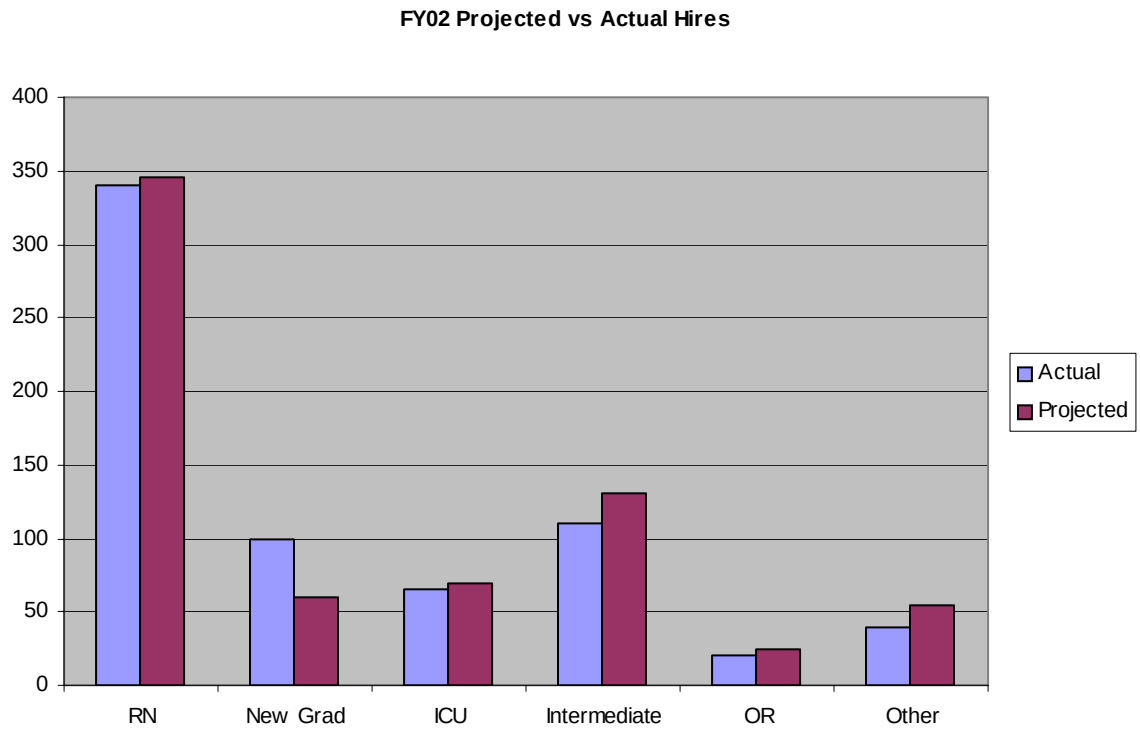
Our challenge is to aggressively recruit new nurses. We have limited ability to recruit into off shifts, but our goal is to do that in order to provide more continuity. The people whom we are recruiting are new nurses; they are young and have varying levels of skill.

Travel companies, companies that recruit nurses for particular blocks of time, are very aggressively recruiting the younger staff, those who want to move around and get experience. Nurses who sign on with a travel company can spend the summer down on the Cape and in the winter in Hawaii or California. Young, single nurses love this lifestyle. For hospitals, it is very difficult after investing money and time in training a traveler to see that person leave.

Brigham and Women's has specific strategies around floating and temporary staff. We do not use agency nurses. What are agency nurses? Agency nurses are nurses who work through a local nurse staffing agency and do not commit to a 13 week assignment at a single institution. The nurse working through an agency may go to a different hospital each day. What we do provide is 13-week contracts for travelers, floating and temporary staff to assure at least 13 weeks of continuity. We also have particular provisions in our contracts that we hope will entice people to extend their contracts and stay for 26 weeks. We are also hoping that we can recruit from these travel companies.

We set an ambitious target for FY02 of hiring 348 nurses and we were just 10 nurses short of achieving that goal.

Chart IV

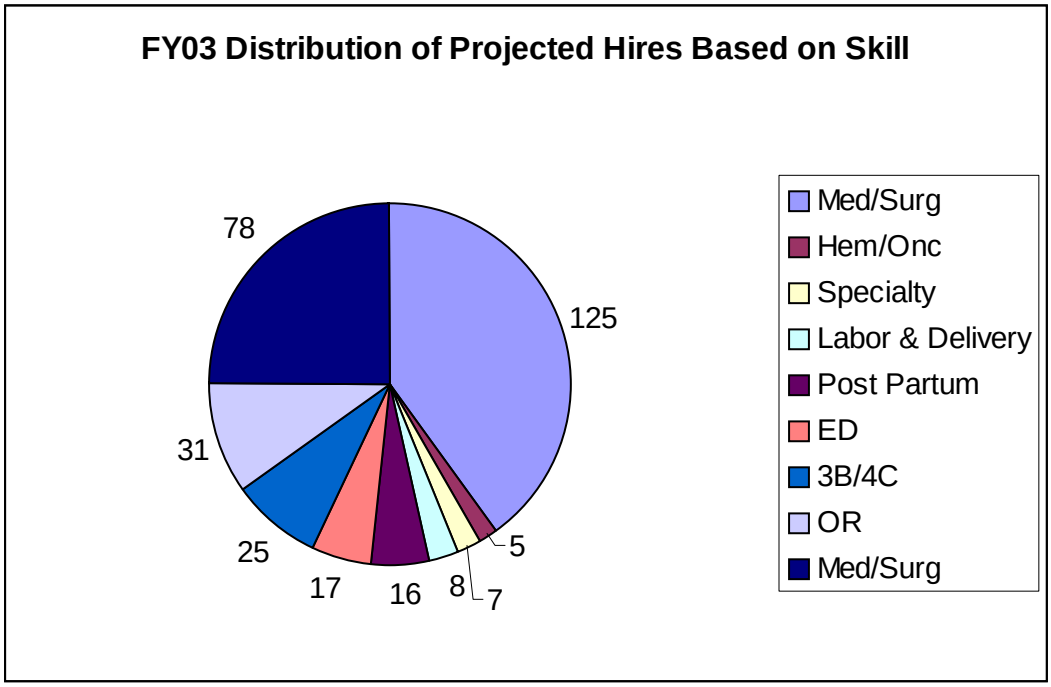


We expected to hire only about 60 new graduates and we hired 100, which put a different demand on the system. We try to entice young nurses who would otherwise leave the organization, to stay by allowing them to learn and grow within our organization. For instance, we have had to hire many ICU nurses and have been able to meet that demand with our critical care intern program. There are two goals to this program: One is to train new nurses. The other is to integrate these new nurses into the staff mix, so that if one nurse takes maternity leave, there is a nurse who comes in and learns on site and is integrated into the unit. This provides continuity, meeting one of our objectives, but is also a sound retention strategy with the nurses meeting their goals of professional growth.

Chart V breaks down our recruitment needs for FY03 of intermediate nurses[1], operating room, and the specialty areas.

[1] An intermediate nurse is someone who works in an inpatient setting that is not ICU. These units are supported by telemetry and have pretty sick patients, but not sick enough to be in the ICUs.

Chart V



Most of our new hires have bachelor's degrees and 17 percent have master's degrees.

We set a recruitment goal again this year, based on the same assumptions of about 300 nurses, and we are about a third of the way through and have achieved a third of our goal. We have hired approximately 30 new grads, 70 experienced nurses, and with regard to diversity we are doing quite well. We shoot for hiring 300 not because a total of 300 will leave, some will leave and retire, but many people reduce their hours. The increased need for staff also comes from the fact that we are growing programs, for instance we are expanding the number of operating rooms we have and we have opened new beds.

Retention Strategies

We do not always have a steady state of staffing. We have tried to achieve it by recruiting effectively, looking at our scheduling strategies, and making sure that these strategies are patient focused and also employee friendly.

Years ago, scheduling was less flexible. The hospital would say, "This is what we need you to do. This is what you are going to do." In response, the nursing staff said, "I don't think so. I'm in demand. I'm holding the cards. I'll go someplace else or I just won't work for a while." And so even though hospitals like people to work these particular schedules, they have to partner with the employees and think of ways to retain people at the unit level, keep them on permanent shifts, keep them happy, manage the internal transfers, and manage the turnover. That is what Brigham and Women's is trying to do now.

We still encourage full-time staff, especially in specialty areas like the operating room (OR) and neonatal intensive care unit (NICU) and areas that are very difficult to recruit into. We considered increasing permanent shift differentials as an enticement for people to work those permanent off shifts. We have done that with patient care assistants (PCAs) and have been successful to some degree. We are also doing that with co-op nursing students, enticing people with money to work permanent off shifts.

In FY03 we had at least 103 new grads come in as rotators and we have to think about retention strategies to keep them. Likewise, we have 107 nurses who will be doing internal transfers or shifting within departments. A third of our staff will be shifting to new jobs in the next year. Even though it is internal turnover, it affects the continuity of our patient care because someone else is coming in to fill that position. It means orienting the new people and matching schedules as the new people may not want the same sort of hours those leaving had.

The Life Course Fit

We have learned that we need to understand the staff and where they are in their lives, but also to help them understand what their commitment is as an employee of a healthcare facility like Brigham and Women's. They have an obligation to be present for the patient. But because we understand that our relationship is a two way street, we try to

find schedules that benefit both the patients and the needs of the staff. The managers at the unit level work with people to try to find out their situations. For example, if somebody wants to go back to school, we work with them so that they get the time off to attend classes. If someone is pregnant, we work with them to plan how long they would like to take off and when they return to work what shift they will be able to work. Likewise, we try to work with people in the sandwich generation, both in the short term as well as the long term. We try to give people the time off that they need. We get frequent requests from nurses who want to take a longer period of time off than they are entitled to for a life experience. For example, a person gets married and they want to go on a long honeymoon or someone who has family in Africa or the Philippines and they want to go home for an extended period of time.

Mandatory overtime is a big dissatisfier amongst staff. Years ago, when hospitals went through budget cuts and fiscal challenges, the patients were still in the beds and to be able to safely take care of the patients, nurses had to put their names in a hat to decide who would do overtime to cover a particular shift. Someone would be expecting to leave on Thursday at 11:30 and if another nurse called in sick or if somebody was on leave, everybody would have to put their names in a hat. It could get very contentious and was a very big challenge and it peaked in October fiscal year ’01. To address this issue we strategized and adopted a policy of no mandatory overtime. Many people opposed this new policy, especially the off-shift administrators who were afraid they would be left with the problem. But the policy worked because it represents a change in philosophy, a spirit of cooperation, working together to find solutions and partnering with the employee. We sent the message to employees that we knew that they wanted flexible work schedules and no mandatory overtime. We also were saying, we hope you understand that we have the needs of patients to keep uppermost in our minds.

We have been able to successfully work with the nurse’s union. Sometimes we have to cajole and convince, but for the most part we have been able to work with them successfully. The most difficult issues involve the more senior people on a given unit who sometimes have a hard time understanding that just because they are senior, does not mean they do not have to give and take a little bit.

For nurses who are looking for recognition, we recognize clinical expertise. Those who have gotten specialty certification and have advanced in the practice of nursing will be recognized monetarily. We have built into the contract reimbursement for specialized certification. Similarly, we acknowledge those who learn a foreign language. We have a lot of Spanish, Russian, and Somali –speaking patients, so we try to encourage people to develop skills and assets that are helpful in caring for this population and then we show recognition.

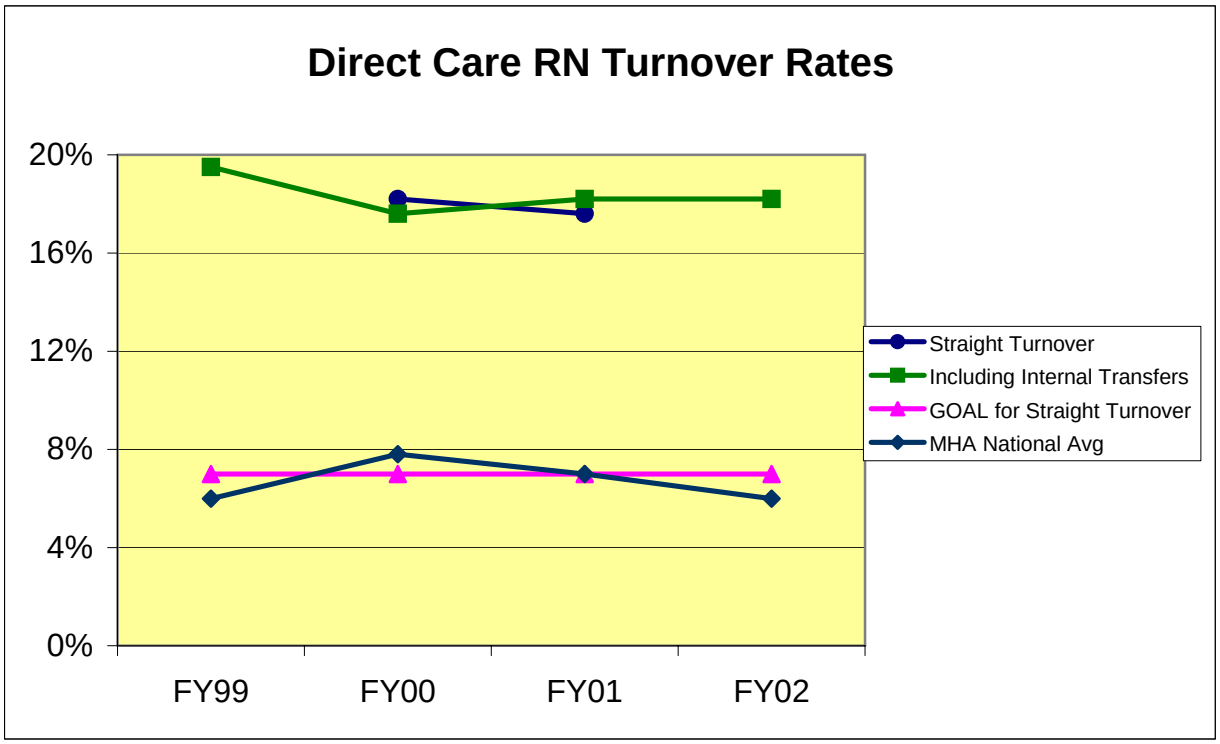
We also try to work with people in changing the particular area in which they work or their direction. A person can work in a particular area for an extended period of time and get burned out and they want a new challenge, and so our managers routinely talk with people about these concerns. If they notice that someone seems dissatisfied, managers are encouraged to bring up the subject and help the nurse problem solve. We hope to keep people energized and have them remain in the workforce.

Internal Transfers

Nurses tend to move if they stay within the organization, which many of our nurses do. They like to move within the department and we encourage them to do that because we would rather have them move within the department or within the organization and manage the turnover versus have them leave. This phenomenon is not new, but it was not encouraged as aggressively as it is now. Supervisors used to be very concerned about losing the infrastructure of their staff. Now they must realize that the infrastructure of their staff is going to change. If you have all your staff on one particular day, that is a great day, but it is only for one day and is probably a blip on the radar screen. We have adopted a philosophy of managing internal transfer, promoting it, and having dialogue between managers, so that people transfer more efficiently.

We hope to keep people energized and have them remain in the workforce.

Chart VI



Tackling Understaffing

We have a couple of safety nets to address understaffing. We have a very large flow pool where we use travelers for 13 week assignments on specific units. If an area is understaffed, the off-shift administrator can look at the flow pool and distribute it according to need. The challenge the off-shift administrators often have is sick calls exceeding the number of flow pool staff to fill in. The off-shift administrators have been given the charge to negotiate, work with the staff, look at other units and ask those administrators to consider if they really need the amount of staff they have. If the census drops in one area, they will shift staff over to another area, and this is managed in a particular way. There are algorithms that they use. We partnered with the staff, especially through the union, to determine what is acceptable and what is not. We came up with clear float guidelines that the union approved.

The Downside to Flexible Schedules

Most nurses are very committed to the care of the patient but because of the flexible schedules and nurses' preferences for fewer hours, we see a loss of intimacy with the patients and their families. The nurses do not know as much about the people they care for and are not as aware of things that the patient might need when they go home as they would have if scheduling continuity had been kept in place. In addition, with the potency of the therapies that we administer today, there is a real possibility of having an unsafe practice develop. We are heavily involved in preventing medication errors, for example, as well as patient falls. We have been noticing that because of the kinds of medication we give people, younger people are falling and injuring themselves. This is something we did not see in the past. It used to be that people who were falling and hurting themselves were 70 or 80 years of age. Now we see people who are 25, 30, 40 years of age. Part of the reason this may be happening is we do not have the relationship with the patient that we used to have.

Future Directions

One of the things that is helping us is that patients' lengths of stay are becoming shorter. While the average length of stay is about five days, if a nurse works five days in a row, theoretically the patient could see the same nurse most of the time. As our length of stay drops and as care is being delivered in short-term units like in cardiac cath labs where people have diagnostic procedures, recover on the unit and six hours later, they are released, balancing patient needs with employees' preferred schedules becomes a bit easier.

We are witnessing a fair degree of program expansion, both for new therapies in the area of diagnostic and interventional studies and different types of operative procedures. These expansions demand more personnel.

To attract more people to the field of nursing, we are reaching out to the immigrant population. We have had some discussion with Roxbury Community College to explore some sort of partnership to help immigrant staff that have English as a second language successfully navigate through the nursing program. We have partnered with Bunker Hill Community College and have a good track record there.

In addition, we have an on site English as a second language program and we try to identify people who are bright and interested, but who have difficulty with the language and the math skills needed to be successful in healthcare. Fleet Bank is another group that we have done some work with. Of course we have a tuition reimbursement program, but I think the fundamental thing that we try to do is get people to be good in their English language skills, which is absolutely critical in order for people to be successful.

When there is no longer this tight labor market and we are under cost control pressures, our recruitment and retention strategies may be scrutinized. We are already seeing cutbacks in Medicare and Medicaid reimbursements and the insurance companies are not paying for things. But institutions that survived cost-cutting days in the past did a couple things that kept them in good stead. First of all, they did not cut their educational programs for new graduates and, in fact, recruited people continuously through that period of time because just as times are going to become difficult and it will appear that the workforce is gaining, we will be back in a cycle where there will be shortages of nurses or the demands will change and we will need more nurses. I would retain those educational programs. I would fight to maintain those kinds of programs for people.

Measuring Success

What are benchmarks as to how well we are doing? We do monitor turnover and we set goals. Our goal is to have turnover be less than seven percent and we have achieved that. Straight turnover is between five and six percent. We are pleased with this figure.

We perform new hire surveys and exit surveys. In addition, we have an employee staff survey that the organization distributes every two years and we have seen an increase in the satisfaction of the employees over the past two years. We also have seen a marked decline in grievances and a marked decline in staff concern forms. These are forms the nurses fill out if they think they are understaffed or that there is some sort of problem. Last year, we had a total of about 100 incidents. This year, year to date through January we have had seven. We always see an increase in these concern forms when we get ready for a union contract negotiation, but we were in contract negotiations last year

and only received 100 for the entire year. It was incredible given the number of shifts and the number of people involved, but only having seven so far since the first of October is a real demonstration of the things that we have put into place that are having a major impact.

Discussant's Comments, Lotte Bailyn

The three points I find so interesting are: the structure of the schedule, the life course fit, and the issue of choice and control. I am looking at this from the nurse's perspective, but keeping in mind that both patient care and nurses' personal lives have to come together. I was struck by how many nurses work part-time. I saw this as good and a number of the nurses that I have spoken to have said that they decided on nursing as a profession because they saw it as a flexible workplace and that they enjoyed nursing. I understand that part time schedules can create some difficulties, but they are extremely important, as is the possibility of doing per diem work. With nursing there is the basic issue of the work being 24/7, which is very different from the legal profession (see working paper #0012, forthcoming, Lauren Rikleen).

From the perspective of the nurse, a longer shift makes the week more flexible. But what is the effect on patient care? The stamina and multitasking of the nurses are remarkable. Is there an issue with long shifts with respect to patient care? The timing of shifts is another structural aspect and, as mentioned, the rotation of shifts can be difficult. Again, I wonder about patient care and home. What fits with continuity of care is consecutive days, which is very significant for patient care.

In terms of the life course fit, I was struck by the fact that the people who choose nights are usually the ones with small children. They say it is easier to have the children taken care of either by a partner but occasionally by mothers or others. It is an easier commute, easier parking, and easier workload. Less goes on at night than during the day. I wonder what this does to the partners, to the family. I think it is good for the children. I do not know how good it is for the marriages or the partnerships.

Regarding the choice and control nurses have over their schedules, I see a possible paradox and anomaly in the system that has so much flexibility with all these different possibilities with 8 hours, 12 hours, and putting it together in different ways.

One of the nurses I talked to had been in a previous job where it was all 8-hour shifts, but she said the difference between that and the Brigham and Women's situation is that when you have all 8-hour shifts, it was possible for the nurses to choose themselves. You think it would reduce the flexibility by having exclusively eight-hour shifts, but maybe the increase in options may inadvertently decrease the ability to choose.

I have noticed a lot of informal changing and wondered whether one could build choice into the scheduling system, without influencing patient care. The only way I think this would be possible would be instead of having an external person making the schedule, whether one could make each pod responsible for its own schedule and whether the nurses could collectively develop the schedule. We have seen this work fairly well in business organizations.

Presenters' Response, Nancy Kruger and Nancy Hickey

We do have some self scheduling and have done so for years. Guidelines set the amount of coverage based on the number of patients and their acuity and then the nurses choose when they want to work. Seniority factors into the scheduling because someone with more seniority gets his or her choice of days.

There is a regular routine for submitting scheduling requests and in some units they even post a blank schedule and people write in what days they are going to work. So the senior person submits when they are going to work and then the next person and when there is a conflict there is a negotiation between the two people or the manager might make some choices on the basis of the person's particular expertise for what might be needed. There is a fair amount of this kind of scheduling and then once the schedule is posted the nurses will swap. The schedules are for four weeks. Some units like the self scheduling, some units do not.