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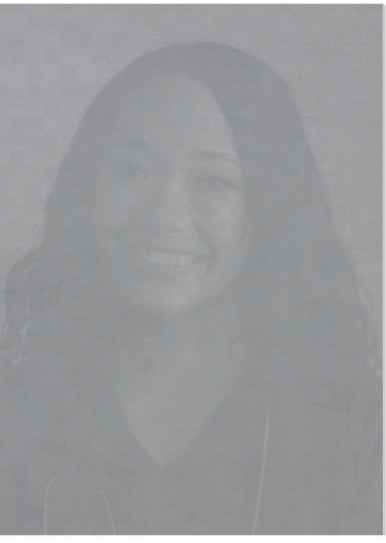
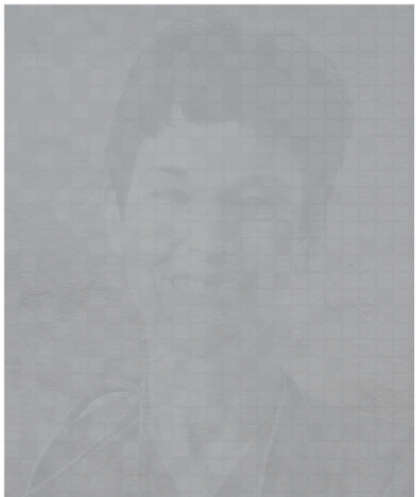


The Staffing Crisis



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From our President

Well, another summer has flown by and I'm wondering just what the heck I did. I planted a garden with carrots, beets, radishes, green beans, broccoli, cauliflower, and lettuce. A greenhouse with tomatoes and hot peppers. Flower pots for the AaNA office deck and for my house. Then I watered. Man, what was I thinking? Then it rained… and rained… and rained. Got my radishes out and harvested lettuce before it could bolt or fall victim to a slug infestation. Phew! Let me know how your summer planting went, as well as your hiking experiences.

This issue of The Alaska Nurse is focused on the staffing crisis in healthcare today. When I first started out as a new nurse, I had 10 patients on the med-surg floor with a CNA. I passed all the meds and then we would split up the patient load so we each had five. I charted on paper SOAP style. Then, the American Nurses Association determined that primary nursing was in the best interest of the patient: fewer medication errors, falls, and bedsores. After that, I had six to seven patients to care for all by myself; the CNA was phased out of acute care. This worked for a while, but patient acuity gradually increased and the patient load didn't decrease. Not enough people were going into nursing as a profession. Nurses were getting older and injuries were increasing. A growing concern: there were not enough nurses at the bedside. The CNA began to be phased back into acute care settings to assist. Now, since I had a helper, my patient load was increased to eight patients, of which I did most of the work as the primary RN. Meanwhile, my CNA had anywhere from 16 to 20 patients.

The way hospitals were staffing was not the intent of emphasizing the primary nurse role at the bedside. Then and today, hospitals were systemically understaffed, leading to dire consequences for both nurses and patients. The fight for safe staffing has been decades-long, with frustratingly small progress. Some unions have been successful in getting staffing ratios in their contracts; most have not. California instituted nurse-to-patient ratios in the 1990s, and has remained the sole state to do so until this year. Recently, a few states have been successful passing safe staffing ratios and related legislation, but not yet enough to turn the tide nationally. Hospitals have been notorious for not heeding the cry for acceptable nurse-to-patient staffing ratios that are safe for the patient and for the nurse. It's time to start talking to your hospital administration about instituting safe staffing policies, talking to your legislator about safe staffing ratios as a law, and when there is a shout-out to write a letter to your senator please do so. It makes a difference!

Stay safe and take care!

Jane Erickson

Jane Erickson, ADN, RN
President, Alaska Nurses Association

In This Issue

AUTHOR GUIDELINES FOR THE ALASKA NURSE: The Editorial Committee welcomes original articles for publication. Preference is given to nursing and health-related topics in Alaska. Authors are not required to be members of the AaNA. There is no limit on article length. Include names and applicable credentials of all authors. Articles should be Microsoft Word documents. Photos are encouraged and should be high resolution. Please include captions and photo credits at time of submission. All content submitted to The Alaska Nurse becomes property of the Alaska Nurses Association. Submit all content by email to Andrea@aknurse.org.

CODE RED
Understaffing = Patient Care Crisis

AFT Staffing Crisis Taskforce Produces Comprehensive Report

INTRODUCTION AND EXECUTIVE SUMMARY

We are in the midst of a dire, worsening healthcare staffing crisis

Any conversation over the last 24 months with a frontline healthcare worker quickly reveals the deep frustration and anger with their employers and sheer mental, physical and emotional exhaustion.

The stories from members of the American Federation of Teachers (AFT) are heartbreaking: A nurse in Connecticut assigned to 11 patients, a healthcare worker in Oregon who spends 20 minutes before each shift in tears trying to muster the emotional strength to go to work, the nurse in Montana who sees a colleague walking away from bedside care, the healthcare worker in New Jersey grieving the death of a colleague who contracted COVID-19 at the hospital. These are dark days for the healthcare workforce.

The COVID-19 pandemic revealed a healthcare system woefully unprepared for the crisis, allowing the world to see a chronic understaffing of our nation's healthcare facilities that existed well before the pandemic. To be clear, this staffing crisis is not new, and it's a crisis of the healthcare employers' making. Their decisions to put revenue ahead of patients and frontline caregivers left the workforce without appropriate personal protective equipment, exposed their employees to increasing levels of workplace violence, stretched patient loads to unprecedented and unsafe levels, and left a workforce exhausted and, for far too many, in mental health distress. As a result of these exploitative working conditions, it comes as no surprise that frontline caregivers are leaving their jobs in record numbers.

There are profound long-term staffing consequences for our country's healthcare facilities. Frontline caregivers are experiencing unprecedented burnout and exhaustion from the trauma of working in perilous conditions. Now they are quitting in record numbers. America's hospitals have failed to fulfill their most basic responsibility: providing a safe place for patients to receive medical care.

A new report from AFT's national staffing shortage taskforce examines our current crisis

As one of our nation's largest unions representing healthcare workers, the AFT and its affiliates have been forced to reckon with dangerously inadequate staffing in our nation's hospitals and healthcare facilities, as well as colleagues who are planning to leave their jobs. Decades of understaffing has reached a crisis point, and it is a crisis of the healthcare industry's own making.

In response to the crisis of staff willing to endure the working conditions of our nation's healthcare facilities, delegates to the American Federation of Teachers' biennial national convention in July 2022 passed a pointed resolution, "Addressing Staffing Shortages in the Healthcare Workforce." This resolution called for the convening of a national taskforce composed of local union leaders and frontline members, which produced a comprehensive report examining six major components of the staffing crisis:

- Barriers to successfully recruit and retain the necessary healthcare workforce
- Unsafe working conditions
- Unsustainable staffing practices and workload
- Inadequate compensation for frontline workers
- Corporate trends to maximize revenue and decrease cost
- Insufficient worker voice and trust

The report is one part of the AFT's ongoing efforts to improve our nation's healthcare system and the working conditions its members endure. It was informed by months of work by AFT's Healthcare Program and Policy Council, roundtable discussions between clinicians and policy experts, surveys of healthcare members, and anecdotal discussions and workgroups composed of healthcare union leaders.

AaNA member Shannon Davenport, who also serves as co-chair of the AaNA Legislative Committee, participated on the staffing shortage taskforce. The full 36-page report, along with references, is available at www.aft.org/healthcare/healthcare-staffing-shortage-task-force-report. This article provides an introduction and executive summary of the report.

Our nation's healthcare facilities were dangerously understaffed prior to the pandemic; today's staffing crisis is really a shortage of staff willing to endure the current working conditions, and it's a crisis of the healthcare industry's own making

The report finds that the staffing crisis in our nation's healthcare facilities is not some mysterious, intractable problem we lack the tools to fix. Rather, given all that the nation's healthcare workforce has endured during the pandemic and before, it was a completely predictable crisis. And with a commitment from healthcare employers to put patients and their workforce above maximizing revenue, it is correctable. The report includes a menu of strategies that can be used to improve our nation's healthcare facilities and offers concrete examples of where they have been successfully used. It is intended to help frame the national discussion about the staffing crisis and to provide a road map to fixing the chronic problem.

As the report concludes: Healthcare workers saw the staffing crisis coming

Healthcare workers, unions and advocates have been warning of a staffing shortage for years, long before COVID-19 entered the picture. We must address how we got here if we are going to recruit the next generation of healthcare workers. Fighting for better working conditions now isn't just about current healthcare workers; it's about the future of healthcare.

Several factors are driving the staffing crisis, including:

The corporatization of healthcare and profit motives led to a systematic underinvestment in healthcare workers' safety and well-being, creating unsustainable work environments.

- Healthcare workers are facing increased mandatory overtime and on-call hours, creating unstable and unsustainable work schedules.
- Healthcare workers are five times more likely to experience workplace violence than other workers.[1]
- 1 in 4 healthcare workers showed signs of post-traumatic stress disorder in May 2020.[2]

Nursing education programs are understaffed, underfunded and costly.

- In 2019, nursing programs turned away more than 80,000 qualified applicants because the programs lacked the necessary faculty, facilities or funding.[3]
- Even if a student secures a spot in a Bachelor of Science in nursing program, they can expect an average of $23,711 in student loan debt.[4]
- There is a nurse faculty shortage driven in part by low pay for these roles compared with other roles in clinical settings available to nurses with advanced degrees. With an average monthly loan payment of $544, many qualified nurses cannot afford to take a pay cut.[5]

The COVID-19 pandemic accelerated the staffing crisis.

- Since the beginning of the COVID-19 pandemic, nearly 1 in 5 (18 percent) of healthcare workers have quit their jobs. And for healthcare workers who have stayed in their jobs, nearly 1 in 3 (31 percent) have considered leaving.[6]
- Between 2020 and 2021, the total number of registered nurses in the workforce declined for the first time in more than five years. This included a loss of 100,000 RNs under the age of 44, highlighting the loss of early and midcareer professionals.[7]

This is a patient safety crisis

When healthcare workers are assigned more patients than they can safely care for, patient safety suffers. Adding just one additional patient to a nurse's workload results in a 7 percent increased risk of a patient dying within 30 days of hospital admission,[8] a 48 percent increased risk of a child being readmitted to the hospital within 30 days,[9] and increased risk of infection.[10]

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Proven strategies—at the national, state, sector, and facility levels—can address this crisis, including:

• Improving recruitment (and diversity in the workforce), with strategies like high school career and technical programs, apprenticeships and nursing bridge programs.

• Expanding targeted financial aid and loan repayment programs, including the National Health Service Corps and the Nurse Faculty Loan Program.

• Enacting federal and state laws mandating safe staffing ratios for the whole care team, putting safe staffing requirements into governmental regulations, and negotiating safe staffing levels in collective bargaining agreements.

• Banning mandatory overtime through a wide-ranging approach: federal and state legislation, regulation and collective bargaining agreements.

• Pushing Congress to pass the federal Workplace Violence Prevention for Health Care and Social Service Workers Act and working with state legislatures on greater safety protections.

• Pushing for pandemic protections in federal law, such as an Occupational Safety and Health Administration standard and the Centers for Medicare & Medicaid Services emergency preparedness rule.

• Advocating for funding and programs to support health professionals' mental health.

• Working at the federal and state levels to increase oversight of mergers and acquisitions in the healthcare industry, including the impact on patient care.

• Making shared governance part of collective bargaining agreements—like the partnership between Kaiser Permanente and the Oregon Federation of Nurses and Health Professionals and other unions.

• And last but far from least, championing the right of healthcare workers to form unions, and fighting employer union-busting tactics.

The staffing crisis in our nation's healthcare facilities is not some mysterious, intractable problem that we lack the tools to fix. Rather, given all that the nation's healthcare workforce endured through the pandemic and before, it is a completely understandable; and with a commitment from healthcare employers to put patients and their workforce above maximizing revenue, it is correctable.

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A UNIQUE OPPORTUNITY FOR NURSES

BECOME A THERAPEUTIC TREATMENT FOSTER PARENT

By Les Gara and Katy Smith
AK Child and Family

Alaska has a crisis-level shortage of foster parents today. Nurses know that we sometimes see foster youth linger in hospitals when there is no foster home available for them. It's heartbreaking!

At any given time across Alaska, nearly 3,000 youth in the foster care system need a place to call home. The support of a healthy, consistent, welcoming home can make a tremendous change in the life of child. Foster youth are often impacted by early childhood trauma that can result in a number of short- and long-term impacts on their ability to be and feel successful throughout their lives.

AK Child & Family (formerly Alaska Children's Services) provides strong support and training for those who can answer the call to become foster parents for youth who need extra therapeutic support. Opening your home to these youth enables them to stay out of undesirable hospital and institutional care. We'd love you to join our team of supportive therapeutic foster parents, especially given the commitment nurses have to healing our community.

"I felt that I had something to give to a child, to make a real difference for a child, and doing this work I get to see the difference I can make every day." When we ask our therapeutic treatment foster parents why they chose to do this work, and why they continue to choose to provide this service, their replies echo this sentiment. Your help, if you're able, can make a big difference for our youth.

Our Therapeutic Treatment Home Services (TTHS) model supports foster families that have a desire to develop the skills needed to work with a treatment team to provide therapeutic support to youth. At AK Child & Family, we make sure parents receive the support they need so that both foster parent and foster youth can be successful.

Foster parents identified as therapeutic treatment parents are carefully trained and matched to a youth's needs. The therapeutic treatment parent works closely with the youth and their family through a coordinated multi-disciplinary treatment team approach to implement the youth's treatment plan, always with the support a family needs. Our foster parents are empowered to act as a key agent in implementing the youth's treatment plan, and to assist in the successful transition from TTHS to reunification with the youth's family when possible.

Therapeutic treatment parents are compensated with a daily stipend that is, on average, three to four times higher than a conventional foster parent stipend ($100/day). And they are supported by a team of providers who are available 24 hours a day, every day of the year, to respond to the needs of the youth as well as the needs of the foster parent as they work to best care for the youth. This includes what is conventionally described as respite services to provide much needed breaks for therapeutic parents in the work that they do with youth in need.

If you or someone you know is interested in becoming a therapeutic treatment parent or would like to know more, please visit www.akchild.org; email us at becomeafosterparent@akchild.org; or call 907-792-4111 to speak with a Licensing Specialist. We'd love to hear from you and help you make a difference in a child's life!

PTSD

A Hidden Consequence of COVID-19

By Stacey Sever, BSN, RN, CCDS
AANA Health and Safety Committee Chair

It has been over three years since life in the United States changed due to the COVID-19 pandemic. Businesses shut down or changed to remote work and schools did the same. Humans were defenseless to a new virus and the onslaught of the disease process. Per the COVID Data Tracker on the Centers for Disease Control and Prevention (CDC) website, as of May 20, 2023, there have been over 6.5 million hospitalizations and over 1.1 million deaths due to COVID-19.[1]

Of those 6.5 million people that were hospitalized, severe COVID illness was life-threatening, and its clinical management can be highly invasive and frightening. Early on, intubation was a treatment modality that was used for the acute hypoxic respiratory failure experienced by patients. Many of these patients were also subjected to other intensive care treatments such as invasive lines and drains, prone positioning, or for some, ECMO or tracheostomy. Patients were separated from loved ones and healthcare workers were suited up in protective gear in such a way that only their eyes could be seen by the patients.

The psychological stressors that accompanied a COVID infection included social isolation, the concern of severe COVID and its possibility of death, concerns about spreading the infection to family members, and the stigma that developed with the virus was compounded with the psychopathological sequelae through direct viral infection of the central nervous system (CNS) or indirectly via an immune response. It has been reported that breathing difficulties commonly experienced by patients with COVID are particularly horrific and have been described as the prolonged sensation of drowning.

Several lines of evidence indicate that severe COVID illness is a risk factor for Post-Traumatic Stress Disorder (PTSD). Research with survivors of past coronavirus disease outbreaks, including Severe Acute Respiratory Syndrome (SARS) and Middle East Respiratory Syndrome (MERS), found that PTSD rates were high following hospital discharge, and remained elevated for months or even years.[2]

PTSD is a potentially debilitating disorder that can develop after exposure to exceptionally threatening events. PTSD is associated with high rates of comorbidity of mental and physical illness.[3] Per the World Health Organization (WHO), surviving severe COVID fulfills internationally recognized definitions of exposure to psychological trauma and is thus a risk factor for PTSD.[4]

PTSD is too often undetected and untreated, resulting in suffering and premature death for patients. It interferes with survivors being able to live a normal life and can precipitate mental health disorders such as depression and substance use disorders.

Recent studies conducted in Korea and Italy found a high incidence of PTSD in patients that were treated for COVID-19 and survived to discharge. In Korea, the prevalence rate of PTSD was 20.3% in patients with COVID-19 who had been hospitalized, treated, and discharged.[5] In Italy, researchers found a PTSD prevalence of 30.2% after acute COVID-19 infection.[6]

Both studies had associated characteristics that include female sex, which has been extensively described as a risk factor for PTSD, history of psychiatric disorders, and delirium or agitation during acute

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SOLVING THE STAFFING CRISIS

State Legislative Approaches

Based on the work of Melanie Myers, AFT Research and Strategic Initiatives, and Haley Quinn, AFT Health Issues
Compiled by Andrea Nutty, AaNA Programs Director

In 2022, the American Federation of Teachers (AFT) began its multi-year Code Red campaign, developed in order to call national attention to the crisis in staffing for nurses and health professionals.

A major goal of the campaign is to make real, lasting changes to working conditions in the healthcare sector through state legislation. AFT's recent actions on the staffing crisis include the release of the Healthcare Staffing Shortage Taskforce Report, following a resolution on healthcare staffing shortages passed at AFT's 2022 convention. (Check out our summary of the report on page 4).

That report and the surrounding dialogue led to many of AFT affiliates introducing strong staffing legislation this year, building upon decades of work in states and at the federal level to address healthcare staffing. Here is a summary of this important work.

Spate of States Introduce Staffing Legislation

Oregon

Oregon will be the first in the nation to set staffing ratios for multiple departments directly in statute, thanks to the advocacy of two AFT affiliates: the Oregon Federation of Nurses and Health Professionals (OFNHP) and the Oregon Nurses Association (ONA).

Passed in June, the new staffing bill is vital to fixing the state's collapsing healthcare system, according to ONA. The legislation creates safe staffing ratios for nurses and CNAs in hospital settings – with specific numerical ratio requirements that vary by unit. It also expands Oregon's pre-existing nurse staffing committee structure to many other healthcare workers.

ONA and OFNHP mobilized hundreds of members to support this bill's passage, and their determination and solidarity ultimately paid off: Oregon's bill marks the first time in two decades that comprehensive nurse staffing ratios legislation has become law.

Washington

Washington's new staffing law was passed earlier this year thanks to the advocacy of AFT affiliate Washington State Nurses Association (WSNA), SEIU Healthcare 1199NW, and UFCW 3000. The law will allow regulators to impose set staffing ratios as well as financial penalties on hospitals that are routinely out of compliance with the plan of their staffing committee. Staffing committees, which are required by Washington law, will also be expanded to include non-RN direct patient care staff.

The new law additionally expands meal and rest break laws to include all frontline staff, closes loopholes to make mandatory overtime laws fully enforceable, and ensures hospitals follow the law. It also provides funding for the Washington State Institute for Public Policy to conduct a study of existing staffing plans, which WSNA calls critical for their continued work to ensure safe staffing in Washington.

New Jersey

In New Jersey, AFT affiliate Health Professionals and Allied Employees (HPAE) has pushed for staffing ratios in each legislative session for the past decade, including this year. In preparation, HPAE released survey research demonstrating that poor staffing conditions are linked inextricably with New Jersey's staffing crisis.

"Our healthcare system is in crisis… Patients are suffering. We must stop the bleeding. The answer must start with an enforceable safe staffing law in New Jersey," says HPAE President Debbie White.

A rally in May brought hundreds of nurses and other healthcare workers out in support of the bill. HPAE members continue to mobilize and push for passage of the staffing bill as the legislative session proceeds.

Connecticut

AFT Connecticut got legislation introduced this year to create staffing ratios for nurses and clarify the state's mandatory overtime provisions. AFT CT packed the bill's first hearing on March 22 with members providing powerful testimony explaining why ratios are the best way to address workforce shortages through improving retention and morale, as well as patient care.

While the original bill didn't pass, safe staffing provisions were included in a biennial state budget. The new statutory language creates hospital staffing committees that will set staff-to-patient ratios for their facility. Facilities out of compliance with the plan of their staffing committee greater than 20 percent of the time will face fines. Additionally, the legislation strengthens Connecticut's prohibition on mandatory overtime while still allowing voluntary overtime for healthcare professionals.

Montana

The Montana Nurses Association (MNA) introduced safe staffing ratios legislation for the first time this session. The bill was tabled, but introducing it allowed MNA to raise awareness about the staffing crisis and engage their nurses in fighting for a real solution, with several testifying in support of the bill. Their bill also would have restricted mandatory overtime.

New Mexico

In New Mexico, Representative Eleanor Chavez introduced staffing ratios legislation this year. The legislation, which did not pass, would have directed the state's Department of Health to develop nurse staffing ratios, following closely California's legislation from the 1990s that paved the way for their nurse-to-patient ratios. The bill also would have created an advisory board, comprised of worker and employer representatives, tasked with developing staffing standards.

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illness. In the PTSD group, they also found more persistent medical symptoms, often reported by patients after recovery from severe COVID-19. PTSD symptoms were highest among those who had been ventilated; 35% of those who had been ventilated endorsed all ten of the PTSD symptoms measured in the studies.[7]

Historically, pandemics have had worldwide long-lasting impacts on societies regarding morbidity and mortality as well as economic impacts. The COVID-19 pandemic was not much different. The general population and healthcare workers all suffered to a certain extent from psychological trauma from the pandemic's consequences.

Studies have shown that healthcare workers should anticipate a high possibility of PTSD among severe COVID-19 patients and should provide appropriate treatment to individuals who have relevant symptoms; thus, PTSD detection through active inquiry and appropriate subsequent treatment is warranted.

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Legislative Solutions for Safer Staffing

There are several legislative approaches to addressing the chronic and worsening staffing crisis that nurses and health professionals confront virtually every day when they report to work. As our healthcare system buckles under the weight of the staffing crisis, the necessity of enacting laws that address safe staffing becomes more and more clear. Here, we provide an overview of three legislative solutions to safer staffing.

Approach #1: Staffing Ratios

What is this approach?

Staffing ratios, sometimes known as safe patient limits, set a limit for the number of patients assigned to one healthcare worker at a time. These vary by department in a hospital given the varying levels of care that is needed. For example, a nurse staffing ratio of 4:1 for an emergency department would require that each nurse in the emergency department be assigned no more than four patients at a time.

Where and how is this approach used?

Outside of collective bargaining, specific staffing ratios are set through one or more of the following mechanisms:

Statute and Legislation

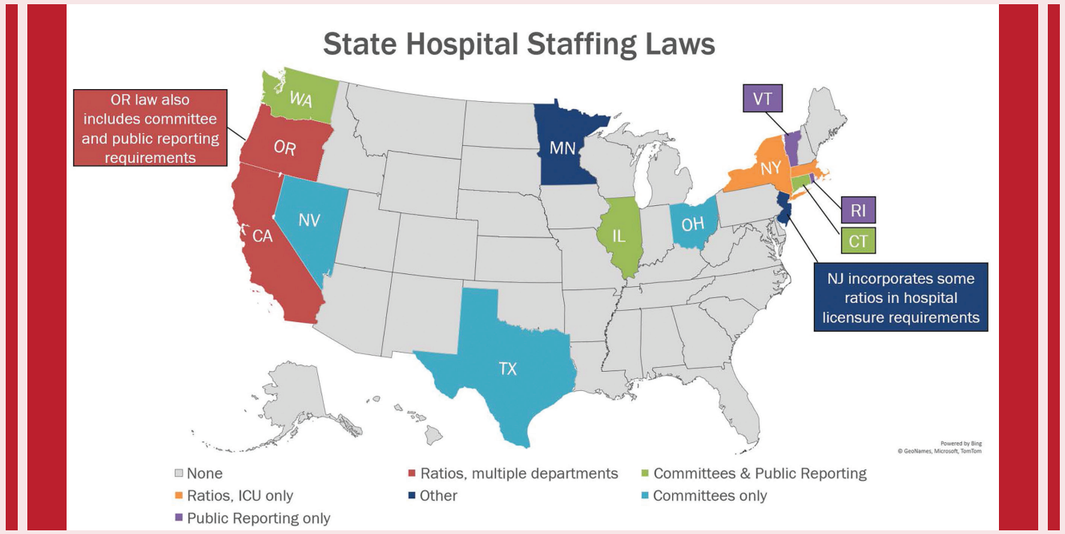
- Oregon will be the first in the nation to set staffing ratios for multiple departments directly in statute effective June 2024, thanks to the advocacy of the Oregon Federation of Nurses and Health Professionals and the Oregon Nurses Association.
- Massachusetts set a mandated nurse-to-patient ratio for intensive care units in a 2014 law. The law requires a nurse-to-patient ratio of 1:1 or 1:2 depending on an acuity assessment using a tool developed in consultation with staff nurses.

Rulemaking and Regulation

- California law charges the state Department of Health with setting specific ratios for multiple departments in acute care, psychiatric acute care and specialty hospitals in the state. California was the first state in the nation to have legally enforceable nurse-to-patient ratios, with initial implementation of this law in 2004.
- New York regulators set a 1:2 nurse-to-patient ratio for intensive care units in 2023 under an improved staffing law, mirroring the Massachusetts standard set by statute.
- New Jersey mandates ratios for several departments, including the ICU, through regulation of its hospital licensure process. However, ratios in New Jersey regulations are weaker than those in Oregon and California, and employers have been able to exploit loopholes in the regulations to diminish their effectiveness.

Mandated Staffing Committee Plans

- Connecticut's new staffing law requires staffing committees with a majority membership of clinical care providers. The committees will propose and vote on the facility's staff-to-patient ratios for each department. Hospitals will face financial penalties if they are found to follow this plan less than 80 percent of the time.
- Washington's new staffing law will allow regulators to impose set staffing ratios as well as financial penalties on hospitals that are routinely out of compliance with the plan of its staffing committee. Staffing committees will also be expanded to include non-RN direct patient care staff.



What are the pros and cons of this approach?

Pros

- Ratios give hospital administrators and workers an unambiguous measurable standard.
- When ratios have the force of law, they can be enforced by a state government.
- Research shows that staffing plans in line with the mandated ratios under California state law produce better patient outcomes.
- Research shows that healthcare workers with patient loads in line with California state law have lower rates of burnout.

Cons

- Ratios alone may not account for the individual needs of certain facilities or departments if input from frontline hospital-level workers is not included.
- Without strong bargaining power for healthcare workers, employers can treat minimum staffing levels as a ceiling rather than a floor for safe staffing.

Approach #2: Staffing Committees

What is this approach?

Staffing committees can take many forms, from being primarily controlled by hospital administration to having robust involvement of a union representing healthcare workers. Staffing committees are intended to be collaborative structures that allow hospital administrators and staff to create staffing plans to provide the best quality of care possible.

Where and how is this approach used?

Staffing committees in various forms exist across the country, many of which are created by collective bargaining agreements. The following states mandate staffing committees: Connecticut, Illinois, Nevada, New York, Ohio, Texas and Washington.

These staffing committees vary widely by state, especially when it comes to enforcement of a staffing plan developed by the committee. In recent years, states have made significant and meaningful improvements to staffing committee laws, creating a stronger voice for direct care staff and stronger enforcement.

With laws passed in the 2023 state legislative session, Connecticut and Washington hospitals will now face legal penalties for not adhering to the staffing plan established by its committee. Under new laws, Washington will also expand staffing committees to include other non-RN direct care staff, and Oregon will create non-RN staffing committees.

What are the pros and cons of this approach?

Pros

- Committees can foster collaboration between care teams and hospital administration.
- Committees can utilize the expertise of healthcare workers directly impacted by staffing plans.
- With strong enforcement, a committee structure can allow for flexibility to meet the unique staffing needs of each hospital and department.
- Information can be gathered and documented, which can strengthen future advocacy for specific state-mandated safe staffing ratios.

Cons

- Some committee structures do not have meaningful worker input. In these cases, workers are consulted as a courtesy or merely to meet requirements for the American Nurses Credentialing Center Magnet status, rather than being valued as collaborators.

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- Some committee structures allow hospital administrators rather than workers or their union to decide which workers participate in a committee.
- Without enforcement, committee members often put in significant work without a clear outcome.

Approach #3: Public Reporting

What is this approach?

Public reporting requirements for hospital staffing levels vary widely across the country and range from posting a daily staffing plan within view of patients at a hospital to public disclosure to a state agency.

Where and how is this approach used?

Connecticut, Illinois, New York, Oregon, Rhode Island, Vermont and Washington all require some form of public reporting for hospital staffing levels by law. In Massachusetts and Minnesota, data is voluntarily reported by the state hospital association but is not required by law.

What are the pros and cons of this approach?

Pros

- Transparency promotes accountability of hospitals and health systems.
- In some cases, public reporting may allow patients to make more informed decisions about their care.
- In some cases, public reporting allows policymakers and advocates to identify areas of chronic understaffing.

Cons

- There is little evidence that public reporting alone directly improves staffing levels. While robust public reporting is a useful tool in developing solutions, it is not a solution by itself.
- Patients rarely have the expertise or resources necessary to make informed decisions about care based on these public disclosures alone.
- Reporting methods and standards vary widely from state to state, making it difficult to draw comparisons.

Safe Staffing in Alaska

The Alaska Nurses Association is committed to passing safe staffing legislation in Alaska. Though achieving this won't be easy, we know it is possible. But it's going to take all of us, standing together, demanding change, and doing what it takes to win. On our first step in this journey, we need your help. We've developed a statewide survey to better understand the current staffing landscape, as well as the experiences and needs of nurses across Alaska. We need as many nurses as possible, from every area of the state, to take our staffing survey. A link to the online survey is below. Please take a moment to fill it out, and share it far and wide with all the Alaskan nurses you know.

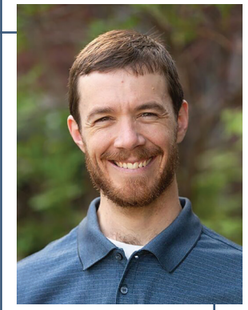
Take AaNA's statewide staffing survey

Visit www.surveymonkey.com/r/SafeStaffingAK

Want to get involved with AaNA's campaign for safe staffing?

Reach out to our legislative committee co-chairs Shannon Davenport (shannon@aknurse.org) and Sara Massmann (sara@aknurse.org).

HOW THE NURSE LICENSURE COMPACT UNDERMINES THE NURSING PROFESSION



By Representative Zack Fields

I have spent an immense amount of energy and political capital to prevent Nurse Licensure Compact (NLC) legislation from undermining nursing safety standards and the bargaining power of Alaska nurses. I think it's important for everyone in the profession to understand the short-term and long-term impacts of NLC legislation. By undermining nurse bargaining power, the NLC would reduce nurse wages and benefits and lead to less safe working conditions. Nurses are on the front lines not just in a clinical environment, but also at the bargaining table, and only by protecting nurse bargaining power can we protect safety standards that patients depend on. It is in the broad public interest for nursing to continue to be a strong middle class job, because nurses with bargaining power use that leverage to hold up safety standards for all patients.

First, let's step back and look at the NLC in the context of broader economic policy. Proponents of the NLC—namely, employers and right-wing special interests funded by extremist billionaires—are pushing the NLC because it will weaken nurse bargaining power. The NLC is consistent with so-called neoliberal economic policy which, over the last 40 years, has resulted in job losses, declines in real wages, off-shoring of good jobs, and annihilation of good wage and benefit packages in a wide range of occupations. The most elemental part of neoliberal economic policy is labor "flexibility," by which far-right ideologues mean the ability of corporations to strip workers of their ability to bargain for wages, scheduling predictability, and safety standards.

Remember that the U.S. used to have many better, middle class jobs, from trucking to manufacturing. Some of those jobs (manufacturing) could be off-shored, while others (trucking) could not. In every case, gutting employee bargaining power to give mega-corporations all the economic power has proven catastrophic for working people. Fundamentally, nursing is subject to the same economics as other professions, and we must protect nursing as a good middle class job in which nurses' bargaining power is essential to hold up wages, benefits, and safety standards.

Given the wages and benefits nurses enjoy today, it may seem abstract to consider that nursing could be less than a good, middle class profession. Yet labor market "flexibility"—specifically, weakening union bargaining power—is precisely what turned trucking into a nightmare job with low wages, terrible safety standards, and long hours. The prevalence of hiring apps makes it easier for large employers to drive down wages and benefits, so integration of digital technology into hiring makes it even more important that we protect nurse and union bargaining power to defend the public interest.

During debate on the NLC in the legislature, I've expressed grave concern about Providence Health and Service's shameless profit-seeking, even targeting poor patients for double-billing. Sure enough, this summer Oregon nurses had to go on strike over compensation and safety at those Providence facilities. Fortunately, Oregon is not in the NLC so Providence couldn't use the NLC to break a strike in Oregon. Given Providence's relentless focus on profits at the expense of its employees and its patients, I have no doubt the AaNA will continue to have tough bargaining discussions in the future, and we need to protect your bargaining power on behalf of all Alaskans who receive care at Providence's facilities.

While protecting your bargaining power as nurses, we do need to expedite nurse licensing in Alaska. When I served as House Labor and Commerce Chair, we held hearings to demand the administration speed up nurse licensure. Fortunately, the former incompetent division director was reassigned, so hopefully the new director can do a better job. In this year's budget cycle, we added nine new positions to speed up licensing. We can have efficient licensing and safe nursing protocols: It's a false choice to say we have to choose between those.

Thank you for what you do every day on the front lines in our healthcare system, and for your work with AaNA to bargain for fair compensation and safety standards. When you bargain for your fellow nurses, you're bargaining for the public good, and we need to protect your bargaining power so Alaskans can enjoy the best possible healthcare system.

Zack Fields (D-Anchorage) represents South Addition, Forest Park, Fairview, Eastridge, North Star, and Downtown Anchorage neighborhoods in the Alaska House of Representatives, and is in his third term in the Alaska Legislature.

OVER 1,000 GRIEVANCES LEAD TO A SHORT-STAFFING ARBITRATION VICTORY

This article originally appeared in Healthwire: AFT Voices in Healthcare, a section of AFT Voices. View the original article and other great healthcare stories at AFTvoices.org.

By Adrienne Coles, AFT Communications Specialist

In The Wizard of Oz, Glinda the Good Witch tells Dorothy, "You've always had the power, my dear; you just had to learn it for yourself." Just like Dorothy, Federation of Nurses/UFT members at NYU Langone Hospital–Brooklyn learned that they, too, had an untapped power when they began to use one of the tools in their contract to challenge unsafe staffing: the grievance.

The Federation of Nurses/UFT reached a groundbreaking arbitration agreement with NYU Langone in late 2022 that required the hospital for the first time to pay nurses for working without sufficient staff. The members used their contract's grievance and arbitration process to challenge the short-staffing issues in many units at the hospital, and the arbitrator found short staffing to be in violation of the contract.

Under the settlement, the hospital paid a total of $137,500 to approximately 250 nurses who worked on the short-staffed shifts covered by grievances filed in 2020 and 2021. In October 2022, the nurses were awarded anywhere from $100 to more than $2,000, depending on how many short-staffed shifts they worked.

Rosemary Scheriff played a huge role in the victory. Scheriff, a registered nurse and union representative at NYU Langone was named 2022 Hospital Nurse of the Year at the federation's annual Professional Issues Conference for filing nearly 1,000 grievances over inadequate staffing. Scheriff also encouraged nurses dealing with short staffing in their departments to fill out grievance forms.

"Nurses are tired of working in these conditions," she says. "We were exhausted."

Scheriff says without nurses working together to go through the grievance process and put it down on paper to back up what is happening, managers could get away with understaffing the hospital.

The process of filing their grievances was time-consuming, says Scheriff. Sometimes her colleagues gripe about having to fill out the grievance forms and complain that it won't work. But the strategy, although tedious, was effective; and most of all, it was successful.

> "*It was a lot of work, but it was worth it,*" she says.

Not only was the arbitrator bombarded by a constant influx of grievances, but the process also forced the hospital to acknowledge — on paper — they don't have enough staff, says Scheriff. "The grievance means that the problem is documented, and now when departments work short on staff and the staff takes action, it makes a difference. We hit them in their pockets."

With their victory, UFT Vice President Anne Goldman, the head of the Federation of Nurses/UFT, told New York Teacher that "many of our colleagues in other hospitals — even those in other unions — do not have the right to grieve short staffing, let alone receive compensation for it. This is an important moment for our union and our profession."

Scheriff agrees. "We have a strong union. Without a union, we would be nowhere. I could not have lasted in nursing without it," she adds. "We have to educate the younger generation of nurses. The union gives them voice and power they need to protect their license and the patient," she says. "It's about leaving them the tools they need to invoke the contract.

"I think what we did was phenomenal, but it's not about the money," says Scheriff. This victory taught members a more significant lesson. "When you work together to make a situation like staffing better for all of us, it will affect all of us," says the veteran nurse. "That's why unions work.

"The money is wonderful, but I want it to create change in the long run. If we can change the system, then maybe we can pass a law to address staffing just like California. I hope this will show nurses how important action is to create change. It's about resilience, persistence and never giving up when you know you're right."

CODE RED

NURSING SHORTAGE OR NURSING STAFFING CRISIS?

By Julie Cottrell, RN

The ongoing discourse around nursing presents a pressing issue: Are we truly facing a nursing shortage, or is it more accurate to say there's a crisis of nurses unwilling to work at the bedside due to current conditions? A careful examination suggests that we are experiencing a staffing crisis that's largely of the hospitals' own making.

While there are some alarming proclamations being made about current and future nursing shortages, a more nuanced look at the data (and at the alarming reality of life as a nurse today) reveals deeper concerns.

According to the U.S. Bureau of Labor Statistics, registered nurse employment is anticipated to grow an average amount – by 6 percent – from 2021 to 2031. This equates to a need for an additional 200,000 nurses over the next decade, with total employment growing from about 3.1 million to 3.3 million. What's important to note though, is that while total growth is modest, this does not include the number of new nurses needed to replace current nurses that retire or leave the profession, projected at 200,000 per year.

In 2020, U.S. nursing schools enrolled 250,000 eager nursing students. (And plenty more want to become nurses; unfortunately, nursing schools turn away tens of thousands of qualified applicants every year due largely to a lack of funding and faculty.) Theoretically, enrollment at current levels should be more than sufficient to meet annual replacement needs. So why are our hospitals and facilities so understaffed?

A startling revelation is that 37 percent of new registered nurses consider changing their job after just one year, with at least one-third of those doing so. If this trend alone kept pace, the U.S. would have a shortfall of about 20,000 nurses by 2031.

Experienced nurses are leaving in droves, too. According to the 2022 National Nursing Workforce Survey, 20 percent of nurses are likely to leave the nursing workforce within the next four years. That spells trouble.

The real cause of the nurse staffing crisis emerges when we explore the lived experiences of nurses. Today, nurses are grappling with the prolonged stresses of the COVID-19 pandemic and rising workplace violence, with nearly 48% of hospital nurses reporting escalating violent incidents. This violence isn't just physical but also includes bullying, intimidation, threats, and verbal harassment. Furthermore, they are routinely expected to take on overtime shifts, often extending beyond their professional capabilities.

Moral injury further compounds these issues. As highlighted in a 2021 white paper, nurses often face situations where profits seem prioritized over their own and their patients' safety. Many nurses also endure inadequate support, concerning salaries, benefits, working conditions, and an overall lack of backing from administrative entities. This overwhelming cocktail of moral challenges has ignited a mental health crisis among nurses, marked by rising depression, anxiety, PTSD, and the concerning phenomenon of compassion fatigue. As a result, more nurses are seeking careers outside bedside care.

While some argue that a nursing shortage persists, it's clear that the larger issue is a multifaceted crisis. This encompasses the aftermath of the pandemic, rampant workplace violence, insufficient nurse-to-patient ratios, and educational institutions not equipped to train the next generation adequately.

One last thing, dear reader. At the beginning of this article, we noted how many nurses are currently

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employed in the United States: 3.1 million. How odd then that, according to the American Nurses Association, there are over 4.3 million nurses in the U.S. So where are all these nurses? Well, I can tell you where they're certainly not: at the bedside.

We don't have a lack of nurses; we have an extraordinary amount of nurses who are no longer willing to put up with the unsafe staffing conditions, unsupportive management, and untenable stress that hospitals have been serving us. That is the real nursing shortage.

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ENSURING PROTECTION AND EMPOWERING NURSES:

Why Professional Liability Insurance Is Critical

By Zingre E. Veenstra, J.D., BSN, RN

Attorney with Cashion, Gilmore & Lindemuth

Nursing is a demanding profession that requires nurses to prioritize the well-being of others. However, amid caring for patients, nurses often neglect to consider their own best interests. Frequently overlooked is the need for a nurse to carry their own professional liability, or malpractice, insurance.

As a nurse and a lawyer, I have encountered numerous misconceptions surrounding the necessity of malpractice insurance. The most prevalent misconception among nurses is the belief that they are covered under their employer's liability insurance. Unfortunately, believing this can put a nurse at risk if they face a professional licensing issue during their carrier.

The most common legal action a nurse will face during their career is a professional licensing issue. A nurse's career may be jeopardized by a professional licensing issue, which typically arises when a complaint is lodged against the nurse's license. Many nurses mistakenly believe that a complaint can only occur when they have done something "wrong" or assume that such issues will never happen to them. This is far from the truth as anyone can file a complaint against a nurse's license, regardless of the validity of the claims.

When a complaint is filed, the nursing board is obligated to investigate the matter (either via a Notice of Complaint or a formal investigation). Contrary to common belief, the liability insurance provided by hospitals and other healthcare employers often does not cover nurses with respect to licensing issues or complaints made to the Board of Nursing. This means that when nurses face a licensing action they are left to handle the financial burden of their defense independently. Even defending against seemingly frivolous complaints can quickly become costly. Without their own professional liability insurance to help shoulder the financial burden, nurses face significant financial barriers in securing legal counsel to help defend them during a licensing action.

Obtaining professional liability insurance is a crucial step in ensuring that nurses' best interests are protected throughout their careers. This type of insurance offers two essential benefits: (1) professional liability insurance provides nurses with financial means to defend themselves against licensing actions and complaints by assisting in covering legal expenses that can quickly accumulate during the defense process, and (2) professional liability insurance provides nurses with a dedicated resource to help protect their professional license and safeguard their best interests.

Nurses play a vital role in healthcare, consistently prioritizing the well-being of others. However, it is essential for nurses to remember that they, too, deserve protection and support. Obtaining malpractice insurance is a proactive step that can ensure nurses' best interests are protected. By having their own insurance coverage, nurses can protect their licenses, reputations, and careers from the potential challenges associated with facing Board or legal action. It is time for nurses to recognize the value of professional liability insurance and prioritize their own well-being, both personally and professionally.

Zingre Veenstra is an accomplished professional with a diverse background in both healthcare and law. As a former critical care nurse, Zingre developed a deep understanding of medical practices and the challenges faced by healthcare providers and hospitals. Motivated by a desire to make a broader impact, she transitioned to the legal field and focused her expertise on medical malpractice defense litigation and professional licensing issues.

THE RETURN OF THE LOVE A NURSE RUN 2023

By Kim Kluckman, RN
AaNA Board & Labor Council Treasurer

The Alaska Nurses Association's Planning Committee was hard at work over the winter months planning the last celebration event of the 2023 National Nurses Week, the return of the in-person event Love A Nurse Run 5K, at Goose Lake Trail, in Anchorage.

After living our lives virtually for so long, the Planning Committee understood the importance of having an in-person experience as well as continue with the virtual run option. After not having an in-person event since 2019, the committee was a tad overwhelmed with organizing the in-person event.

Like so many other race committees, the amount of snowfall this past winter caused concern for trail conditions. We rescheduled the race from its normal date in May, during National Nurses Week, to Saturday June 24th hoping for sunshine and dry pavement.

“This is our first in-person run since the beginning of the COVID-19 pandemic. The turnout was great, the weather cooperated nicely, and the trail was awesome!” described Jane Erickson, RN, President of the Alaska Nurses Association, and official trail sweeper. “It’s been wonderful working with Skinny Raven. Their professional help with planning, advertising and race execution was significant to the events success.”

Many community businesses came out to support the Alaska Nurses Association and celebrate the 2023 Nurses Week with donations to offset event costs. The Planning Committee would like to highlight the contributions of Alaska Pacific University, Freeze Frame Photography, Grand Canyon University, Golden North Van Lines, Great Harvest Bread Company, Kaladi Brothers Coffee, Providence Alaska Medical Center, Stellar T-Shirt Designs and Subway.

We would like to continue our thanks to the individual volunteers, members of the Board of Directors and members of the Alaska running community for providing hands-on support during Bib Pick up and on Race Day.

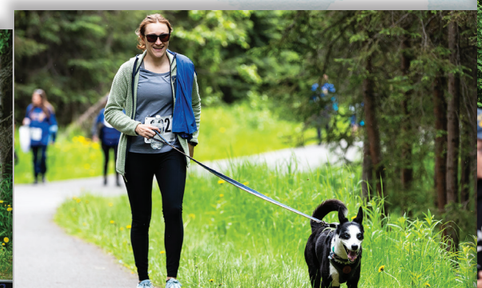
Organizing an event takes a lot of time and dedication. The nurse leaders of the Alaska Nurses Association really stepped in, and we lifted each other up, filled in the gaps for each other and called out to friends and family for favors. “It’s good to get our name out there and show support for the community," said Donna Phillips, RN, Labor Council Chair.

The Love A Nurse Run 5K has been a fundraising event for the Alaska Nurses Foundation for the last several years. The proceeds of the run bring free continuing education (CE’s) opportunities to nurses around the state as well as providing support to our local nursing student cohorts. The Foundation for Alaska Nurses has been providing educational scholarships to the Association's educational events and providing volunteer opportunities for the student nurses during their community rotation and a seat on the Board of Directors. In addition to supporting our next generation of nurses, the Foundation also highlights the RN’s end-of-life by holding an Honor Guard ceremony to celebrate their dedication to the profession.

If interested in planning, volunteering, or attending next year’s Love A Nurse Run, please email me, I’d love to hear from you! Thank you to all the in-person and virtual runners, walkers, and hounds for participating in this successful event. See you in 2024!

It’s so great to be back!

Kimberly Kluckman RN



Calendar of Events

Wheezin', Sneezin' & Itchin' in Alaska
in-person
Hosted by AAFA Alaska Chapter
September 8-9, 2023
Girdwood
www.aafaalaska.com

Book Club virtual
"The Woman They Could Not Silence"
Hosted by AaNA
September 13 @ 6 PM
Contact hours available
www.aknurse.org

TUESDAY TALKS
virtual
Hosted by AaNA
Forensic Nursing
Presented by Amy Knutson, BSN, RN & Angie Ellis, MSN, RN
September 19 @ 6 PM
Contact hours available
www.aknurse.org

Alaska Native Diabetes Conference
October 3-5, 2023
Anchorage
cvent.me/402wXq

Nursing Narratives
in-person
Hosted by AaNA
October 12 @ 8 PM
Beartooth Theatrepub
www.aknurse.org
beartooththeatre.net

Pre-Conference Sessions 2023 Trending Topics in Nursing Conference
hybrid
Hosted by AaNA
October 12, 2023
Anchorage & Virtual
www.aanaconference.org
www.aknurse.org

2023 Trending Topics in Nursing Conference
hybrid
Hosted by AaNA
October 13-14, 2023
Anchorage & Virtual
www.aanaconference.org
www.aknurse.org

2023 General Assembly
hybrid
Hosted by AaNA
October 14, 2023
Anchorage & Virtual
www.aknurse.org

Book Club virtual
Hosted by AaNA
October 14, 2023
Anchorage & Virtual
www.aknurse.org

Alaska Emergency Nurses Association Conference with TCRN Review
November 1-3, 2023
connect.ena.org/ak/home

Alaska Board of Nursing Meeting
November 8-9, 2023
Anchorage
nursing.alaska.gov

Book Club in-person
Ongoing, meets every other month
Hosted by AaNA
November 2023
Contact hours available
www.aknurse.org

TUESDAY TALKS
virtual
Hosted by AaNA
End-of-Life Doulas
Panel Discussion
November 21 @ 6 PM
Contact hours available
www.aknurse.org

Holiday Helping Hands AaNA Holiday Assistance Program for Nurses
November - December 2023
www.aknurse.org

Alaska Maternal Child Health & Immunization Conference
March 19-21, 2024
alaskamchconference.org

Visit www.aknurse.org/events for frequent updates and information on AaNA events and local continuing education opportunities.

Want to list your event? Send information to andrea@aknurse.org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