Correctional Health Services Workplace Environment Assessment

MARICOPA COUNTY, ARIZONA

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TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

CHAPTER 1: INTRODUCTION AND OVERVIEW

Introduction and Overview:

65th North Group was engaged by Maricopa County to conduct a Correctional Health Services (CHS) workplace environment assessment and to recommend operational, organizational, and staffing improvements.

Within CHS operations there are several administrative divisions including finance, medical inventory, business information technology, data analysis, legal services, education / training, clinical liaison, health information management, and forensic services contract administration. Direct patient care operations occur throughout several clinics, including Lower Buckeye Jail (LBJ) outpatient, mental health unit, and infirmary; Intake, Transfer, and Release; Watkins; Estrella; Towers; and 4th Avenue. Clinical and administrative functions occur at the various clinics as well as a Security Building in downtown Phoenix that primarily houses administrative staff.

At the end of November 2021, there was a total patient count of 6,171. There are 512 authorized positions within CHS, of which 507 are full-time and 5 are part-time. As of the end of November 2021, 377 of those positions were filled, representing a 26.37% vacancy rate.

The County should consider each recommendation provided in this report; however, a recommendation should not be implemented if it is inconsistent with state law, county policy, or will conflict with practices in other county departments.

Study Scope and Methodology:

This study was undertaken to provide an objective third-party workplace environment assessment of CHS operations, staffing, and leadership and to make recommendations for improvement. Based on the results of the assessment, the project team compared existing practices to best practices in public sector management, leadership, and healthcare operations to guide the recommendations found in this report.

The review and analysis process utilized for this study included:

- Conducting in-person, email, or telephone interviews with employees.
- Collecting data both on-site and electronically to develop a detailed and accurate understanding of operations and organizational structure.

- Making on-site observations.

- Utilizing best practices from a variety of professional organizations, including but not limited to:

    ⇒ National Commission on Correctional Health Care (NCCHC).

    ⇒ Government Finance Officers Association (GFOA).

    ⇒ Society for Human Resources Management (SHRM).

    ⇒ Committee of Sponsoring Organizations of the Treadway Commission (COSO).

    ⇒ National Institute of Corrections (NIC).

    ⇒ The project team's own extensive knowledge and experience with organizational management and leadership.

The project team held numerous multi-disciplinary focus group meetings at several different facilities to elicit feedback from staff on the CHS workplace environment. There were eight (8) focus group questions asked at the meetings, which were:

1. Name the greatest strengths of CHS (what do you like about working at CHS)?
2. Is there room for improvement as it relates to the work environment or management and leadership (and what are the greatest weaknesses of CHS)?
3. Do you receive recognition from your manager for a job well done? How often?
4. Does management set clear goals?
5. How comfortable do you feel providing upward feedback to your supervisor?
6. How respected do you feel by your direct supervisor and the entire executive team?
7. Describe the CHS culture in one word.
8. Do you have the resources you need to be successful?

At the start of each focus group meeting, participants were provided with questions to answer privately, submitting their responses in writing directly to the project team. These responses were held confidential and presented in an aggregate format, with the results discussed in Chapter 3, Section 5 “Leadership Training”.

In addition to focus groups, all managers and supervisors were individually interviewed to obtain their views on various aspects of the CHS workplace environment. While questions were similar to those asked in the focus groups, they provided employees the opportunity to answer in a private setting. Interview questions were:

1. Tell me about your position – what are you responsible for accomplishing on a daily, weekly, and monthly basis?
2. How many people report to you and to whom do you report?
3. Tell me about some of the really positive things about your job and working for CHS.
4. Are there things that you wish would be improved within the organization? If so, please tell me.
5. Tell me about the following within CHS:
    a. Working conditions
    b. Ability to have open communication and collaboration
    c. Delivering quality and timely services
    d. The relationship with supervisors, subordinates, peers, and MCSO staff
    e. Are you valued?
6. Tell me about staff turnover and morale. Do you think it is typical for any organization or is it either better or worse here? Why?
7. If you could change only one thing within CHS, what would it be and why?
8. What is the best thing about working here?
9. Is there anything else that you’d like to share with us.

In addition to conducting interviews with managers and supervisors, the project team completed an additional 45 interviews of non-supervisory personnel, to obtain a more complete assessment of the CHS workplace environment.

These process components provided an in-depth understanding of Maricopa County Correctional Health Services operations, staffing, organizational structure, and leadership.

Organizational Strengths:
While the focus of the study was to identify areas for improvement with operations, organizational structure, staffing, and leadership, there were several existing organizational strengths noted over the course of the overall assessment. Examples of these strengths include:

- The organization is accredited from NCCHC.
- There is a separate education and training unit available for all new employee orientation training as well as ongoing employee training needs.
- The organization generally has good policies and procedures in place.
- The organization has actively addressed concerns related to employee turnover and the need to recruit and retain qualified talent.
- Employees generally really enjoy working with their fellow staff members.
- The department has its own finance and HR team members.
- Employees have a good working relationship with Maricopa County Sheriff's Office detention employees.
- Employees are motivated to see organizational improvements, and this could make "change" easier to implement.
- Employees were cooperative and helpful during this assessment.

These are only some of the noted strengths that provide a strong foundation for improved operations and organizational structure.

Summary of Key Findings:
The table below provides a summary of the recommendations developed to improve CHS operational practice, staffing and organizational structure, and leadership. The recommendations include a priority: Low, Medium, or High, along with a recommended

timeframe for implementation. Generally, high priority recommendations should be implemented within 6 months, medium priority within one (1) year, and low priority within two (2) years; however, some timeframes with a higher priority might be longer than the timeframe for a lower priority recommendation due to complexities associated with implementing certain recommendations.

Table 1: Summary of Key Findings

#	Recommendation	Priority	Timeframe
	OPERATIONAL PRACTICES		
1	*The education department should revamp their new employee orientation (NEO) training to ensure that only a core group of topics are presented to everyone over the course of two days and then each classification (or groups such as RN and LPN) has its own individualized training syllabus for the rest of NEO.*	Medium	1 year
2	*The human resources department should be responsible for ensuring the "onboarding process checklist" is complete (background checks complete, employees have computer access, employees have badge access, etc.) for all new employees prior to their first day of work.*	Medium	1 year
3	*Each trainer (as addressed in Chapter 3 of this report) should be responsible for ensuring all new employees in training status have completed checklists for all clinic locations prior to being released from training.*	High	6 months
4	*The CHS deputy director should perform quarterly internal reviews by reviewing records from a sample of new hires from the prior three months to determine if any did not have appropriate computer access, badge access, etc. prior to their first day of NEO.*	High	6 months
5	*Within the confines of reducing the risks of COVID exposure, the education division should work to implement on-site and in-person training throughout the CHS organization.*	Low	2 years
6	*To reduce risk of non-compliance with county mandated training, the education department should continue to monitor all employee training requirements and the completion rates for those required training courses while*	High	6 months

#	Recommendation	Priority	Timeframe
	sending a training deficiency report directly to the employee's manager every month.		
7	*If the same employee shows up on consecutive monthly training deficiency reports, the education department should notify the CHS deputy director – who shall then hold the appropriate manager accountable.*	High	6 months
8	*Modify CHS policy "Continuing Education and Professional Credentials" with a revision date of February 22, 2021 to allow for out-of-state conference attendance, a flat dollar amount and time off allowance for completion of credentialing-related annual training each year, and a requirement to reimburse the county a prorated amount if an employee leaves county employment after receiving payment but before the end of the year.*	Medium	1 year
9	*CHS should develop a universally applied process for reporting missed or delayed medication passes so that any issues related to medical care can be evaluated and acted upon by senior management.*	High	6 months
10	*The DON should develop a policy that makes it clear to staff what they are to prioritize if they believe they will not be able to complete daily medical care tasks on their shift.*	High	6 months
11	*The nurse manager should complete a patient safety report and forward to the DON through the assistant director of nursing over operations (ADON-operations) before the end of the shift in which the missed care occurred.*	High	1 year
12	*The ADON-operations should work with the ADON-administration to evaluate the root causes behind missed medical care to develop real-time solutions.*	High	1 year
13	*The DON should use missed medical care data as one of the evaluation factors for the ADONs and nurse managers for their annual evaluation.*	Medium	1 year
14	*The ADON – administration should review health needs requests from a time to respond perspective on a quarterly basis, sampling documentation to determine whether the 24-hour timeframe is met. Appropriate staff*	High	6 months

#	Recommendation	Priority	Timeframe
	should be held accountable for the results of these reviews.		
15	*Maintain accurate data on employee call outs to include employee position and clinic location so management can perform regular data analysis to identify employee call out patterns and trends.*	High	6 months
16	*If aligned with County policy, consider implementation of an employee recognition program, and communicate the requirements for recognition as well as the recipients of awards to all CHS employees.*	Medium	1 year
17	*Ensure employees and managers review, approve, and sign timecards for every pay period.*	High	Immediately
18	*Offer current RNs who were not eligible for a sign-on bonus with a similar bonus, paid out over a two-year period.*	Medium	1 year
19	*Complete a staffing study that includes an evaluation of the ability to implement 12-hours per day, 36-hours per week direct patient care nursing schedules.*	High	3 months
20	*Managers should be responsible for updating ADP data for employee leave, including properly identifying FMLA leave (consulting the county human resources as needed).*	High	3 months
21	*Implement a process that ensures all applicants receive the same information on the work environment in a correctional health setting, and everyone receives the same information about the need to float to different clinics.*	High	6 months
22	*Each new clinical direct patient-care applicant should be required to spend two (2) hours shadowing a "peer" classification prior to moving forward in the application process.*	High	1 year
23	*Continue to assess the pay structure for difficult to fill positions to remain market competitive.*	Medium	1 year
24	*The medical director and director of nursing should review all "Clinical Practice Guidelines" to ensure the reference material is still appropriate and applicable.*	Low	2 years
25	*Policies and procedures should generally be uniform throughout all work areas within CHS and CHS should*	Medium	1 year

#	Recommendation	Priority	Timeframe
	consult with their accreditation manager to ensure site specific policies are only applicable when a site does things differently than other sites.		
26	*CHS should continue with its comprehensive policy review, with the understanding that some employees currently tasked with writing policies do not have policy writing or policy development experience.*	Medium	1 year
27	*Consider an incentive to CHS clinical staff with direct patient care responsibility if they use little-or-no sick leave throughout the year.*	Medium	1 year
28	*Explore the possibility of modifying County HR policy HR2415 "Employee Leave" to allow CHS clinical employees with direct-patient care responsibilities to buy back 100% of their earned and accumulated sick leave each year or offer a once-a-year bonus to those employees if they had no or limited sick time usage throughout the year.*	Low	18 months
29	*Modify CHS's "Time and Attendance" policy so that if an employee brings a doctor's note for being sick or injured that would lead a reasonable person to believe they should not work a particular shift, that that sick leave will not count as an "occurrence" toward potential disciplinary action.*	High	3 months
30	*Modify CHS's "Time and Attendance" policy to remove the statement under section II "Policy" that says employee are expected to remain at work for their entire work schedule. Managers must have discretion to approve an early shift departure.*	High	3 months
31	*Modify CHS policy "On-Call Policy for Nurse Leadership" to provide nurse managers with a compensated benefit for being "on-call".*	Low	1 year
32	*The deputy director should regularly solicit input from non-HR staff related to HR performance.*	High	6 months
33	*CHS management should use human resources employees as a tool to assist them in their work as they are a support group, rather than using them as an extension of the manager himself or herself.*	High	6 months
34	*Adopt performance measures for the department,*	Medium	1 year

#	Recommendation	Priority	Timeframe
	communicate them with employees, regularly review progress toward successful completion of the measures, and hold employees accountable for performance measure success.		
35	*Employee goals and objectives for the employee's annual performance evaluation should be developed between manager and employee.*	Medium	1 year
36	*Employee goals and objectives should be linked to established CHS performance measures when possible.*	High	1 year
37	*Managers should keep employee performance notes throughout the year, to assist whoever completes an employee's annual performance appraisal evaluation.*	High	3 months
38	*Manager evaluations should use a "360 evaluation" tool to obtain views from multiple organizational stakeholders as to the effectiveness of that manager's workplace performance.*	Medium	1 year
39	*Assign project management quality control for all CHS projects to a "Special Projects Manager".*	Medium	1 year
40	*Project managers should receive project management certification from the Project Management Institute.*	Low	2 years
41	*Nurse managers should file a weekly report to their ADON on the number of health needs requests and inmate grievances submitted and the status of those requests / grievances.*	High	6 months
42	*The ADON (operations) should sample a portion of weekly nurse manager reports on the status of inmate health needs requests and grievances to ensure their accuracy – while addressing any systemic issues with delayed responses to these requests / grievances.*	Medium	1 year
43	*Begin an organization-wide strategic planning process between 6 and 12 months after a new CHS director is in place.*	Medium	1 year
44	*The CHS executive team should consider the adoption of a simplified values statement of one word: "Caring", to guide employee work actions and interactions.*	Medium	1 year
45	*The medical director, chief of psychiatry, and forensic services manager should meet monthly with MCSO leadership to review the effectiveness of that month's*	Medium	9 months

#	Recommendation	Priority	Timeframe
	power squad utilization.		
46	*When power squad members are not available for use by CHS staff, then CHS should not be required to pay for that employee's salary for the times they were not available.*	Low	2 years
47	*Consider the costs and benefits of assigning at least one power squad member to assist psychiatric and mental health staff at each clinic during the hours these staff are working.*	Medium	1 year
48	*Consider the costs and benefits of the use of non-traditional means for seeing patients, such as the use of mini-clinics throughout the jail system.*	Low	2 years
49	*CHS should evaluate the costs and benefits of participating in a nurse residency program.*	Low	2 years
50	*The medical director, director of nursing, nurse managers, and other members of the CHS executive team should meet to review where processes and forms are not currently standardized across multiple locations to determine whether standardization is appropriate.*	Medium	1 year
51	*The medical director, pharmacist, chief of psychiatry, director of nursing, and other executive staff should consider the costs and benefits of implementing a "medication holiday" to improve medication pass effectiveness.*	Medium	1 year
STAFFING, ORGANIZATIONAL STRUCTURE, AND LEADERSHIP			
52	*Create an annual performance measure for voluntary nursing turnover to be no more than 10%.*	High	2 years
53	*Eliminate one (1) Director of Nursing (DON) position.*	High	9 months
54	*Create one (1) position for an Assistant Director of Nursing – operations (ADON – operations), overseeing nurse managers, the clinical float team, infection control, and diagnostic / ancillary services.*	High	9 months
55	*Create one (1) position for an Assistant Director of Nursing – administration (ADON – Administration), overseeing the education unit and staffing / scheduling.*	High	9 months
56	*Create one (1) Special Projects Manager position, reporting directly to the deputy director.*	High	9 months

#	Recommendation	Priority	Timeframe
57	*Modify reporting relationships so that all provider, nursing, pharmaceutical, mental health, and dental-related positions fall under the medical director.*	High	9 months
58	*Create one (1) additional assistant medical director position.*	High	9 months
59	*Modify reporting relationships so that the medical director has three direct reports: the director of nursing and both assistant medical directors.*	High	9 months
60	*Modify reporting relationships so that one assistant medical director oversees the dental director, pharmacy director, chief of psychiatry, and the mental health director while the other assistant medical director oversees providers at every clinic as well as quality management / utilization management.*	High	9 months
61	*Consider a future reporting relationship of the mental health director reporting to the chief of psychiatry.*	Medium	2 years
62	*Create a clinical float team comprised of seven (7) RN's, three (3) LPN's, three (3) CHT's, and lead by an assistant director of nursing – operations (ADON – operations).*	High	1 year
63	*Excluding the ADON – operations, pay members of the clinical float team a stipend, regardless of the number of trainees the team member has assigned to him or her at any given time.*	Medium	1 year
64	*Provide a stipend for all hours worked "floating at another facility" to any employee not on the clinical float team.*	Medium	1 year
65	*Each member of the clinical float team should provide weekly updates to their supervisor on how well received they were at the various clinics throughout the week and any clinic-specific issues that they believe should be addressed.*	High	1 year
66	*Once a shift has begun, only the ADON – operations should approve an employee not on the clinical float team to be floated.*	High	1 year
67	*There should be a competitive application process, the completion of an oral board interview, and having the employee's last employee performance evaluation at least "standard" to be selected to be a member of the*	High	9 months

#	Recommendation	Priority	Timeframe
	clinical float team.		
68	*Executive staff should "round" at least once monthly – ensuring they take the time to meet with and talk to employees under their supervision.*	High	Immediately
69	*Nurse managers should work an RN or LPN shift at least once per month – performing RN or LPN responsibilities for the shift.*	High	6 months
70	*Require leadership training of all newly promoted supervisors / managers and ensure all managers receive annual in-house leadership training.*	High	1 year
71	*Consider the costs and benefits of backfilling clinic mental health patient-care positions when an employee calls out on leave.*	Medium	1 year
72	*Ensure management engages in regular communication with employees to ensure everyone is kept informed as to the direction of CHS as a whole and the employee's individual division or unit, as well as allowing employees the opportunity to be heard.*	High	6 months
73	*Complete a staffing study to identify appropriate staffing levels in the clinics, minimum staffing levels, opportunities to improve the staffing / call out process, whether nursing staff can work 12-hours per day / 36-hours per week schedules, and from which clinics will staff be pulled from first (and last) during times of employee call outs.*	High	3 months
74	*Consider the costs and benefits associated with establishing a "charge nurse" designation and paying a stipend for an RN working in this designation to assist nurse managers with supervisory responsibilities.*	Medium	1 year
75	*Provide for an independent analysis and assessment of the DON's workload with recommendations that will help him excel in his new position.*	High	6 months
76	*Clarify director and deputy director expectations to provide clear guidance on what each person should be focused on throughout their workday.*	High	6 months

CHAPTER 2: OPERATIONAL PRACTICES

The following are recommendations to further improve operational practices within the Correctional Health Services (CHS) department:

2.1 TRAINING

Employee training is essential to the success of many organizations, CHS included. Training comes in many forms and starts with new employee orientation, followed by new employee "field training", monthly and annual in-house training, continuing education training required for certain employees to maintain licensure, and leadership training. Training currently provided includes a mix of both online, in-person computer-based, and hands-on in-person training. While more in-person training used to be conducted, the department has reportedly shifted away from that model, at least in part due to concerns with COVID.

New Employee Orientation (NEO):
When a new employee starts employment with CHS, that employee is processed by human resources and then handed off to CHS education for up to five (5) days of new employee orientation (NEO). Based on interviews with dozens of employees at all levels of the organization (from providers to executive team members, RNs, LPNs, mental health positions, etc.), new employee orientation is generally ineffective. While some of the information provided is very important, employees report that they sit through hours of "training" on topics that have nothing to do with their job responsibilities and there are times in which the "trainer" leaves the room for hours on end.

A review of the syllabus for "New Employee Orientation – Welcome to Correctional Health Services" revealed several sessions that are not appropriate for every classification attending NEO. Examples include:

- Patients with chronic disease and other special needs
- Games inmates play, security in the jails, MCSO, and radios
- Violent and assaultive behaviors
- Infectious disease prevention and control
- Treatment issues related to drug abuse
- Electronic health records
- Suicide prevention and intervention
- On-site diagnostic services
- Non-emergency health care requests

- Medication administration

These are examples of topics taught by a CHS clinical nurse educator, that are appropriate for clinical staff, but not for administration staff. While employees report that certain employees are allowed to leave NEO early if a course is deemed inappropriate for their position, numerous employees report that they are still sitting through many hours of unnecessary training that could be better spent.

The education department should revamp their new employee orientation (NEO) training to ensure that only a core group of topics are presented to everyone over the course of two days and then each classification (or groups such as RN and LPN) has its own individualized training syllabus for the rest of NEO. New employee orientation will still be up to five days long; however, it should be revamped to maximize employee time utilization (both trainer and new employee). More "core" focus should be on county and CHS policies, payroll, HR training, NEOGOV, etc.

Several employees reported that they did not have access to their county login to access anything on the computer on their first day of NEO (some for several days), and supervisors didn't receive training on completing performance evaluations and other supervisory topics. CHS has an employee "onboarding process" matrix for who is supposed to do what to ensure a new employee is ready to go on their first day of NEO. This is a very good matrix; however, interviews indicate that it is not always followed. Employees reported feeling deflated on their first day when they could not access computer systems, had to sit through training that had nothing to do with their position, and after completing NEO did not know the County's way to complete basic forms or general processes.

While the education department should ensure appropriate supervisory training for all new supervisors in NEO (and newly promoted supervisors), the human resources department should be responsible for ensuring the "onboarding process checklist" is complete for all new employees prior to their first day of work. The CHS deputy director should perform quarterly internal reviews by reviewing records from a sample of new hires from the prior three months to determine if any did not have appropriate computer access, badge access, etc. prior to their first day of NEO.

The education department should ensure that each classification has appropriate training specific to the employee's future work and they should be responsible for verifying new employees have all appropriate computer access prior to their first day of NEO.

New Employee "Field Training" and Checklists

After a new employee completes their new employee orientation requirements, they are sent to their work assignment for additional training. For all direct patient care positions, there are checklists already developed for trainers to sign off on when their trainee completes certain tasks – to ensure knowledge in multiple areas. Each clinic has its own checklist since things are done differently at many of the various clinics.

When asked for copies of completed checklists for employees over the past several months, the project team expected to receive hundreds of checklists, since each clinic as their own and each employee clinical employee should receive orientation at all clinics; however, CHS provided only two completed checklists. This indicates that there is a breakdown in ensuring and documenting whether employees are trained and oriented at each clinic location, regardless of their primary work location.

A recommendation in chapter three of this report is for the creation of a clinical float team, to be led by an assistant director of nursing (ADON). There are several reasons for this recommendation, which will be explored later in this report; however, new employee training checklists should be used for each new employee having direct patient contact / care responsibilities.

Each float team member (addressed in Chapter 3) will also be an agency trainer (preceptor), responsible for ensuring all training checklists are completed prior to a "trainee" being released from training status.

Meeting Training Requirements

The education division is reported to have previously gone to clinics on a quarterly basis to provide important in-person training. Such services are often highly beneficial for employees receiving the training as it allows for "real-world" training opportunities. The education division already has training topics developed and should work to implement on-site and in-person training throughout the CHS organization within the confines of limiting COVID exposure.

The education division also monitors all required training requirements for employees throughout CHS. They have checklists to ensure each employee meets their required minimum annual training requirements and they regularly reach out to employee's supervisors when an employee is late on meeting those requirements. It is reported that some managers do not respond to the education division regarding training deficiencies in a timely manner, or at all. To reduce risk of non-compliance with county-mandated training, the education department should continue to monitor all employee training

requirements and the completion rates for those required training courses while sending a training deficiency report directly to the employee's manager every month.

The employee's manager should review the training deficiency report and work to ensure the training requirements are met before the next month's report is due. If the same employee shows up on consecutive monthly training deficiency reports, the education department should notify the ADON - Administration – who shall hold nursing staff accountable as well as coordinate with other managers as appropriate if the employee with the training deficiency works outside of a nursing classification.

Continuing Education and Licensure

Continuing education training is a requirement for licensed professionals working at CHS. The County has a good travel policy in place; however, a review of CHS's internal policy on "Continuing Education and Professional Credentials" dated February 22, 2021, reveals a need for policy edits.

This policy currently restricts continuing education training to "in-state" venues only, yet for many providers, nursing positions, and certain mental health classifications, the most beneficial conferences and training opportunities often occur outside of Arizona. To limit one's ability to maintain licensure by limiting travel for training is not recommended and as such, the department should modify its existing policy. The following modifications are recommended to the "Continuing Education and Professional Credentials" policy:

- Remove all reference to any requirement that conferences or training must be "in-state" to be approved.

- Allow for a flat rate dollar amount by classification to be used for continuing education related to maintaining licensure status regardless of where training is located. This amount will be on a reimbursement basis and any amount spent over the authorized dollar value will be the employee's responsibility to cover. Additionally, each classification should be allotted up to a certain number of hours each year to be used for certification-related training. CHS will need to take into consideration certifications that require both annual training and training that is spread out over more than one year to determine an appropriate amount of time to allow to attend licensure-related training. The following are classifications should have their own time off and dollar value allotment, with exact time and amounts to be determined by the CHS executive team:

    - Physician, psychiatrist, dentist, physician assistant, nurse practitioner, psychologist, and pharmacist.

- Registered nurse, licensed practical nurse, and registered radiologic technologists. The hours and dollar values should only be authorized if the education department is not able to provide annual training.

- Mental health professionals, mental health licensed associates and any other licensed professionals (e.g., certified public accountant).

- Require an employee who used any portion of their annual licensure training dollar allotment throughout the year, but leaves employment before the end of the year, to reimburse the County a prorated amount – to be taken from the employee's final paycheck.

By implementing these recommendations, employees will be better positioned to obtain the training that is most beneficial for their certification and thus should most benefit the CHS organization.

Leadership Training:
Leadership is an important topic and a vital one for the success of the CHS organization. Leadership training can be improved within the organization, both for newly appointed supervisors and managers as well as for those employees who have been in leadership positions for many years. As this is a vital topic, it is discussed in greater detail in sections 3.4 and 3.5 of this report.

Recommendation: *The education department should revamp their new employee orientation (NEO) training to ensure that only a core group of topics are presented to everyone over the course of two days and then each classification (or groups such as RN and LPN) has its own individualized training syllabus for the rest of NEO.*

Recommendation*: The human resources department should be responsible for ensuring the "onboarding process checklist" is complete (background checks complete, employees have computer access, employees have badge access, etc.) for all new employees prior to their first day of work.*

Recommendation: *Each trainer (as addressed in Chapter 3 of this report) should be responsible for ensuring all new employees in training status have completed checklists for all clinic locations prior to being released from training.*

Recommendation*: The ADON - administration should perform quarterly internal reviews by reviewing records from a sample of new hires from the prior three months to determine if any did not have appropriate computer access, badge access, etc. prior to their first day of NEO.*

Recommendation: *Within the confines of reducing the risks of COVID exposure, the education division should work to implement on-site and in-person training throughout the CHS organization.*

Recommendation: *To reduce risk of non-compliance with county mandated training, the education department should continue to monitor all employee training requirements and the completion rates for those required training courses while sending a training deficiency report directly to the employee's manager every month.*

Recommendation*: If the same employee shows up on consecutive monthly training deficiency reports, the education department should notify the CHS deputy director – who shall then hold the appropriate manager accountable.*

Recommendation: *Modify CHS policy "Continuing Education and Professional Credentials" with a revision date of February 22, 2021 to allow for out-of-state conference attendance, a flat dollar amount and time off allowance for completion of credentialing-related annual training each year, and a requirement to reimburse the county a prorated amount if an employee leaves county employment after receiving payment but before the end of the year.*

2.2 PRIORITIZING MEDICAL CARE

There are a wide variety of negative consequences that can possibly happen if medication passes, wound care, and other medical care is not provided in an appropriate timeframe. Negative consequences are first and foremost related to a patient's well-being, but they can also be associated with lawsuits, NCCHC accreditation status, etc.

An important note before discussing missed medical care is that the project team considers Maricopa County CHS to be operating under crisis standards of care at the time of our assessment. This is due to significant nursing shortages that exist not only within CHS, but also at a national and regional level. These nursing shortages are in several industries – hospitals, nursing homes, correctional facilities, etc. COVID and associated COVID protocols only add to the challenges faced by nursing staff across the country.

According to the National Center for Biotechnology Information:

> *"Crisis standards of care" is defined as a substantial change in usual healthcare operations and the level of care it is possible to deliver, which*

> *is made necessary by a pervasive (e.g., pandemic influenza) or catastrophic (e.g., earthquake, hurricane) disaster. This change in the level of care delivered is justified by specific circumstances and is formally declared by a state government, in recognition that crisis operations will be in effect for a sustained period. The formal declaration that crisis standards of care are in operation enables specific legal/regulatory powers and protections for healthcare providers in the necessary tasks of allocating and using scarce medical resources and implementing alternate care facility operations*.[1]

While the county has been aggressively working to mitigate any effect these shortages will have on operations through a wide-variety of recruitment and retention efforts, there is only so much CHS can do given these exceptional challenges. Additionally, it was reported that the sheriff's office detention staff had numerous openings and when detention officers are unable to assist CHS staff in a timely manner, it creates additional challenges for CHS operations.

Missed medical care:

Numerous clinical staff reported in interviews that they have missed medication passes on several occasions and that when this happens, they complete paperwork to document the missed medication pass as well as the reasons behind it. Available data from the Quality Management Department shows that there were 38 missed medication passes during the three-month period from September through November 2021, with only two of the reasons behind those missed medication passes due to an MCSO lockdown. Interviews revealed that wound care and medication passes have been missed for up to three-days in a row.

Regardless of the reasons behind them, it is possible that missed medication passes are not being reported to management for documentation. Discussions with staff at a clinic revealed that they are told to document a missed medication pass in their own computer file, without forwarding that information onto anyone else. Based on a review of reported missed medication passes and the clinics from which they are reported, it is possible that some missed medication passes are not being reported.

CHS must develop a universally applied process for reporting missed or delayed medication passes, missed wound care, or other care that is not happening so that any issues related to medical care can be evaluated and acted upon by senior management in a timely manner.

[1] Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK32748/

Interviews further revealed that during times when there are staff shortages on a shift, some employees are left unaware of what medical care management wants prioritized (medication pass, wound care, or some other function). In such a situation, staff are left to their own best judgement to determine what needs to get done if there is not enough time in a shift to complete all tasks.

The DON should develop a policy that makes it clear to staff what they are to prioritize if they believe they will not be able to complete daily medical care tasks on their shift. Additionally, it is important that all nurse managers are aware of when there is the possibility of missed medication passes, wound care, or any other regularly provided medical service. This policy should require the DON be notified, through the chain of command, within 30 minutes of the probability of a missed medication pass, missed wound care, or other missed regularly provided medical care. The DON should determine whether the medical director needs notification and if medical care is missed, then the DON should ensure the CHS director is notified within 24 hours of the missed medical care.

The nurse manager should do what they can to limit the risk that missed medical care will occur and should complete / forward a patient safety report to the DON through the assistant director of nursing over operations (ADON-operations) before the end of the shift in which the missed care occurred. The ADON-operations should work with the ADON-administration to evaluate the root causes behind the missed care to develop real-time solutions. The DON should use missed medical care data as one of the evaluation factors for the ADONs and nurse managers for their annual evaluation.

Health Needs Requests:

For patient safety reasons and accreditation standards, health needs requests completed by patients are to be addressed within 24 hours of receipt. Interviews with staff indicate that health needs requests sometimes take weeks to review, and several were found by an employee sitting in a desk drawer up to a month after they were completed. While this is understandable from the perspective of significant nursing shortages in the region and industry (of which Maricopa County and CHS have been aggressively working to mitigate this shortage on CHS operations), it is best practice to get these review times down to 24 hours.

The ADON - administration should review health needs requests from a time-to-respond perspective on a quarterly basis, sampling documentation to determine whether the 24-hour timeframe is met. The ADONs and nurse managers should be held accountable for the results of these reviews.

***Recommendation**: CHS should develop a universally applied process for reporting missed or delayed medication passes so that any issues related to medical care can be evaluated and acted upon by senior management.*

***Recommendation:** The DON should develop a policy that makes it clear to staff what they are to prioritize if they believe they will not be able to complete daily medical care tasks on their shift.*

***Recommendation:** The nurse manager should complete a patient safety report and forward to the DON through the assistant director of nursing over operations (ADON-operations) before the end of the shift in which the missed care occurred.*

***Recommendation:** The ADON - operations should work with the ADON - administration to evaluate the root causes behind missed medical care to develop real-time solutions.*

***Recommendation:** The DON should use missed medical care data as one of the evaluation factors for the ADONs and nurse managers for their annual evaluation.*

***Recommendation:** The ADON – administration should review health needs requests from a time to respond perspective on a quarterly basis, sampling documentation to determine whether the 24-hour timeframe is met. Appropriate staff should be held accountable for the results of these reviews.*

2.3 EMPLOYEE CALL OUTS

Information in this section is provided to highlight and analyze employee call outs by position, clinic, type of leave, and date for a three-week period in October 2021. The following table shows there were a total of 227 employee call outs for all clinics during this three-week period, with an average of 10.81 call outs per day.

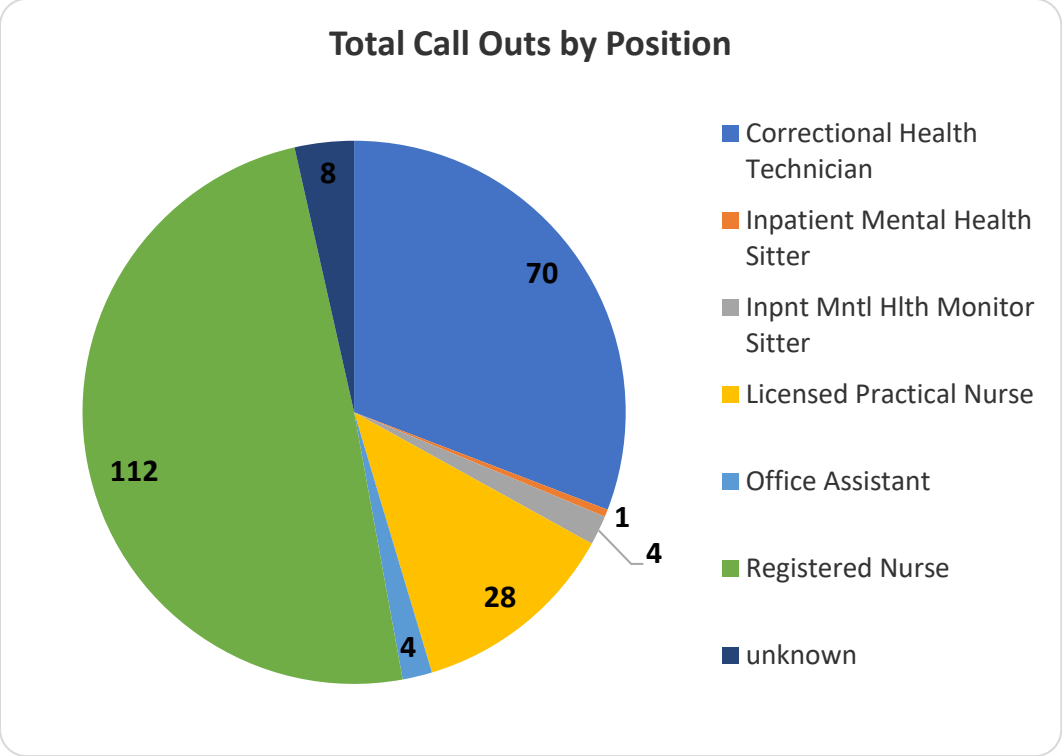
Table 2: Call out Data by Position

Classification	Number of Call Outs	Average Per Day
Correctional Health Technician	70	3.33
Inpatient Mental Health Sitter	1	0.05
Inpatient Mental Health Monitor Sitter	4	0.19
Licensed Practical Nurse	28	1.33

Classification	Number of Call Outs	Average Per Day
Office Assistant	4	0.19
Registered Nurse	112	5.33
unknown	8	0.38
Grand Total	**227**	**10.81**

Data show an average of 10.81 call outs per day across all clinics and positions. Most call outs were for registered nurses with 112 of them, or 5.33 per day.

Figure 1: Call Out Data by Position Pie Chart



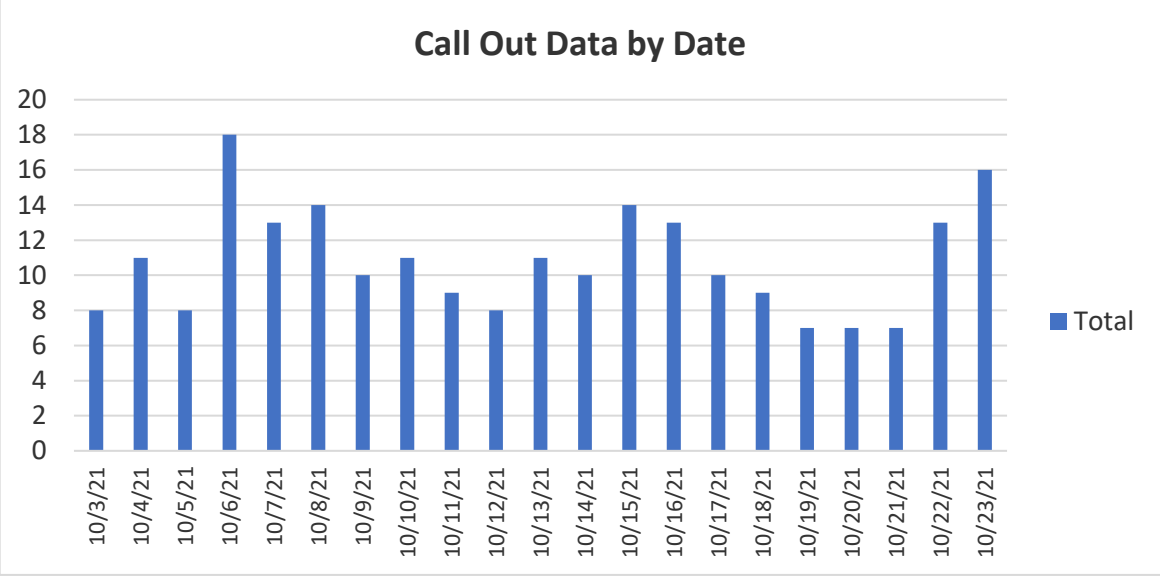
Call out data by date shows that there were no days of the week that resulted in an unusually higher percentage of call outs (weekends did not have higher than average call outs). While one weekend had higher callouts than the other days that week, this generally was not the case for the entire three weeks analyzed.

Table 3: Call Out Data by Date

By date / all clinics	Number of Call Outs
10/3/21	8
10/4/21	11

By date / all clinics	Number of Call Outs
10/5/21	8
10/6/21	18
10/7/21	13
10/8/21	14
10/9/21	10
10/10/21	11
10/11/21	9
10/12/21	8
10/13/21	11
10/14/21	10
10/15/21	14
10/16/21	13
10/17/21	10
10/18/21	9
10/19/21	7
10/20/21	7
10/21/21	7
10/22/21	13
10/23/21	16
Total	**227**

Figure 2: Call Out Data by Date



Total callouts over the 21 days of data provided was 227, for an average 10.81 callouts per day. The highest day was October 6, 2021, with 18 callouts. The following table

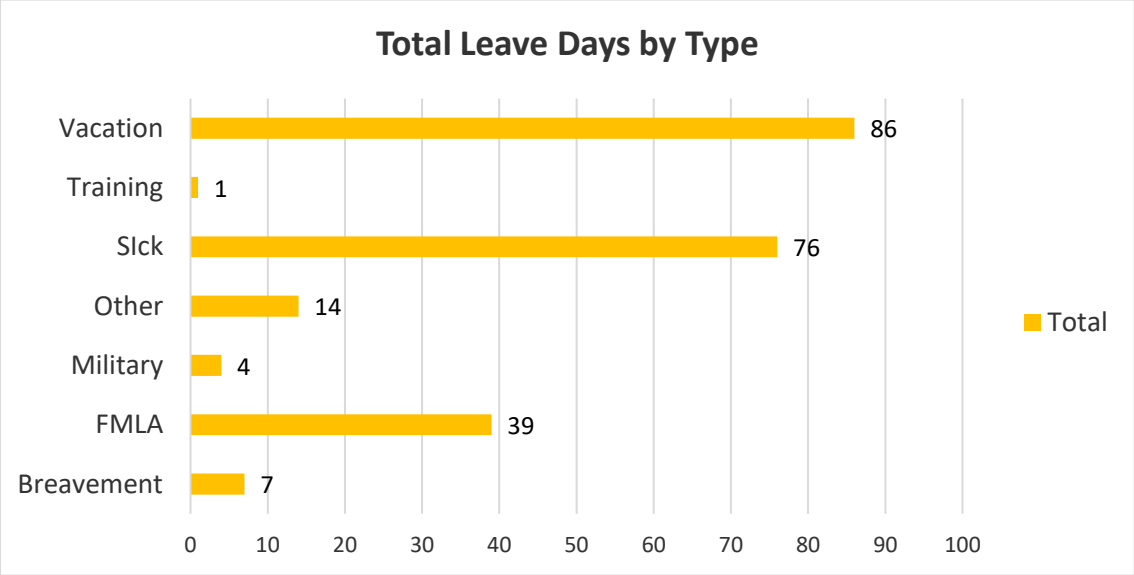
provides data on the type of leave taken, along with the average number of that type per day.

Table 4: Call Outs by Type of Leave Taken

Type of Leave	Total # of Days	Average per Day
Bereavement	7	0.33
FMLA	39	1.86
Military	4	0.19
Other	14	0.67
Sick	76	3.62
Training	1	0.05
Vacation	86	4.10
Total	**227**	**10.81**

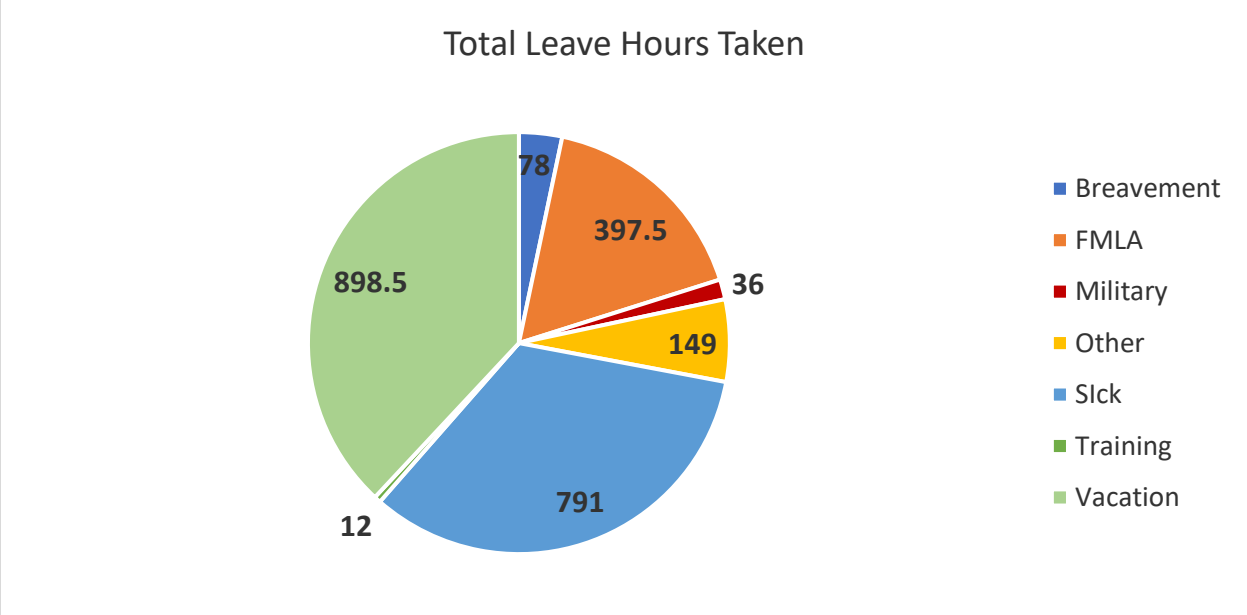
The data show sick leave and FMLA combined account for 115 of the 227 total leave days, or 50.67% of total leave taken. While COVID leave is a realistic possibility for some of this sick time, the information shows a need to consider alternatives for addressing the relatively high amount of sick and FMLA leave taken. Per County policy, employees are authorized a certain amount of sick leave each year, based on an employee's length of service. Modifications to county-wide policies that affect more than just CHS operations are not recommended; however, if the County is able to apply policy modifications to only staff that work within a correctional environment with direct patient (or inmate) contact, then limited modifications to policy might have a positive effect on sick leave usage. This topic is addressed more fully in section 2.7 of this report.

Figure 3: Employee Leave by Type



The following graphic displays a pie chart of the total number of hours taken by type of leave:

Figure 4: Type of Leave Taken in Hours



When looking at clinic-specific data, call outs are spread evenly across the various clinics.

Figure 5: Call Out Data by Clinic

Clinic	Number of Call Outs
4th Avenue Intake	30
4th Avenue Outpatient Care	19
Durango Outpatient Care	19
Estrella Outpatient Care	27
LBJ Infirmary	32
LBJ Mental Health	30
LBJ Outpatient	32
LBJ Self-Surrender	3
Towers Outpatient	9
Unknown	9
Total	227

Except for the Towers facility which had nine (9) call outs, call outs remain relatively consistent across clinics (generally between 19 and 32). Staff currently utilize spreadsheets to document and monitor this data; however, with eight (8) positions listed as unknown and nine (9) locations listed as unknown, employees who document leave data should double-check to ensure they have all data recorded before reporting it. Management will be challenged to routinely analyze call out data to determine patterns or trends if basic data remains missing. The pending staffing study is expected to provide additional insight into this matter.

Management should regularly assess employee call out data to determine if there are any identifiable patters in locations with more call outs than others, a greater percentage of a certain classification that calls out more than others, or any other patters that might help management improve overall workplace effectiveness. To complete these analyses, it is important that complete data be maintained related to employee call outs. There were 17 “unknown” clinics for call out data and without this information, management will have a more difficult time assessing whether a particular clinic is experiencing more call outs. This data is useful when considering an employee time and attendance policy, which is addressed later in this report.

***Recommendation**: Maintain accurate data on employee call outs to include employee position and clinic location so management can perform regular data analysis to identify employee call out patterns and trends.*

2.4 EMPLOYEE RECOGNITION PROGRAM

Interviews and survey results reveal that morale is very low within the CHS organization. Many employees feel unappreciated and while one division within CHS reportedly implemented an employee recognition program by recognizing someone as "employee of the month", that recognition reportedly was not publicized, and other employees did not even know there was such a program or what criteria was used to receive recognition.

CHS has the leadership team in place to encourage and recognize employees for their great work. While not every employee who is deserving of recognition will always receive it, having an employee recognition program in place can help improve employee morale.

Suggestions for consideration include:

- Perfect attendance rewards. Every month each clinic can raffle off an award and all employees with perfect attendance receive an entry. Awards can be any item valued at an amount to be determined by CHS.

- Employee of the month recognition. The executive team should determine an appropriate reward as well as the criteria and review process for receiving an award.

- Employee of the year. There can be multiple employees of the year, to include manager of the year, employee of the year, and employee of the year – lifesaving award; however, there should only be one of each category across all CHS locations.

Employees should be made aware of these programs and employees should be encouraged to submit their peers, subordinates, and managers for recognition. The total cost to implement this recommendation is dependent on the types of awards chosen by CHS.

***Recommendation**: If aligned with County policy, consider implementation of an employee recognition program, and communicate the requirements for recognition as well as the recipients of awards to all CHS employees.*

2.5 SIGNING / APPROVING EMPLOYEE TIMECARDS

Approving of employee work hours by the employee and supervisor is both a requirement of CHS and is best practice to reduce the risk of unintentional work hours claimed when they were not worked, or unintentional leave hours deducted when the

employee worked that day. It only takes a minute for an employee to review time submittal data; however, information gleaned from interviews revealed that about 24% of nursing employees' timecards do not regularly have the employee's signature on them.

An important management job function is to provide effective supervision, which includes management of time worked. Information from interviews is that about 60-70 timecards are not approved by managers on a regular basis. All employees should be held accountable to ensure their own timecards are reviewed for accuracy and signed every pay period and each manager with the responsibility to review those timecards must be held accountable to ensure they reviewed, approved, and signed timecards.

The finance manager can assist with accountability by notifying the following people based on the number of unsigned or unapproved timecards:

- Nursing staff:
    - First incident: ADON – administration.
    - Second incident: DON.
    - Third incident: Medical Director.
- Psychiatric and mental health staff:
    - First incident: Mental Health Director or Chief of Psychiatry, depending on the appropriate reporting relationship.
    - Second incident: Assistant Medical Director.
    - Third incident: Medical Director.
- Providers:
    - First incident: Medical Director
- Other CHS staff:
    - First incident: The appropriate manager one-level up from the employee involved.
    - Second incident: CHS Deputy Director

Additionally, and consistent with performance measure recommendations elsewhere in this report, each manager should have a performance measure that addresses the number of missed signatures on timecards by pay period and that measure should be used in part during their annual performance evaluation. An example of an appropriate performance measure is that no manager shall have more than two pay periods with an incident of an unsigned or unapproved timecard.

Recommendation: *Ensure employees and managers review, approve, and sign timecards for every pay period.*

2.6 RECRUITMENT AND RETENTION

CHS has experienced both recruitment and retention challenges in the recent past. While it is true that nursing recruitment is highly competitive since they are in high demand and could work in a variety of different clinical settings (hospitals, nursing homes, jails, etc.), the County recognizes these challenges and has been actively working to improve recruitment efforts and retention rates.

The County human resources department created a "Registered Nurse (RN) Recruitment and Retention Recommendations" document, dated May 14, 2021, in which several recommendations were made. These recommendations included a $6,000 RN sign-on incentive (paid in three parts over a two-year time). This sign-on bonus is expected to help recruitment efforts; however, it is not helping with retention of existing staff.

RN Bonuses

CHS should consider offering the same "sign on" bonus amount as a retention bonus to existing RN staff, also paid out over a two-year period. Eligibility will be for any RN currently employed with CHS who was not eligible for a sign-on bonus. If the RN receives a minimum of a satisfactory score on the next performance evaluation, one year from the date of approval of the retention bonus that employee is eligible for a bonus. Two years from approval of the retention bonus and with another standard or higher performance evaluation, that same employee will be eligible for another retention bonus. This provides incentive for RN's not to leave CHS employment and look for a "bonus" elsewhere and it provides a more even playing field for all registered nursing staff. The exact amount of the bonus should be up to CHS leadership and be dependent on budgetary approval; however, a recommended amount would be the same dollar value as the current RN new employee sign on bonus.

Recruitment and Retention Efforts Overview

Recruitment and retention efforts include the RN sign-on bonus mentioned above, additional funding for critical recruitment and retentions, working on an H-1B visa RN recruitment program, social media presence, modernizing recruitment brochures, cold calls, establishing relationships with nursing schools, attending job fairs, partnering with workforce development, implementing expedited job offers and onboarding processes, relocation packages, flexible work schedules, 24/7 leadership support, improved NEO, “mandatory kindness training”, increasing leadership and other training opportunities, and implementing new medication dispensing machines. While each of these initiatives is great in theory and some have been very well received, not all of them have been rolled out successfully.

Nursing Shifts

Several nursing staff indicated they want to work 12-hour shifts, similar to their hospital counterparts. CHS should continue with an additional study to determine the feasibility and appropriate implementation of 12-hour nursing shifts for direct patient care clinical staff.

New Hire Interviews

The current process for bringing new staff onboard is one that does not always follow the same path from the beginning. Different CHS or HR employees conduct interviews and information from newly hired nursing staff indicate that they are frequently not told about the need to float or what the work environment is really like. While every applicant likely understands they will be working in a correctional institution setting, one’s perceived work environment compared to being inside a jail for 40+ hours each week can be different.

To reduce risk of losing newly hired employees due to an incomplete understanding of the CHS working environment, CHS should implement a process that ensures all applicants receive the same information on the work environment in a correctional health setting, everyone receives the same information about the need to float to different clinics, and everyone receives a tour of at least one jail facility. More “truth-in-advertising” should reduce subsequent turnover.

CHS has many excellent qualities that appeal to employees and while these qualities are important to communicate with new applicants, being honest about the work environment is also very important. Ideally and within the confines of staffing constraints, each new clinical patient care applicant should be required to spend two (2) hours shadowing a “peer” classification prior to moving forward in the application process. This peer shadowing can occur later in the application process, but it should

occur before hiring. The clinical float team (addressed in Chapter 3) would be an ideal place for this shadowing to occur, as these team members are all trainers and they each regularly float to different clinics.

Nursing Pay Structure

Nursing pay is just one part of recruitment and retention efforts, but with nursing shortages throughout the Phoenix area (and nation), it takes on slightly more importance than it otherwise might. CHS developed a "Premium Pay Plan Policy/Procedure" that was effective October 14, 2021. This document is well developed and provides for a variety of financial stipends to hourly rates to both recruit and retain highly qualified staff in difficult-to-fill positions. Updated information shows the average RN pay in the Phoenix area for prison / correctional nurse roles is[2]:

- Scottsdale $82,893
- Tempe $80,052
- Phoenix $78,117
- Gilbert $77,039
- Yuma $73,873

Registry rates are reported to be in the range of $60 per hour for an RN position. The County's own analysis done in May 2021 indicates area RN wages are as high as $55.66 per hour. The annual market average RN salary with a "jail premium" is between $67,333 and $108,821 annually.

The County's study results recommended an increase in RN pay to $32.37 - $52.32 per hour. To be competitive, this pay range should be implemented and ideally, the starting salary should be higher if the organization wants to attract newer nurses. The County will need to consider whether to increase the top end pay as well or allow compression to occur between the starting and top out salary. The exact rate of pay CHS should offer is dependent on additional analysis; however, CHS should continue to analyze its pay structure for difficult to fill positions and remain market competitive.

Recommendation: *Offer current RNs who were not eligible for a sign-on bonus with a similar bonus, paid out over a two-year period.*

Recommendation: *Complete a staffing study that includes an evaluation of the ability to implement 12-hours per day, 36-hours per week direct patient care nursing schedules.*

[2] Wage data come from GHR Travel Nursing, Indeed, nurse.com, and Glassdoor.

Recommendation: *Implement a process that ensures all applicants receive the same information on the work environment in a correctional health setting, and everyone receives the same information about the need to float to different clinics.*

Recommendation: *Each new clinical direct patient-care applicant should be required to spend two (2) hours shadowing a "peer" classification prior to moving forward in the application process.*

Recommendation: *Continue to assess the pay structure for difficult to fill positions to remain market competitive.*

2.7 POLICY REVIEW AND MODIFICATIONS

Overall, CHS policies are very good as they are consistent with NCCHC requirements. Current policies include governance and administration, disease prevention, ancillary health care services, personnel and training, patient care and treatment, special needs and services, medical-legal, and clinical.

Overall Policy Review

An assessment of existing policies revealed that some of them were last reviewed several years prior. For example, there are several "Clinical Practice Guidelines" that reference standards or scientific journal articles from over 10 years ago. These should be reviewed by the medical director and DON or designee for current applicability.

Numerous policies were specific to each clinic even though they dealt with topics applicable throughout CHS operations. While it is understood that accreditation requirements require site-specific policies, that might not mean that each location must have their own full set of policies. Policies that are clinic-specific but applicable to each clinic can make it more difficult for employees to ensure they are following proper policies / procedures. Policies and procedures should generally be uniform throughout all work areas within CHS with site specific policies provided only when that site must do something differently. CHS should confirm with their accreditation manager on the reasonableness of providing site specific policies only when something must be done differently at that site.

The department is currently performing a comprehensive policy review utilizing a team of employees from throughout the organization. This process should continue, and the department should not hesitate to bring in an outside policy writing consultant to help facilitate this process. Policy-related recommendations are meant to help reduce employee sick leave call outs, improve morale related to the newly adopted CHS time

and attendance policy, and address a concern related to an on-call policy for nurse leadership.

Reducing employee sick leave call outs

As identified in section 2.3 of this report, there were 227 call outs over a three-week period, averaging 10.81 call outs per day. Per County policy HR2415, "EMPLOYEE LEAVE", classified employees earn sick leave at a rate of 0.0333 hours per paid hour worked with a cap of hours earned ranging from 40.0 hours a year to 59.8 hours per year, depending upon months of credited service.

An option for consideration to reduce the number of sick leave call outs for employees who could have come to work is to offer an incentive to employees who either do not use any sick leave in a year or use a yet to be determined low amount of leave. The key is to offer an incentive to "not use" sick leave unless it is necessary and appropriate. As recommended below, not counting a sick leave day toward the time and attendance policy if the employee brings in a doctor's note for the leave is another way to help reduce call outs.

Because it generally costs more money to backfill positions with the use of registry or in-house staff working at overtime rates, it could cost the County less money to offer an incentive for sick leave time not used throughout the year. There are different methodologies to consider; however, due to the potential costs involved and with the knowledge that only clinical employees have their shifts backfilled, any potential buy back should be limited to only clinical positions with direct patient care responsibilities.

This recommendation could have implications on county policy outside of CHS and therefore any modification to existing policy should be specific to working in a correctional environment with direct patient (inmate) contact. It is important to remember that sick leave is a county offered benefit and the intent with any incentive is not to encourage someone from not utilizing that benefit if needed, but rather to discourage employees from calling out sick when in fact they knew they could have come into work that day. CHS should evaluate the potential cost savings from a sick leave buyback program as compared with the use of employees on overtime or the use of registry to cover vacant direct-patient care clinical shifts.

Time and attendance policy

The department recently implemented an updated "Time and Attendance" policy, updated November 8, 2021. This policy was implemented in part to address the growing number of call outs by employees who might not actually be sick. The concern is that

employees are provided with a county benefit of earned sick leave and the policy appears to punish employees for using their benefited leave time – even if they are sick.

Interviews revealed that numerous employees were upset with this policy as they feel it punishes the employees who show up to work every day by having them being written up for leaving work a few minutes early after having been called in hours early for their shift or for using sick leave when they are actually sick. If an employee is called in four hours early and works those four hours plus their entire shift, but wants to leave 10 minutes early because his or her replacement is present and briefed, a supervisor should have the discretion to approve the employee leaving "early" without that employee risking disciplinary action against them.

With 50.67% of all leave during the analysis period taken due to combined sick and FMLA reasons, it is understandable that the department updated its time and attendance policy to address the systemic sick call outs throughout numerous areas within CHS – with the assumption that it was possible that some of them were not due to illness or injury.

As employees earn sick leave and it is a county benefit to use it, there should be more discretion in implementation of disciplinary action. As the policy currently stands, an employee with ten (10) occurrences is subject to dismissal. In the unfortunate case that an employee is sick for a couple of days over a weekend or a county holiday three times in a year, then by policy they are subject to termination. Such strict adherence to what was intended to reduce unnecessary sick call outs is likely increasing employee anxiety and decreasing morale.

The policy should be modified so that if the employee brings a doctor's note to work after their illness, then it will not count as an "occurrence". Current policy suggests the employee should provide a doctor's note if absent for at least three days but stays silent on whether it still counts toward an occurrence or what happens with less than a three (3) day absence. Combine this with the implementation of a sick leave buy-back program and the department should realize improved employee morale and fewer sick call outs.

On-call policy for nurse leadership

CHS's on-call policy for nurse leadership requires nurse managers to be on-call for 12-hour shifts, including holidays and weekends, without compensation for that additional workload. While true that nurse managers are exempt employees and are not subject to FLSA's overtime rules, there is currently a high vacancy rate for the nurse manager

position and ensuring nurse managers receive fair compensation for having to put in a lot of extra hours each month would be appropriate.

CHS may have other ideas on a fair benefit for on-call nurse managers; however, the point is that interviews with nurse managers revealed that while some of them do not get called very often, others seem to take several phone calls while on-call. One nurse manager commented that they are authorized to adjust out their work shift based on how many calls they took while on-call, while other nurse managers said they do not receive that benefit. The policy should be uniformly applied to all nurse managers.

CHS should consider providing nurse managers with a benefit for being on-call. While some on-call will result in no calls to a nurse manager, other times might result in several time-consuming calls. Regardless, being on call means the nurse manager will not be able to be totally free of work responsibilities and as such CHS should consider some sort of equally applied benefit for all nurse managers for time spent in an on-call status.

***Recommendation**: The medical director and director of nursing should review all "Clinical Practice Guidelines" to ensure the reference material is still appropriate and applicable.*

***Recommendation**: Policies and procedures should generally be uniform throughout all work areas within CHS and CHS should consult with their accreditation manager to ensure site specific policies are only applicable when a site does things differently than other sites.*

***Recommendation**: CHS should continue with its comprehensive policy review, with the understanding that some employees currently tasked with writing policies do not have policy writing or policy development experience.*

***Recommendation:** Consider an incentive to CHS clinical staff with direct patient care responsibility if they use little-or-no sick leave throughout the year.*

***Recommendation**: Explore the possibility of modifying County HR policy HR2415 "Employee Leave" to allow CHS clinical employees with direct-patient care responsibilities to buy back 100% of their earned and accumulated sick leave each year or offer a once-a-year bonus to those employees if they had no or limited sick time usage throughout the year.*

***Recommendation**: Modify CHS's "Time and Attendance" policy so that if an employee brings a doctor's note for being sick or injured that would lead a reasonable person to believe they should not work a particular shift, that that sick leave will not count as an "occurrence" toward potential disciplinary action.*

***Recommendation**: Modify CHS's "Time and Attendance" policy to remove the statement under section II "Policy" that says employee are expected to remain at work for their entire work schedule. Managers must have discretion to approve an early shift departure.*

***Recommendation**: Modify CHS policy "On-Call Policy for Nurse Leadership" to provide nurse managers with a compensated benefit for being "on-call".*

2.8 HUMAN RESOURCES MANAGEMENT

While discussing the workplace environment with CHS employees, there were several who reported a concern about how they felt regarding previous human resources (HR) employee interactions with which they were involved. Concerns ranged from HR employees doing management's work, to not necessarily being thorough with a workplace investigation, to not responding to emails or phone calls.

Some concerns were related to HR taking on a management responsibility role, such as informing employees of a promotion or informing them of the results of a disciplinary investigation. While it is not necessarily wrong for HR to assume this level of responsibility, better practice is for a manager to take these opportunities to meet with the employee and discuss the promotion of disciplinary matter. Human resources staff should be used by management as a support tool, rather than as an extension of the manager himself or herself. If HR conducts a workplace investigation, the results of that investigation should be provided to the involved employees' manager(s), who should be the ones to inform the employee(s) of any outcomes.

Regardless of the accuracy of these reports, it is appropriate to ensure the deputy director provides CHS oversight over HR functions that affect CHS operations. The deputy director should routinely meet with non-HR staff to solicit input on HR performance. Managers have opportunities to connect with employees to inform them about workplace decisions (including promotions, reassignments, discipline, etc.) and while HR can perform these functions, they generally be completed by management.

***Recommendation:** The deputy director should regularly solicit input from non-HR staff related to HR performance.*

***Recommendation**: CHS management should use human resources employees as a tool to assist them in their work as they are a support group, rather than using them as an extension of the manager himself or herself.*

2.9 PERFORMANCE MEASURES

Within CHS operations, employees have goals and objectives to meet for their annual evaluation (discussed in more depth in section 2.10, Performance Evaluations); however, there generally are not formalized performance measures in place within CHS for which most employees are aware. Highly successful public organizations often have established performance measures that they develop, communicate, apply, monitor, and evaluate on a regular basis.

Once established, senior management should review success toward each measure monthly while communicating with the team any successes or needs to adjust performance to meet expectations. Employee performance evaluations are often based in-part on one's own contributions toward the achievement of success with established organizational performance measures.

Every performance measure should have its intent listed along with necessary data structures. While the selected benchmarks for each of these measures may be different, they show the core data types which should be collected, reported upon, and compared to a standard to realize the benefits of continuous performance measurement and improvement.

There are numerous professional organizations that can provide useful performance measure benchmarks for CHS to consider. According to the U.S. Department of Health and Human Services Health Resources and Services Administration, the areas of finance, operations, and clinical care are core essential areas to have established performance measures to gauge organizational success. They recommend performance measures for each of the following six focus areas:

- **Safety** – avoiding injuries to patients from the care that is intended to help them.
- **Effective** – avoiding underuse and overuse.
- **Patient-centered** – providing care that is respectful and responsive.
- **Timely** – reducing wait times and potential harmful delays.

- **Efficient** – avoiding waste of equipment, supplies, ideas, and energy.
- **Equitable** – providing care that does not vary in quality[3].

Additionally, five keys to management success are as follows:

- Measurement.
- Leadership.
- Continual improvement management.
- Knowledge management.
- Strategic business planning.

Each of these areas should have at least one performance measure developed in coordination with CHS and county management, with employees held accountable for achieving the performance measures.

The following is an overview of local government performance measures:

- A tool to assist in the evaluation of the quality and effectiveness of operations. It is accomplished by collecting, analyzing, and reporting performance-related data.
- Measures can be based on inputs (resources used), outputs (activities performed), efficiency measures (ratio between inputs and outputs), or outcomes (results achieved).
- Government accountability is often a driving factor in local government use of performance measurement.
- Align measurements with your strategic goals. What has the greatest effect on the people served? Tie to outcomes when possible.
- What is the measure? Why is it important? How are we doing?

[3] Performance Management and Measurement, retrieved from https://www.hrsa.gov/sites/default/files/quality/toolbox/508pdfs/performancemanagementandmeasurement.pdf

An example of information that could be published on the CHS's website to highlight transparency and how the department is doing toward accomplishing their performance measure objectives is as follows:

What is the measure? Retention after one year for new hire CHS clinical employees is 85% or greater.

Why is it important? Employee retention is vital to the overall success of CHS operations. Hiring an employee is costly and retention of good employees can reduce productivity loss, assist with recruitment efforts, reduce the loss of institutional knowledge, improve overall organizational performance, and maintain a higher-level of overall positive employee morale.

How are we doing? In the most recent fiscal year, CHS retained 86.25% of its clinical employees.

The following table provides an overview of suggested performance measures that can be adopted by CHS:

Table 5: CHS Performance Measures

Measure	Intent	Necessary Structures	Suggested Benchmark
Timely Access to Healthcare Services			
Health Needs Requests Response Times	This measures the time it takes for CHS staff to respond to a patient Health Needs Request. Times will vary depending on fluctuations in staffing levels, patient acuity, and other factors; however, if the average response time is high, that could be indicative of a need to perform a root-cause analysis.	Management will monitor and record all patient Health Needs Requests on a weekly basis.	≤ 24 hours
Employee Recruitment and Retention			

Measure	Intent	Necessary Structures	Suggested Benchmark
Employee Recruitment Events	CHS will hold recruitment events to ensure job seekers are aware of the benefits of working for Maricopa County CHS.	Human resources and CHS management will coordinate recruitment events.	≥ 3 recruitment events annually
Employee Recruitment Success	Recruitment events must be effective at attracting individuals to apply for a position with CHS.	HR will maintain records of the number of events held v. the number of applicants from those events.	≥ 15 applicants per event
New Hire Employee Retention	This measures the amount of new hire employee turnover within one year of hire.	HR will monitor and evaluate employee turnover within one year of hire.	≤ 15% turnover rate for new hire employees
Employee Retention (at least one year of service)	This measures the amount of employee turnover for staff with at least one year of service.	HR will monitor and evaluate employee turnover for staff who have at least one year of service.	≤ 8% of employees with at least one year of service
Employee Leadership Development			
Number of new supervisory employees offered leadership training	This measures employee leadership development opportunities provided.	CHS will need to maintain accurate employee leadership training records	≥ 95% of new supervisory employees
Employee Satisfaction			
Number of employees who indicate they are satisfied with their CHS work environment.	This measures employee job satisfaction with the ability to compare results year-over-year.	Management will conduct employee job satisfaction surveys on an annual basis.	≤ 80% of employees indicate an overall level of job satisfaction

These are recommended performance measures and there should be more of them, created in conjunction with County and CHS leadership. Once measures are developed and adopted, they must be communicated and routinely monitored by CHS management to ensure they are on-track and that they are successfully achieved each year. Employee performance appraisals should be linked to completion of performance measures.

Recommendation: *Adopt performance measures for the department, communicate them with employees, regularly review progress toward successful completion of the measures, and hold employees accountable for performance measure success.*

2.10 EMPLOYEE PERFORMANCE EVALUATIONS

Non-Management Employees

Employee performance evaluations are held annually. Discussions with numerous employees revealed that there are goals and objectives attached to an employee's performance evaluation; however, the employees often believe that there isn't much effort put into what these goals are, and they are often not discussed with the employee again until the next annual evaluation.

To be most effective, goals and objectives should be developed between employee and manager, with the manager reviewing progress toward goal completion with the employee at least quarterly. As is recommended later in this report, managers should meet with their direct report employees at least quarterly and during this time, the manager should review the employee's progress toward performance evaluation goal and objective completion.

There can be significant benefit if employee goals and objectives are directly tied to CHS performance measures. Both manager and employee should review performance measures to determine how the employee's goals and objectives can directly or indirectly contribute toward performance measure success.

Management Employees

Information from interviews revealed that not all managers were keeping notes on employee performance and some employees reported having their evaluations completed by a brand-new manager, within weeks of supervising the employee, without the benefit of any prior notes on that employee's performance. It is essential that management employees keep written notes on each of their direct reports to aid in the completion of an annual performance evaluation.

Employee job satisfaction within CHS at the time of the assessment was very low. A tool to better identify possible concerns in the workplace is to consider the use of a 360-degree evaluation for all CHS managers. A 360-degree evaluation involves multiple organizational stakeholders completing an evaluation on the manager, with the results used (in-part) in determining the manager's overall performance. The use of a 360-degree evaluation for managers should result in the identification of possible management concerns early on as well as let employees know that County management takes seriously their views on manager performance.

***Recommendation**: Employee goals and objectives for the employee's annual performance evaluation should be developed between manager and employee.*

***Recommendation**: Employee goals and objectives should be linked to established CHS performance measures when possible.*

***Recommendation**: Managers should keep employee performance notes throughout the year, to assist whoever completes an employee's annual performance appraisal evaluation.*

***Recommendation**: Manager evaluations should use a "360 evaluation" tool to obtain views from multiple organizational stakeholders as to the effectiveness of that manager's workplace performance.*

2.11 PROJECT MANAGEMENT QUALITY CONTROL

A concern heard from several employees at all levels of CHS was that there are many special projects ongoing, sometimes one on top of the other, and projects aren't always rolled out effectively. Employees whose job description is not that of a project manager are often assigned project management responsibilities and while the employees are likely capable of performing adequately in this function, it not only takes away from their primary job responsibilities when they are assigned project management tasks, it also can lead to a project that is not necessarily managed as it would be by someone whose primary job is that of project manager.

Project management quality control will be better served and thus will reduce risk that projects will not be completed timely, within budget, or completed effectively with the implementation of a new classification within CHS as "Special Projects Manager". This recommendation is provided within Chapter 3 of this report.

Any employee responsible for project implementation and project management should be trained in project management functions. The Project Management Institute provides project management training and certification and is commonly used by local government employees responsible for project management success. The certification emphasizes the soft skills needed to lead a project team in a changing environment, it reinforces the technical aspects of successfully managing projects, and it highlights the connection between projects and organizational strategy.[4] To best achieve excellent results with all aspects of project management quality control and successful outcomes, CHS should ensure that its project managers are trained and certified in project management.

Recommendation: *Assign project management quality control for all CHS projects to a "Special Projects Manager".*

Recommendation*: Project managers should receive project management certification from the Project Management Institute.*

2.12 INMATE GRIEVANCES AND HEALTH NEEDS REQUESTS

Multiple reports from different clinics are that inmate grievances and health needs requests are not being responded to in a timely manner. There are several reasons provided, including being short staffed by MCSO, short staffed at CHS, and not having clear direction from nurse managers on what the priorities are to be for nursing duties when short-staffed (previously addressed under section 2.2). While inmate grievances can be completed with a computer tablet, they can also be handwritten. A report from nursing staff was that numerous health needs requests were found in a desk drawer – "weeks" after they were completed and filed by the inmate.

In addition to grievances being required under the Prison Litigation Reform Act, from both an accreditation standpoint and more importantly to reduce risk of possible medical harm coming to a patient, medical grievances and health needs requests should be addressed within 24 hours of receipt. To reduce risk of not meeting the 24-hour timeframe for responding to grievances and health needs requests, each nurse manager should be required to file weekly reports with the assistant director of nursing - operations (this position is addressed in Chapter 3) identifying whether medical grievances or health needs requests exceeded this 24-hour timeframe.

These reports should indicate the number of electronic and manual grievances and health needs requests received as well as the status of each request. Any request that

[4] https://www.pmi.org/certifications/project-management-pmp

took longer than 24 hours to address shall require a written explanation from the nurse manager. While this process will take time to complete, the value of ensuring these important tasks are completed outweighs the extra effort to file these reports.

The ADON should sample a portion of each weekly data to ensure its accuracy and address any matters of concern related to systemic issues with delayed responses to health needs requests or grievances.

***Recommendation**: Nurse managers should file a weekly report to their ADON on the number of health needs requests and inmate grievances submitted and the status of those requests / grievances.*

***Recommendation**: The ADON (operations) should sample a portion of weekly nurse manager reports on the status of inmate health needs requests and grievances to ensure their accuracy – while addressing any systemic issues with delayed responses to these requests / grievances.*

2.13 STRATEGIC PLANNING

Strategic planning is the process of identifying long-term goals and objectives for an organization and determining how best to achieve them and there is value to strategic planning within the CHS organization.

The process to perform effective strategic planning at an organization-wide level is not currently being done at CHS; however, the mental health division is currently undergoing a strategic planning process following a known / established process. The CHS mental health strategic planning process is inclusive of multiple stakeholders, and it provides the group the opportunity to create a vision for what they want to accomplish in the future as well as a roadmap of how to get there. This strategic planning is important to keep the organization and each division / unit focused on the bigger picture and how to get there. The process followed within mental health is recommended when the time is right to complete strategic planning at an organization-wide level.

CHS employees generally feel very overworked and as if they do not have time to take on any more responsibilities. CHS will soon have a new director appointed and this person needs time to assess operations and provide important input into the strategic planning process. This will allow CHS management time to continue implementing important modifications to existing management work processes as well as give employees time to “catch their breath”.

There are a lot of changes happening right now and we recommend beginning the strategic planning process at an organization-wide level between 6 and 12 months after a new director begins work. The new director should have time to listen to employees and understand what will be necessary to guide the organization's future. While strategic planning is important, delaying implementation for a few months would be beneficial in this instance.

Recommendation: *Begin an organization-wide strategic planning process between 6 and 12 months after a new CHS director is in place.*

2.14 VALUES STATEMENT

While a mission statement is a concise statement of an organization's reason for existence and a vision statement provides a forward-looking viewpoint of the organization's "ideal state", a values statement lists an organization's core principles. It is this values statement that guides and directs employee actions and helps shape organizational culture. The Society for Human Resources Management lists three questions to consider when crafting an organization's values statement:

- What values are unique to our organization?
- What values should guide the operations of our organization?
- What conduct should our employee uphold?[5]

Many organizations that have adopted values statements often have several "values" they adhere to, with the goal for employees to know them and to live by them. There are some cultural challenges within the CHS organization and employees should be provided with a values statement that is simple and direct – to guide their actions and interactions with others. These interactions must include dealings with subordinates, peers, MCSO, clients, and supervisors.

After having visited all clinic locations and spending hundreds of hours with CHS staff assessing the workplace environment, the project team believes that CHS should consider the adoption of a values statement that is exceptionally simplified and can guide employee behavior throughout the organization. The values statement can be one word: "Caring". To display kindness and concern for others is a value that can guide all CHS actions and interactions across and throughout the organization.

[5] Retrieved from the Society for Human Resources Management at https://www.shrm.org/resourcesandtools/tools-and-samples/hr-qa/pages/isthereadifferencebetweenacompany%E2%80%99smission,visionandvaluestatements.aspx

Employees display an incredible amount of caring for patients and adopting a values statement with “caring” as the value, it can also guide everything else that employees do, whether as a provider, an RN, an LPN, a CHT, a mental health professional, an administrative support member, or any member of management. Organizational culture often takes significant time to change; however, the CHS executive team should evaluate the potential significant positive outcomes associated with using the value of “caring” to guide actions and interactions throughout the organization.

***Recommendation**: The CHS executive team should consider the adoption of a simplified values statement of one word: “Caring”, to guide employee work actions and interactions.*

2.15 MCSO POWER SQUAD UTILIZATION

CHS and the sheriff’s office have an agreement on the utilization of “power squad” members to assist CHS with completion of their responsibilities. As every interaction with CHS and an inmate (client) must have MCSO involvement to some degree, CHS has an agreement where a “power squad” is created and these MCSO detention officers are paid for from CHS, while working for the sheriff’s office. In a perfect world, the power squad is available 100% of the time to ensure that CHS medical staff can interact with their clients with little to no delay.

There are times in which MCSO needs to pull these power squad members to cover other detention-related responsibilities and yet other times in which MCSO staffing levels are such that the facility is essentially on lock-down. When this occurs, it is sometimes more difficult for CHS staff to obtain MCSO’s timely assistance in being able to interact with CHS clients.

The power squad methodology can be highly effective when it is adequately staffed and the overwhelming response from CHS employees was that they like and get along very well with MCSO staff. To alleviate concerns with power squad members not being readily available to assist CHS staff with their assigned job responsibilities, the medical director, chief of psychology, and forensic services supervisor should hold monthly meetings with MCSO leadership to discuss any issues related to power squad usage. Hopefully everything is going smoothly; however, if any adjustments need to be addressed, this is an appropriate venue for those timely discussions.

If MCSO is regularly using CHS “power squad” staff for their own purposes (which they can do as they are MCSO employees), then there should be an agreement in place that MCSO shall be required to pay for the salary of those employees for the hours they

were not readily available to CHS staff. These issues should be worked out and regularly addressed in the monthly meetings.

Mental health staff are required to make routine contact with clients and must also have the assistance of MCSO to do this. Power squad members are generally used for medical staff; however, there would be benefit to having at least one MCSO employee assigned to psychiatric and mental health staff at each clinic during the hours in which these staff are working.

Based in part on the recommended reporting relationship reorganization, every month the medical director, chief of psychiatry, and forensic services manager should meet with MCSO leadership to discuss power squad utilization.

An additional consideration for CHS is to explore non-traditional means for seeing patients outside of the typical clinical areas, such as the possibility of utilizing mini-clinics.

***Recommendation**: The medical director, chief of psychiatry, and forensic services manager should meet monthly with MCSO leadership to review the effectiveness of that month's power squad utilization.*

***Recommendation**: When power squad members are not available for use by CHS staff, then CHS should not be required to pay for that employee's salary for the times they were not available.*

***Recommendation**: Consider the costs and benefits of assigning at least one power squad member to assist psychiatric and mental health staff at each clinic during the hours these staff are working.*

***Recommendation**: Consider the costs and benefits of the use of non-traditional means for seeing patients, such as the use of mini-clinics throughout the jail system.*

2.16 NURSE RESIDENCY PROGRAM

A nurse residency program focuses on new entry-level nurses to provide opportunities for them to learn and improve as they transition into practice. There is an evidence-based curriculum that incorporates three key areas:[6]

- Leadership

[6] https://www.aacnnursing.org/nurse-residency-program

- Patient outcomes
- Professional development

Nurse residency programs are often paid residencies designed for nurses with less than a year of nursing experience. The graduates work directly with a preceptor (trainer) for hands-on instruction and classroom-style lectures. By participating in the nurse residency program, CHS will have the opportunity to provide valuable learning opportunities for new nurses, to have additional nursing help, and to possibly recruit these nurse residents to become employed with CHS long-term. With the challenges facing CHS staffing, there may be benefit for participating in a nurse residency program. Nurses in a residency program are in a separate classification and can be paid at a separate compensation rate.

These nurses gain valuable experience, CHS obtains needed help while paying a lower overall rate, and hopefully the new nurse will remain with CHS after completion of the program. According to the AACN nurse residency fact sheet, the national average for new nurse retention after one year is 82.5%; however, that rises to 90.4% for nurses in a nurse residency program.

***Recommendation**: CHS should evaluate the costs and benefits of participating in a nurse residency program.*

2.17 STANDARDIZATION OF FORMS AND PROCEDURES

According to interviews with clinical staff, the forms used at different clinics are not always the same. These forms are reported to be for a “Man Down / Rapid Response” and “ER Send outs”. Because the information on these forms will not need to be unique to an individual clinic, they should be standardized and implemented throughout the CHS organization. Employees further report that there is little-to-no standardization of processes for many basic procedures used at different facilities.

When an organization has multiple locations but is responsible for doing the same or a similar function at each location, those functions should be essentially the same. If an employee floats from one facility to another, that employee should know the forms and procedures in use at “their” facility will be the exact same ones used at the other facility. The more standardization of processes that exist between each of the clinics within CHS, the less risk of unintentional employee error in completing a form or following an established process. According to the Harvard Business School, organizations standardized process for several important reasons: it facilitates improved communications about how the organization operates, it can enable smooth handoffs

across operational boundaries within an organization, and it makes it possible to compare measures and performance[7]. Improving on existing standardization between locations should help CHS further improve accountability, provide for better patient outcomes, and allow for more opportunities to improve processes and educate staff.

While standardization of forms and processes should be improved within CHS operations, it is important for management to remember that according to the Society for Human Resources Management (SHRM), organizations should still allow some flexibility to achieve results at different work sites by focusing more on outcomes than specific processes and procedures[8].

The medical director, director of nursing, nurse managers, and other members of the CHS executive team should meet to review where processes and forms are not currently standardized across multiple locations to determine whether standardization is appropriate. The medical director should ultimately be the decision maker as to the standardization of forms and procedures.

***Recommendation**: The medical director, director of nursing, nurse managers, and other members of the CHS executive team should meet to review where processes and forms are not currently standardized across multiple locations to determine whether standardization is appropriate.*

2.18 MEDICATION HOLIDAYS

A medication holiday is the intentional interruption of pharmacotherapy for a specific purpose and a defined period. Medication holidays can be used for the assessment of efficacy and tolerability of drug therapy and simultaneously provide relieve to the number of medications passed for one or two days each week.

From interviews and available data, medication passes are missed with some degree of regularity. A medication holiday has the potential to improve med pass effectiveness while not causing patient harm. A medication holiday will involve collaboration with the medical director, pharmacist, chief of psychiatry, and director of nursing. They will review individual patient medical records to determine if a patient really needs all medications and if so, do they need them every day of the week. If appropriate, a medication holiday is implemented for medication that is not mood stabilizing or

[7] Harvard Business School, retrieved from https://hbswk.hbs.edu/archive/the-benefits-of-business-process-standards
[8] The Society for Human Resources Management, retrieved from https://www.shrm.org/hr-today/news/hr-magazine/spring2020/pages/5-tips-for-working-with-employees-at-multiple-sites.aspx

required to sustain life and as an example, a 500-pill med pass is reduced to a 100-pill med pass two days per week.

Additionally, the clinical team should audit actual medication pass times. Combining medications that don't have interactions will decrease the time it takes to complete a medication pass. While never missing a medication pass is ideal, it is better to have all mood stabilizing and life-sustaining drugs provided than not at all due to a missed medication pass.

***Recommendation**: The medical director, pharmacist, chief of psychiatry, director of nursing, and other executive staff should consider the costs and benefits of implementing a "medication holiday" to improve medication pass effectiveness.*

CHAPTER 3: ANALYSIS OF STAFFING, ORGANIZATIONAL STRUCTURE, AND LEADERSHIP

Staffing levels, organizational structure, and leadership are all vital areas for the CHS organization as these provide for a solid foundation for future success. The following are recommendations to further improve staffing, organizational structure, and leadership within CHS operations.

3.1 EMPLOYEE TURNOVER

This section is provided as an overview of historical CHS employee turnover as it will provide the foundation for the recommendations found later in this chapter.

Data in the table below show the authorized positions and vacancy rate for those positions as of the end of November 2021.

Table 6: Authorized Positions & Vacancy Rates

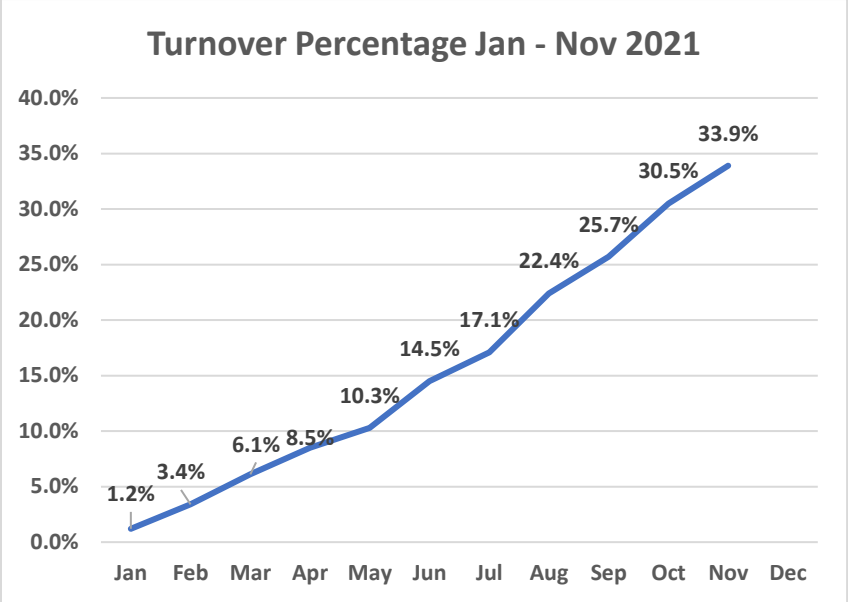
Position	Authorized Positions	Filled	Vacancy Rate (%)
Mental Health (all classifications)	84	63	25%
CHT	72	60	16.67%
LPN	69	36	47.83%
RN	110	86	21.82%
Nurse Manager	16	9	43.75%
Provider (all classifications)	51	49	3.92%
Administrative (all classifications)	45	40	11.11%

Data show that for all nursing positions, there was a 28.47% vacancy rate (267 authorized positions with 191 of them filled). Provider positions had the lowest vacancy rate at 3.92%, while LPN positions had the highest vacancy rate at 47.83%. This data is a snapshot in time for the then-current vacancies. The closer an organization is to having a less then 10% annual turnover rate, the better since turnover costs the organization money (recruitment, training, overtime to fill open positions, etc.), there is a loss of institutional knowledge, and high turnover can be a contributing factor for lower employee morale. The following data is historical turnover for various positions within CHS.

The project team analyzed turnover data from January 2021 through November 2021, which represents 91.67% of an entire year. During this time there were 140 terminations, of which 89.29% of them were voluntary resignations. Of all terminations, 24 were CHTs (17.14%), 22 were LPNs (15.71%), 35 were RNs (25%), and 8 were

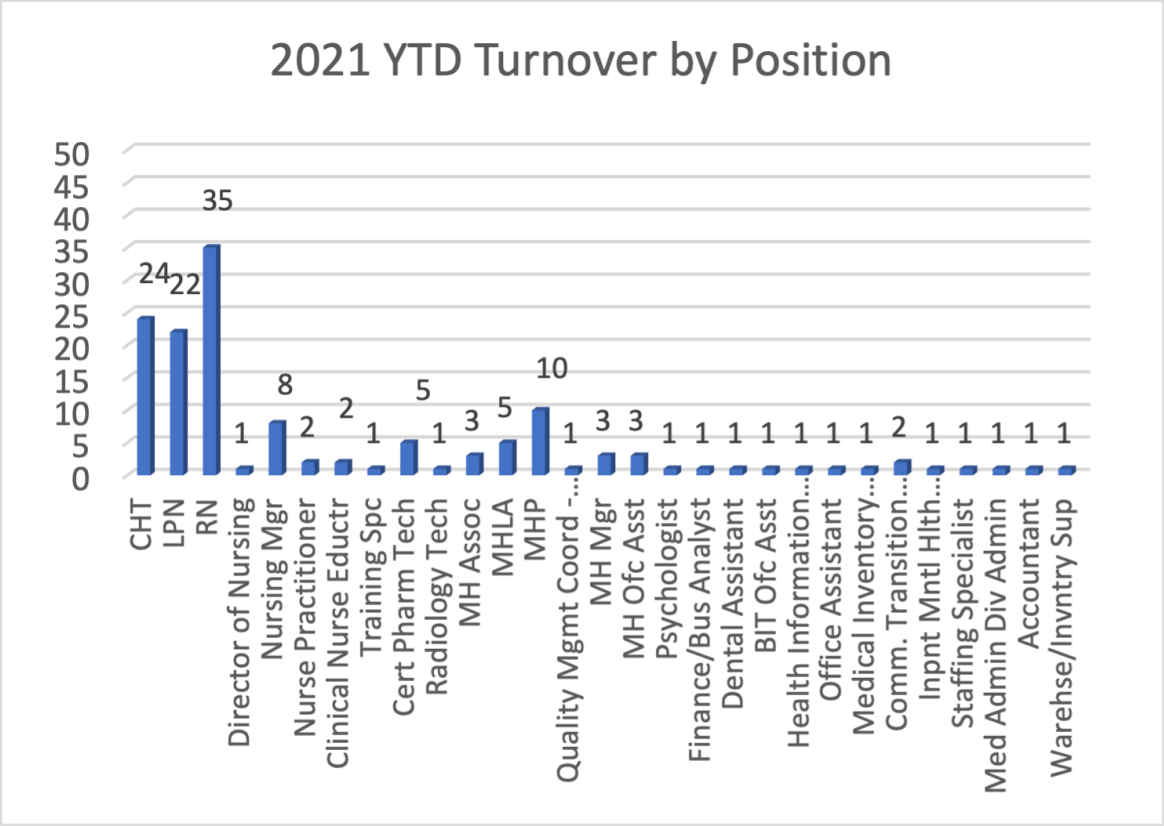
nurse managers (5.71%). The following figure shows that 33.9% of the entire CHS workforce turned over during the first 11 calendar months of 2021.

Figure 6: 2021 Turnover as a Percentage of the Workforce



Data show that over 10% turnover occurred just within the first five months of the calendar year.

Figure 7: 2021 Turnover Jan - Nov by Position



From leadership to recruitment, to retention, to organizational structure and shift work / floating – each of these functional areas can have an impact on employee turnover.

While there are numerous reasons for employee turnover, CHS leadership should be held accountable for improving annual nursing turnover percentage rates. One of the performance measures (as discussed in Chapter 2, section 9) that CHS should establish is an annual voluntary turnover percentage of no more than 10% for each department and division (e.g., nursing, psychiatry, providers, mental health).

***Recommendation**: Create an annual performance measure for voluntary turnover by department and division to be no more than 10%.*

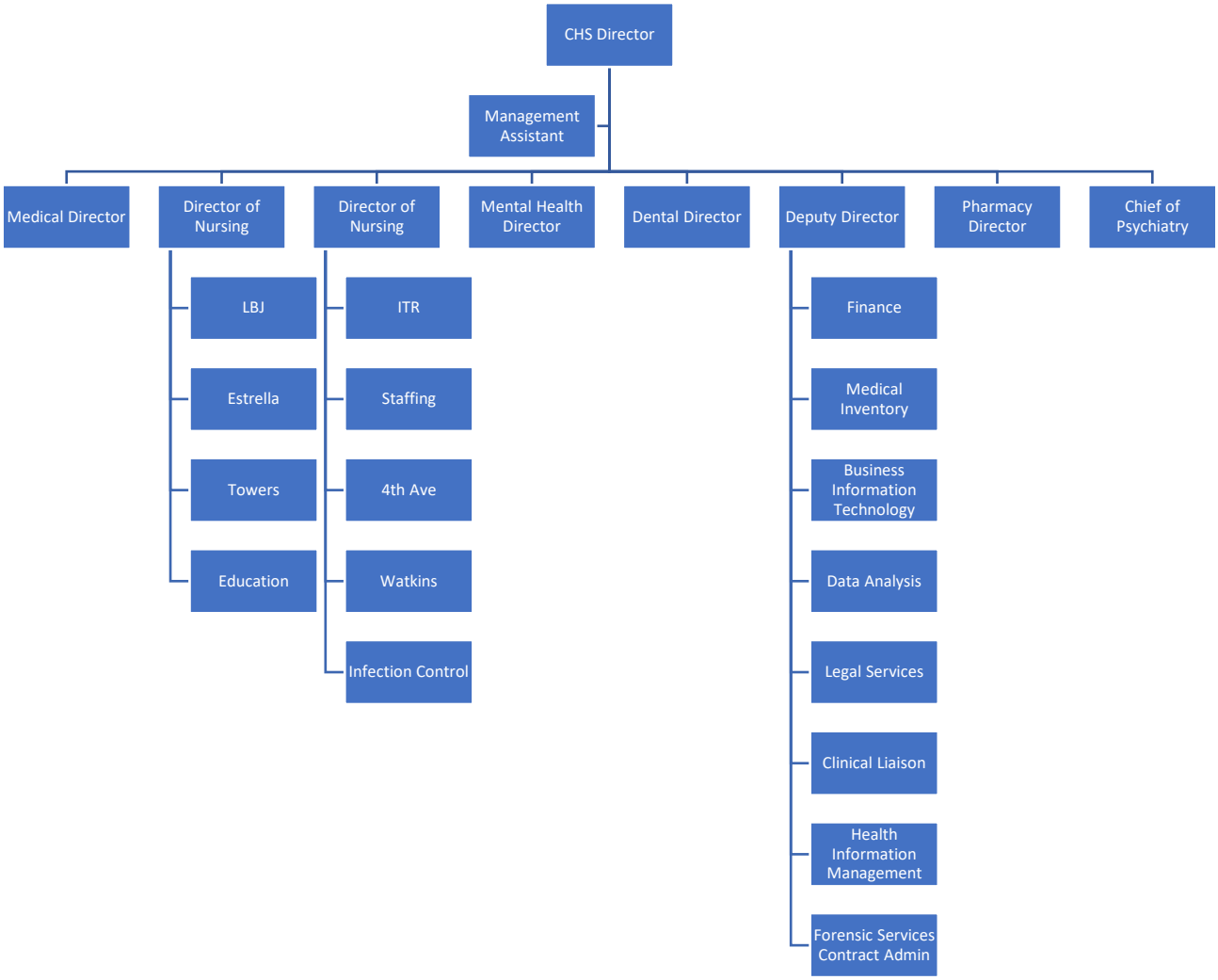
3.2 ORGANIZATIONAL STRUCTURE

Current Organizational Structure

The overall CHS organizational structure is generally flat, with numerous direct reports to the CHS director – not allowing that person adequate time to be effective at running the organization. The following organization chart provides a high-level overview of

reporting relationships within CHS. There are numerous additional reporting relationships elsewhere within the existing structure (such as the medical director has an assistant medical director over certain clinics).

Figure 8: Current Organizational Structure



Concerns with the existing organizational structure:
With two DON's overseeing different clinics, it can lead to a lack of clear direction for the organization. While CHS originally modeled this after MCSO having a "captain" over each jail, the director of nursing position is different and there should only be one "director". Currently the director of nursing is being pulled in numerous different directions at once, not allowing him the time or providing the necessary resources to ensure he is providing effective services.

While new employees receive “training” in the form of new employee orientation, that training is reported to not always be effective and numerous employee interviews revealed that “field training” was not effective. Additionally, when employees float, they are sometimes met with negative comments at their new clinic and / or given the “bad jobs” for the shift. These issues are further addressed later in this report under the clinical float team recommendation. By creating an assistant director of nursing – operations and having this person lead a clinical float team – responsible for floating to cover open shifts as well as training all new RN’s, LPNs, and CHT’s, it will relieve anxiety from staff as they will not have to float as often and when they float, they are more likely to be well-received at the new clinic.

Special project management is currently handled by multiple people, most often the director of finance for CHS, and while all good intentioned, these employees are not project managers and do not have related training. This recommendation is more fully developed elsewhere in this report; however, it is important to mention it here as an issue with the current CHS organizational structure.

While the department has a management analyst position, there will be a benefit to creating an assistant director of nursing – administration. This person would be responsible for direct oversight of employee education / training, scheduling / staffing, budget performance, and a wide variety of important daily, weekly, monthly, and annual analyses.

The CHS deputy director and medical director should regularly consult one another on matters affecting CHS operations and as such, both should be on the same line within an organizational chart. Not only is this level of collaboration important for continued operational improvement, but this will also enhance the deputy director’s ability to oversee clinical operations if assigned and in the director’s absence.

CHS should take a more holistic approach to health care by having the medical director oversee all medical, dental, psychiatric, mental health, and pharmaceutical functions throughout the organization. Because of the number of providers throughout the organization as well as numerous other direct reports to the medical director, there should be two assistant medical directors. One will supervise all providers from every clinic as well quality management / utilization management. The other assistant medical director will be responsible supervision of the pharmacy director, dental director, mental health director, and chief of psychiatry. This structure will allow the two assistant medical directors to focus on daily operations plus necessary chart reviews while providing the medical director the opportunity to have three direct reports – thus freeing up time to perform necessary chief medical officer functions.

Direct reports to the medical director should be the director of nursing and the two assistant medical directors. While there are differences in functions that psychiatry and mental health perform, there is value to having the chief of psychiatry overseeing all psychiatric and mental health functions. At this time this will not be recommended; however, it is something for CHS to consider in the future.

When looking at CHS as an entity-level organization, it is typical to find the finance manager as a direct report to the chief administrative officer, in this case the CHS director. Having finance as a direct report of the CHS Director will allow for quicker response to overall financial analysis matters regardless of the area within CHS needing analysis and it will provide the finance manager with fewer levels of supervision to bring financial matters to the director. While there is no real concern with the current structure, by moving the finance manager out from under the supervision of the deputy director, it should provide CHS slightly more flexibility and timeliness as it relates to financial management functions.

Recommended Modifications to Positions

Based on the information presented above and to better control the flow of information throughout the department and ensure staff accountability throughout CHS operations, the following modifications should occur (which include a brief overview of job responsibilities):

Director of Nursing – One (1) of the currently authorized two (2) DON positions should be eliminated. The director of nursing will have both operational and administrative support with the creation of two ADON positions, one over operations and the other over administration. With these positions in place, the DON's primary responsibility is to ensure a high-level of morale for nursing staff, to ensure shifts are adequately covered, and to focus on both nursing recruitment and retention efforts.

Assistant Director of Nursing (operations) – This is a new position responsible for management and oversight of all day-to-day operational nursing activities. The position directly supervises the clinical float team, is responsible for ensuring smooth nursing-related operations at all clinics and is responsible for ensuring all clinical employee trainees meet minimum standard training requirements before being released from "trainee" status. This is an FLSA exempt position reporting directly to the director of nursing.

Assistant Director of Nursing (administration) – This is a new position responsible for running daily, weekly, and monthly data analyses related to nursing work

performance, call out data, employee turnover rates, budgetary performance, etc. as well as being responsible for employee recruitment and retention efforts, nurse training and education, assisting senior staff with the preparation of the annual budget, and other administration-related tasks. Direct reports include the staffing / scheduling unit as well as CHS education. New employee orientation and continuing education responsibilities fall directly under the ADON – administration. This is an FLSA exempt position reporting directly to the director of nursing.

Special Projects Manager
Information related to the position of special projects manager can be found in chapter 2, section 11 of this report; however, the recommendation to create one (1) special project manager is found here. If CHS determines that there will not be enough projects on a regular basis for this position, then it can be added to another classification as deemed appropriate by County HR.

Chief of Psychiatry
This position could oversee all mental health-related care and as such, CHS should consider this as an option at some point in the future. If this were the case, the mental health director would report to the chief of psychiatry.

Mental Health Director
In the future, this position could report directly to the chief of psychiatry.

Medical Director
This person should oversee all health care functions within the CHS organization and should have three direct reports: the director of nursing and two assistant medical directors.

Assistant Medical Director(s)
There should be two (2) assistant medical directors. One will be responsible for oversight of all providers at every clinic plus quality management / utilization management while the other would be responsible for oversight of the dental director, pharmacy director, chief of psychiatry, and mental health director. Both assistant medical directors will have responsibility for chart review.

The following is a summary of organizational structure modifications:

- Eliminate one (1) Director of Nursing (DON) position.
- Create one (1) position for an Assistant Director of Nursing – operations (ADON – operations). Direct reports to the ADON – operations will be nurse managers at

all clinics, the clinical float team, infection control, and diagnostic / ancillary services.

- Create one (1) position for an Assistant Director of Nursing – administration (ADON – Administration). Direct reports for the ADON – administration will be the education unit and staffing / scheduling.

- Create a Charge Nurse position that offers a stipend for hours worked in that classification (recommended in section 3.9).

- Create a Clinical Float Team where all members are field trainers and are expected to float daily. The team's supervisor will be the ADON – operations and details on its purpose and makeup are provided in section 3.3 of this report. Staffing this team should be a priority over filling other vacant clinical positions as this team will not only float but will also train all new clinical staff.

- Modify reporting relationships so that all provider, nursing, pharmaceutical, mental health, psychiatric, and dental-related positions fall under the oversight and supervision of the medical director.

- Create one (1) additional assistant medical director position.

- Modify reporting relationships so that the medical director has three direct reports: the director of nursing and the two assistant medical directors.

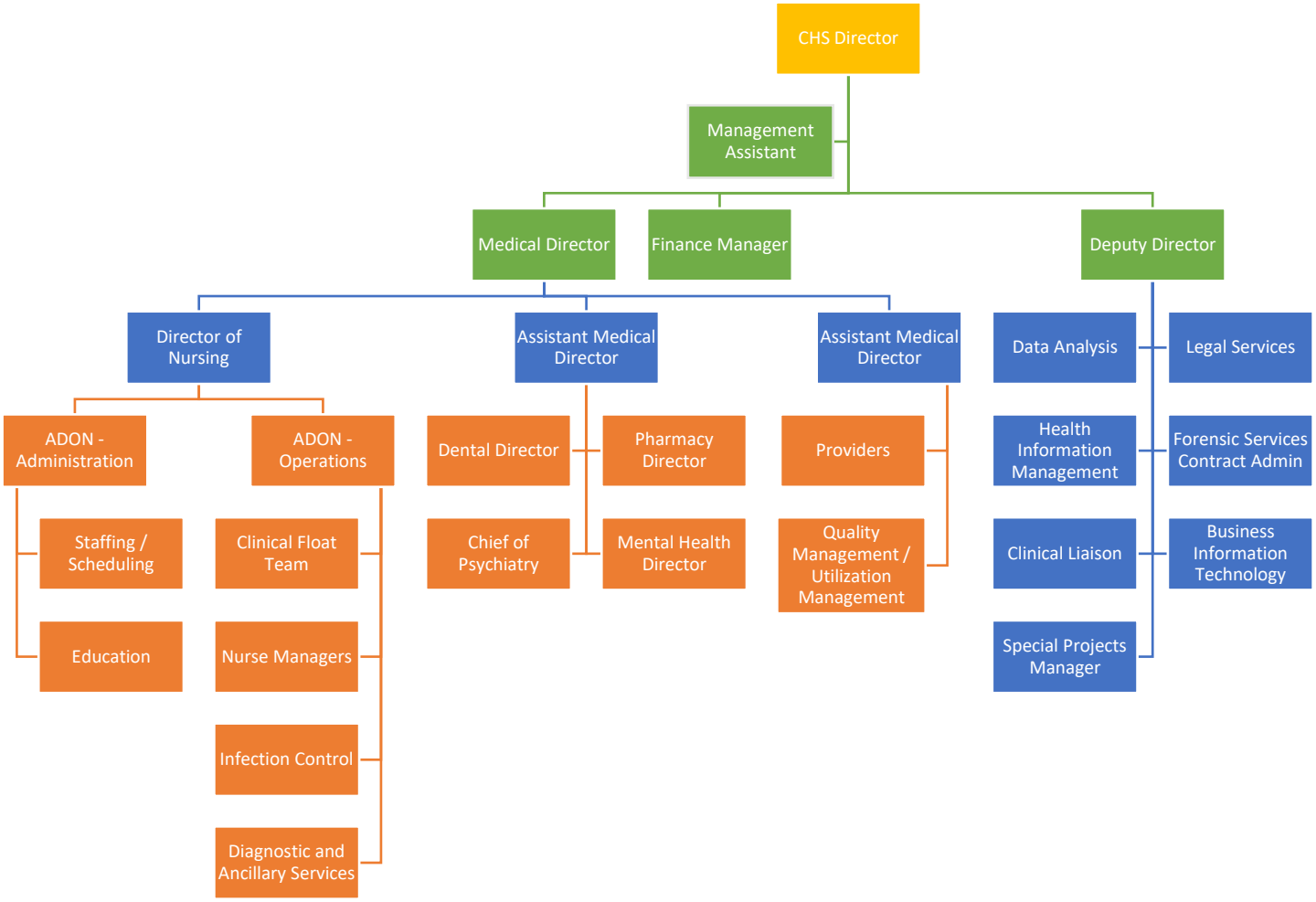
- Modify reporting relationships so that one assistant medical director oversees the dental director, pharmacy director, chief of psychiatry, and the mental health director while the other assistant medical director oversees providers at every clinic as well as quality management / utilization management.

- Create one (1) position of Special Projects Manager and have that person report to the CHS deputy director (recommended in section 2.11).

Recommended Organizational Structure

To improve reporting relationships by ensuring all medical, dental, pharmacy, and mental health services are overseen by a medical director; to provide for more oversight for the CHS deputy director; to improve clinical field training, to improve overall employee morale and reduce stress associated with floating, and to provide for improved results related to special project management, the following is a recommended organizational structure (not including charge nurse positions as those are assigned by nurse managers only on an as-needed basis for employees who qualify to be charge nurses):

Figure 9: Recommended Organizational Structure



All other positions and staffing levels remain the same. As the County already has job descriptions created for similar positions either within CHS or elsewhere in the County, recommended class specifications for the special projects manager position, the two ADON positions, a charge nurse classification, and clinical float team members will be provided upon request. In addition to staffing recommendations found elsewhere in this report, the County should revise its existing CHS organization structure as follows:

Recommendation: *Eliminate one (1) Director of Nursing (DON) position.*

Recommendation: *Create one (1) position for an Assistant Director of Nursing – operations (ADON – operations), overseeing nurse managers, the clinical float team, infection control, and diagnostic / ancillary services.*

Recommendation: *Create one (1) position for an Assistant Director of Nursing – administration (ADON – Administration), overseeing the education unit and staffing / scheduling.*

Recommendation: *Create a Charge Nurse position that offers a stipend for hours worked in that classification.*

Recommendation: *Create one (1) Special Projects Manager position, reporting directly to the deputy director.*

Recommendation: *Modify reporting relationships so that all provider, nursing, pharmaceutical, mental health, and dental-related positions fall under the medical director.*

Recommendation*: Create one (1) additional assistant medical director position.*

Recommendation*: Modify reporting relationships so that the medical director has three direct reports: the director of nursing and both assistant medical directors.*

Recommendation*: Modify reporting relationships so that one assistant medical director oversees the dental director, pharmacy director, chief of psychiatry, and the mental health director while the other assistant medical director oversees providers at every clinic as well as quality management / utilization management.*

Recommendation*: Consider a future reporting relationship of the mental health director reporting to the chief of psychiatry.*

3.3 CLINICAL FLOAT TEAM

Employee interviews revealed that most employees dislike floating for a variety of reasons, to include being unfamiliar with the new clinic and possibly having never been there before, being given the “bad jobs” while the regular staff take the easy jobs, having employees be “mean” and treat you like an outsider, and other reasons. During a three-week analysis of employee call outs (see Chapter 2, Section 3), there were an average of 10.81 call outs per day.

Of these call outs, an average 1.33 LPNs, 5.33 RNs, and 3 CHTs called out. With the need to have more effective training for new employees, the need to ensure all nursing staff receive hands-on training at each clinic, to ensure trainers sign off on already established forms related to training at each clinic, to reduce the anxiety and stress level of employees if and when they will have to float, and to establish a more formalized clinical employee training program, CHS should establish a “Clinical Float Team”.

Such a team would be made up of employees who are RNs, LPNs, and CHTs while being supervised directly by the assistant director of nursing – operations. Every member on this team will be a trainer (preceptor), with direct responsibility for ensuring that every trainee is introduced to each clinic, each trainee is competent to work independently within their assigned clinic with the ability to float if needed, and every employee has established trainee forms signed off – indicating that the employee has been trained “at each clinic”.

After completing new employee orientation, each new clinical employee will be assigned to a trainer (from the clinical float team). A trainer might have more than one trainee assigned to him or her at any given time. If an RN, LPN, or CHT calls out, a member of the clinical float team will be the first to fill that position. The clinical float team member will not only fill that shift but will likely have additional help with them in the form of one or more trainee. If all clinical float team members are assigned at the various clinics for a shift and additional float needs exist, then the existing practice for filling those positions will occur. Clinical float team members should be paid a premium for their services as a constant floater and trainer.

The amount of time that each trainee will be in a trainee status will be dependent on the position (RN, LPN, or CHT); however, an example is having a comprehensive 4-week full training period. The first three weeks would be with one trainer, followed by a final week with a second trainer. By putting a trainee with more than one trainer, the trainee will gain an even better perspective on operational aspects of the position within CHS and CHS will be able to better evaluate the trainee’s performance.

A portion of the final week of training will be more “shadowing”, where the trainer allows the employee to perform their job responsibilities without significant intervention. The time to complete training can be reduced or increased as needed depending on whether a trainee is returning to the CHS workforce after having worked there before or whether an employee needs a little extra time to complete all training tasks.

When a trainee is ready to complete their training, the final trainer will be responsible for ensuring all training forms are completed (for each clinic) and that these forms are forwarded to either the education department or human resources (for recordkeeping, whichever CHS deems most appropriate).

By having the ADON – operations as the clinical float team supervisor, it is less likely there will be all the current issues in the clinics with nursing staff who float. When a floating employee shows up to help at a clinic, that floating employee’s direct supervisor

is the ADON – operations. If a “regular” clinic employee is also present, that employee will be less inclined to try and give the floater the “bad jobs” or otherwise treat them poorly since those employees report to a nurse manager yet the floaters report directly to the ADON – operations. Each member of the clinical float team should provide weekly updates to their supervisor on how well received they were at the various clinics throughout the week and any clinic-specific issues that they believe should be addressed.

At present, employees report that they are frequently called to float after their shift has begun. In the future, any requests to float that occur outside of the “clinical float team” and after a shift has begun, should be first approved by the ADON – operations.

Based on the current vacancy rates by position and historical call out data, this team should be made up of 14 members: One (1) ADON-operations, seven (7) RNs, three (3) LPNs, and three (3) CHTs. Because coverage will need to be seven days a week, this number of employees is not enough to cover every day on both day and night shifts; however, this will significantly reduce the amount of floating time that other employees who are not on this team will have to do.

Staffing the clinical float team should be a priority over filling vacant positions in clinics as this team will not only float daily (thus relieving floating pressure put on the system and the associated stress it can cause employees), but the team will be responsible for thoroughly training all new clinical staff members and getting them comfortable in each of the different clinics. If successful, this program can be expanded to include psychiatric and mental health staff in the future.

Employees on the team will receive their regular salary plus an additional amount as determined by CHS, regardless of the number of trainees assigned to them at any given time. There will be a need to divide up the team into different shifts (days and nights), with employees notified approximately two hours before a shift begins as to the location of their shift. If an employee is not on the team but is required to float, that employee should receive a stipend, or all hours worked while floating.

To be selected to be a clinical float team member, the process should include a competitive application, a minimum of a satisfactory evaluation on the most recent performance review, and successfully passing oral interviews.

Recommendation*: Create a clinical float team comprised of seven (7) RN’s, three (3) LPN’s, three (3) CHT’s, and lead by an assistant director of nursing – operations (ADON – operations).*

***Recommendation**: Excluding the ADON – operations, pay members of the clinical float team an hourly stipend, regardless of the number of trainees the team member has assigned to him or her at any given time.*

***Recommendation**: Provide an hourly stipend for all hours worked "floating at another facility" to any employee not on the clinical float team.*

***Recommendation**: Each member of the clinical float team should provide weekly updates to their supervisor on how well received they were at the various clinics throughout the week and any clinic-specific issues that they believe should be addressed.*

***Recommendation**: Once a shift has begun, only the ADON – operations should approve an employee not on the clinical float team to be floated.*

***Recommendation**: There should be a competitive application process, the completion of an oral board interview, and having the employee's last employee performance evaluation at least "standard" to be selected to be a member of the clinical float team.*

3.4 MANAGERS TO "ROUND"

Numerous interviews with staff revealed that they do not always know who their supervisor is, or they have not seen their manager in months, and it was reported that nurse managers did not even know they had a new employee under them that started a month prior. Information received included comments such as managers make decisions without knowing what happens on the floor each day and while managers can more effectively manage personalities (addressed later in this chapter), simply being present and available for staff can pay significant dividends on both organizational effectiveness and employee morale. Employees need (and want) direction, and this occurs best when managers are routinely present in the employee's work environment.

According to a LinkedIn article, titled "As a Leader, Does Visibility Matter? dated December 11, 2014, effective leaders lead by example. They are visible, available, caring, and by being present in their employee's work environment, they can quickly recognize whether the employee needs support or help[9]. Managers must be approachable and venture out "in the field" on a regular basis.

[9] https://www.linkedin.com/pulse/leader-does-visibility-matter-jj-digeronimo/

At a minimum, executive staff should make rounds at least once a month, if not more often, stopping to talk with employees in all areas within which they supervise. Managers should know and understand what is happening "in the trenches", they must understand actual workload and work challenges, and they should take the time to engage employees in conversation about their work. An additional benefit is that organizational communication (discussed in 3.7 below) can be significantly improved with regular "rounding". Many managers already do this; however, this recommendation is general in nature and will serve as a reminder to all managers of the importance of being there with and for the employees within whom they work.

To have improved clinical outcomes and an even better understanding of the various challenges RN's and LPN's face, all nurse managers should work the floor one day each month – filling a normal RN or LPN shift (performing RN or LPN responsibilities for the shift).

Recommendation: *Executive staff should "round" at least once monthly – ensuring they take the time to meet with and talk to employees under their supervision.*

Recommendation: *Nurse managers should work an RN or LPN shift at least once per month – performing RN or LPN responsibilities for the shift.*

3.5 LEADERSHIP TRAINING

While training is addressed in Chapter two of this report, it is worthwhile to further explore the importance of providing leadership training to managers and first-line supervisors within the CHS organization. As part of the assessment of the CHS workplace environment, the project team surveyed CHS employees who were able to participate in the various work group sessions held at the different clinics.

Focus Group Survey Questions

There were nine questions asked of employees, seven (7) of which used a Likert scale and two (2) that asked for a narrative response. Scores for each Likert-scale question ranged from one (1) to five (5), with five being the "best" score possible, indicating a high degree of satisfaction or a positive view. There were a total of 109 individual responses. For each question, there was a total of 545 possible points. Points were totaled for each question and then given a percentage, based on the total possible points.

Questions 1-4 and 6-7 had the following scale:
Strongly disagree (1), Disagree (2), Undecided (3), Agree (4), Strongly agree (5).

Question 5 had the following scale:
Excellent (5), Good (4), Fair (3), Poor (2), Very Poor (1)
These questions, including the total score for each question, were as follows:

Question #1: CHS is a great place to work – total score of 332 for a 60.92%, Grade D.

Question #2: CHS provides me with appropriate training – total score of 288, or 52.84% of the total possible score, Grade F.

Question #3: I have an appropriate work / life balance – total score 356, or 65.32% of the total possible score, Grade D.

Question #4: Regarding my work, I am provided clear direction and I know what is expected of me – total score 305, or 55.96% of the total possible score, Grade F

Question #5: How would you rate employee morale – total score of 226, or 41.47% of the total possible score, Grade F.

Question #6: I am kept informed about what's going on within CHS, I am involved and my supervisor(s) ask for my input, and I am valued – total score of 274, or 50.28% of the total possible score, Grade F.

Question #7: Employees are recognized for their great work and held accountable for their work performance – total score of 238, or 43.67% of the total possible score, Grade F.

Questions 8 and 9 requested a narrative response:

Question #8: If you could change just one thing about CHS, what would that be? Most responses were directly related to overall management or improving staffing levels.

Question #9: What is the best thing about working at CHS (not related to direct patient care)? Most responses were the colleagues with whom the employee worked or employee benefits.

The following table shows each question and how many responses were a 1, 2, 3, 4, or 5.

Table 7: Focus Group Likert Scale Question Results

Score	Q1	%	Q2	%	Q3	%
(1)	15	**13.76%**	16	**14.68%**	8	**7.34%**
(2)	17	**15.60%**	39	**35.78%**	24	**22.02%**
(3)	32	**29.36%**	23	**21.10%**	19	**17.43%**
(4)	38	**34.86%**	30	**27.52%**	47	**43.12%**
(5)	7	**6.42%**	1	**0.92%**	11	**10.09%**
Score	**Q4**	**%**	**Q5**	**%**	**Q6**	**%**
(1)	21	**19.27%**	38	**34.86%**	26	**23.85%**
(2)	30	**27.52%**	39	**35.78%**	35	**32.11%**
(3)	13	**11.93%**	20	**18.35%**	22	**20.18%**
(4)	40	**36.70%**	10	**9.17%**	18	**16.51%**
(5)	5	**4.59%**	2	**1.83%**	8	**7.34%**
Score	**Q7**	**%**				
(1)	30	**27.52%**				
(2)	45	**41.28%**				
(3)	18	**16.51%**				
(4)	16	**14.68%**				
(5)	0	**0.00%**				

Of note is that 100% of respondents did not say they strongly agreed with employees are recognized for great work and held accountable for their work performance. Only one employee provided a score of "5" for CHS providing appropriate training and only two employees rated a "5" for employee morale.

Additionally, when looking at the 1's plus 2's and then the 4's plus 5's for each question, we are looking at whether there is a favorable response to the question verses an unfavorable response. You always want the percentage of 4 and 5 responses to be greater than the percentage of 1 and 2 responses, indicating a greater percentage of employees have a favorable view of the issue. The following table shows the ranking of 1's plus 2's and 4's plus 5's for each of the seven Likert-scale questions.

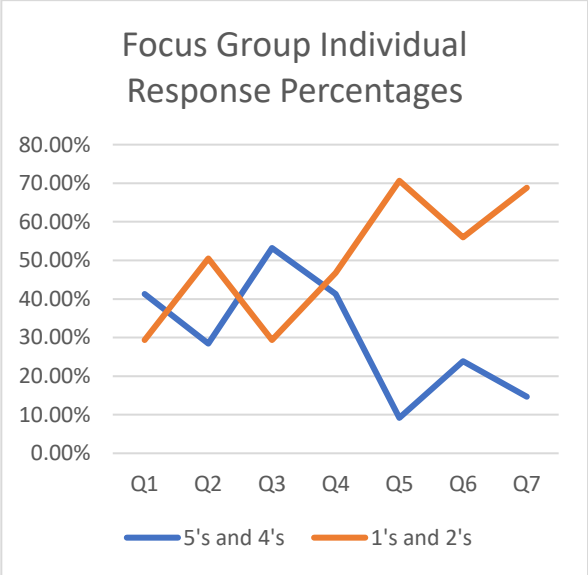
Table 8: Favorable Response Rating

Question	5's and 4's	1's and 2's
Q1	41.28%	29.36%
Q2	28.44%	50.46%
Q3	53.21%	29.36%

Q4	41.28%	46.79%
Q5	9.17%	70.64%
Q6	23.85%	55.96%
Q7	14.68%	68.81%

The data show that in 5 of 7 questions, or 71.43% of the time, the 1's and 2's had a higher percentage than the 4's and 5's with the greatest differential being the question on employee morale. Employee morale had 70.64% of respondents rank it a 1 or a 2, with only 9.17% rank it a 4 or a 5.

Figure 10: Focus Group Response Differential



The closer the two chart lines are to one another per question, the less of a deviation from a neutral response. You do not want to see a big deviation if the orange line is above the blue line, which is indicative of more employees ranking a question as poor / very poor or disagreeing / strongly disagreeing.

Table 9: Positive Percentage Ranking – Lowest to Highest

Positive Percentage Ranking of lowest to highest by Question	
#5	Employee morale
#7	Employee recognition for good work
#6	I am kept informed, I am asked for input, I am valued
#2	Appropriate training
#4	I am provided clear direction and I know what is expected of me
#1	CHS is a great place to work
#3	Appropriate work / life balance

Importance of Leadership Excellence

The data above is clear indication of the importance of how leadership can improve employee views on morale, recognition for a job well done, how well employees are kept informed, whether employees are asked for input, whether employees feel valued, whether they receive adequate training opportunities, whether they are provided with clear direction and know what is expected of them, whether they have a positive work-life balance, and whether CHS is a great place to work.

According to the Society for Human Resources Management, employees generally leave an organization for one of four (4) reasons:

- **"Employee dissatisfaction.** Attack this issue with traditional retention strategies such as monitoring workplace attitudes and addressing the drivers of turnover.
- **Better alternatives**. Retain employees by ensuring that the organization is competitive in terms of rewards, developmental opportunities, and the quality of the work environment. Be prepared to deal with external offers for valued employees.
- **A planned change**. Some employees may have a predetermined plan to quit (e.g., if their spouse becomes pregnant, if they get a job advancement opportunity, if they are accepted into a degree program). However, increasing rewards tied to tenure or in response to employee needs may alter the plans of some employees. For example, if a company is seeing exits based on family-related plans, more generous parental leave and family-friendly policies may help reduce the impact.
- **A negative experience.** Employees sometimes leave on impulse, without any plan for the future. Generally, this is the result of a negative response to a specific action (e.g., being passed over for a promotion or experiencing difficulties with a supervisor). Analyze the types and frequencies of work-related

> issues that are driving employees to leave. Provide training to minimize prevalent negative interactions (e.g., harassment, bullying, or unfair and inconsistent treatment) and provide support mechanisms to deal with those problems (e.g., conflict resolution procedures**,** alternative work schedules or employee assistance programs)."[10]

Leadership is essential in a public organization and while it is said that some leaders are born, it is true that most leaders are developed. Leadership within CHS can directly affect employee dissatisfaction and whether an employee has a negative experience (two of the reasons listed by SHRM).

Leadership Training

The reasons for leadership training are many, including increased productivity, improved employee morale, reduced employee turnover, improved risk management, building teamwork, and helping to implement organizational change. Leadership training itself is known to help clarify an organization's vision and values, it can improve career opportunities for valued employees, it improves one's communication skills, it improves listening skills, and it can help a person be more influential. CHS should offer leadership training to all its management and lead role staff.

CHS provides some leadership training to some managers; however, there isn't a formal program or process in place to ensure that all managers are provided leadership training on a regular basis. Newly promoted supervisors should be required to have leadership training within three months of promotion and all supervisors / managers should receive annual in-house training on effective leadership.

Such training will not only show the employee that CHS cares about them and their success as a leader, but as importantly it will help develop leadership skills within them that will be applied to their work environment – benefiting all employees with whom they work. Leadership training can be performed in-house, from a seminar, online, at a conference, or from some other means.

Recommendation*: Require leadership training of all newly promoted supervisors / managers and ensure all managers receive annual in-house leadership training.*

[10] https://www.shrm.org/resourcesandtools/tools-and-samples/toolkits/pages/managingforemployeeretention.aspx

3.6 BACKFILLING MENTAL HEALTH POSITIONS

CHS values its commitment to both medical and mental health treatment for its clients. While positions within a nursing classification are backfilled when an employee calls out for a shift, it is reported that the same generally does not happen for mental health classifications, except for within the mental health unit.

The MHU houses the most acutely mentally ill patients and patients that are at risk of self-harm. The table below identifies the breakdown of census numbers on December 3, 2021, within the mental health unit. Of note is that some of the housing units are used by MCSO to house general population inmates when needed and these patients are not admitted into the mental health unit, but rather the beds are utilized as overflow.

Figure 11: Mental Health Unit Census

Unit Name	Classification	Census 12/3/2021
P1A	Male Closed Custody Step Down	**12**
P1B	Male Medical Observation (All Classifications)	**13**
P2A	Male Step-Down Unit	**11**
P2B	General Population Housing (not MHU patients)	**(25)**
P3 A&B	Male intake unit (no closed custody inmates)	**26**
P4A	Male Step-Down Unit	**24**
P4B	Male - Ad Res/NOC patients	**7**
P5A	Female Step Down	**7**
P5B	Female intake unit (All Classifications)	**12**
P6A	General Population Housing (not MHU patients)	**(2)**
P6B	Overflow for the male intake unit	**11**
	Total	**150**

After subtracting out the general population inmates in P2B and P6A, on this day there were 123 patients admitted to the MHU. The unit has 256 available beds for use.

Important mental health services occur throughout all clinics and not just within the MHU. CHS invests in the mental health of those booked into the MCSO jail system with important services provided by employees working multiple different classifications, including but not limited to:

- Mental health manager
- Mental health associate

- Mental health licensed associate
- Mental health professional
- Behavioral health technician
- Psychiatric nurse practitioner or physician's assistant
- Psychiatrist

Apart from ITR, mental health staff generally work varying hours between 6:00 am and 8:30 pm. At ITR, there are two employees (one mental health associate and one mental health licensed associate) scheduled to work an overnight shift three or four days per week, depending on the week. At ITR, two to three days each week are not scheduled to have night shift mental health employees on duty.

CHS should evaluate the costs and benefits of backfilling clinic mental health patient-care positions when an employee calls out on leave so that important services continue to be provided. This analysis must include a review of whether the MCSO power squad will be utilized to assist mental health staff complete their client appointments since if MCSO will be unavailable to assist mental health staff, then backfilling open positions will not be appropriate.

Recommended staffing levels, including minimum recommended staffing, will be a part of an upcoming staffing study report.

***Recommendation**: Consider the costs and benefits of backfilling clinic mental health patient-care positions when an employee calls out on leave.*

3.7 ORGANIZATIONAL COMMUNICATION

Effective communication at all levels of the organization is important toward operational success and it is not just about holding more meetings. Employees want and often need to feel informed and included in what is happening within CHS. Interviews with numerous staff revealed that employees do not feel as if CHS management keeps them informed on department goals or objectives beyond the employee just being told what to do each day.

To better keep employees informed and being consistent with the recommendations from section 3.4 above, each manager should also hold meetings with their direct reports at least once per month to communicate important information about CHS and to receive direct feedback from their subordinates. These monthly meetings will help ensure employees are kept informed, feel valued, and are provided an opportunity to give input into the direction of CHS as appropriate. There should be a regular

discussion on organizational goals and objectives and there should be regular reviews of success toward established organizational performance measures.

Employees should be encouraged to provide active feedback on any concerns they have as this is the time for open and honest communication between the team. Management should follow up on all feedback and provide an update to that employee, or the group as appropriate, no later than the following monthly meeting. Executive team members are encouraged to periodically attend meetings arranged by their subordinates as those employees meet with their supervisor.

Recommendation: *Ensure management engages in regular communication with employees to ensure everyone is kept informed as to the direction of CHS as a whole and the employee's individual division or unit, as well as allowing employees the opportunity to be heard.*

3.8 SCHEDULING / STAFFING

Scheduling for nursing staff is currently a concern for many employees at CHS. While some employees really enjoy their schedules, others do not enjoy floating, they do not like that they cannot work 12-hour shifts, and minimum staffing levels as established by the DON are frequently not met. These are all priority issues that will be addressed in an upcoming CHS staffing study in which appropriate staffing levels for each clinic, minimum staffing levels by position and clinic, which clinics will have to donate staff to other clinics during call out situations, and the potential for 12-hour nursing shifts will be independently evaluated.

Another concern is that there are multiple calendars used to document and identify employee staffing needs (nurse managers for example use their own calendar while scheduling staff use another one). The need to get all relevant stakeholders using the same schedule will be addressed in the upcoming staffing study.

Finally, staffing employees receive information from managers if an employee is on "FMLA" leave; however, staffing members might not be FMLA experts and as such, it is possible that FMLA leave could be misclassified. Staffing should be focused on filling shifts and not ensuring leave time is properly documented – this should be the responsibility of each manager for the employees who report to them. It should be the responsibility of managers to ensure FMLA leave is properly identified and if there are any questions, the county's human resources department is available for consultation.

Recommendation: *Complete a staffing study to identify appropriate staffing levels in the clinics, minimum staffing levels, opportunities to improve the staffing / call out process, whether nursing staff can work 12-hours per day / 36-hours per week schedules, and from which clinics will staff be pulled from first (and last) during times of employee call outs.*

Recommendation*: Managers should be responsible for updating ADP data for employee leave, including properly identifying FMLA leave (consulting the county human resources as needed).*

3.9 CHARGE NURSES

Interviews revealed that there are often in which a nurse manager is not working directly with the employees in which they supervise. There might be a nurse manager on-duty; however, there are also multiple locations and multiple floors at certain clinics and having someone present at those locations who can act in a supervisory capacity, will benefit CHS operations.

One of the goals with implementing a “charge nurse” designation is to help manage personalities. The concern is that multiple employees reported during their interviews that other employees are often mean, people point fingers in other people’s faces, and some employees appear to be in a bad mood most of the day. Anyone can have a bad day; however, CHS is a professional workplace and having someone on shift that is readily available in the workplace with the authority to control these types of situations, to direct staff on what different priorities need to be for the day and make other supervisory-related decisions will be of benefit to the organization.

CHS should consider implementing a charge nurse position (not a unique classification), which will result in no more than one employee per shift in a designated area being designated as the charge nurse. Charge nurses should only be assigned in that status if multiple nursing staff are working at the same time and a nurse manager will not be readily available on the floor during the shift. Charge nurses will be assigned that status at the start of a shift and if so assigned, should receive an hourly stipend for all hours worked in that capacity. Only a nurse manager or higher should assign charge nurses for a shift and most shifts and clinics likely will not have charge nurses working at any given time.

A charge nurse will have received supervisory and leadership training and they will have limited supervisory authority. They will have the ability to assign work, assist nurse

managers in the completion of employee performance evaluations, and make limited decisions in the absence of a nurse manager.

By having a supervisor or charge nurse on every floor, it will provide for clearer guidance on what needs to be accomplished and individual personalities of staff will be better managed. Employees need and want active supervision, guidance, encouragement, and recognition. An assignment as a charge nurse will help nurse managers run a smoother shift.

***Recommendation**: Consider the costs and benefits associated with establishing a "charge nurse" designation and paying an hourly stipend for an RN working in this designation to assist nurse managers with supervisory responsibilities.*

3.10 PROVIDING THE DIRECTOR OF NURSING (DON) A ROADMAP FOR SUCCESS

The director of nursing is new to the position and has been without the assistance of ADONs. As such, the DON may benefit from a comprehensive and independent analysis of current workload with recommendations that will help him excel in his new position.

***Recommendation**: Provide for an independent analysis and assessment of the DON's workload with recommendations that will help him excel in his new position.*

3.11 CHS DIRECTOR AND DEPUTY DIRECTOR EXPECTATIONS

While the job descriptions for the director and deputy director should not change, there should be a clarification to the expectations of what each employee should be focused on with his or her daily responsibilities.

The director should focus his or her time and efforts on improving employee morale, being visible in the clinics and throughout the organization, providing policy guidance, long-term visioning, being the face of the CHS organization, ensuring adequate staffing levels, and meeting budgetary expectations.

The deputy director should be focused on coordinating with the medical director to help ensure smooth operations and assisting the director with policy guidance, long-term visioning, ensuring employee morale is high, ensuring adequate staffing levels, meeting budgetary expectations, and implementing special projects in a timely and effective manner, etc. While it is inappropriate to provide an ordered list of tasks that will always take priority over other tasks since the type of leadership work performed by the deputy

director is vast and varied. HR liaison duties, internal audits, and general oversight of assigned divisions should be worked into daily tasks so that the general priority is on coordinating with the medical director to ensure smooth operations and achieving performance measure results.

***Recommendation**: Clarify director and deputy director expectations to provide clear guidance on what each person should be focused on throughout their workday.*

APPENDIX: BEST MANAGEMENT PRACTICES DIAGNOSTIC ASSESSMENT

As part of the workplace environment assessment of Maricopa County Correctional Health Services operations, the project team compared existing practices to best management practices. The best management practices shown are derived from two primary sources:

- Performance standards or best practices established by governmental entities or relevant professional associations, which include but are not limited to the following:
    - ⇒ National Commission on Correctional Health Care (NCCHC).
    - ⇒ Government Finance Officers Association (GFOA).
    - ⇒ Society for Human Resources Management (SHRM).
    - ⇒ Committee of Sponsoring Organizations of the Treadway Commission (COSO).
    - ⇒ National Institute of Corrections (NIC).
- Effective practice based on our expertise and extensive experience with local government operations and management.

The purpose of this diagnostic assessment was to develop an understanding of operations and to identify opportunities for improvement. A GAP analysis was completed based in part on this document, which helped guide the final report and recommendations for continued improvement.

The table below shows the best management practice or standard in the left-hand column, followed by an indication of whether CHS meets the target or if there is room for improvement.

Table 10: Best Management Practices Diagnostic Assessment

Best Management Practices	Meets Target	Room For Improvement
The Department has an established safety plan. **Comments:**	✓	
A formal process exists for ensuring compliance with policies, regulations, and accreditation standards. **Comments:**		✓
The 3-year average annual rate of employee turnover is less than 10%. **Comments:**		✓
Staff receive appropriate training and professional development. **Comments:** Professional development training should be improved.		✓
The Department's activities are tracked and reported on using a set of performance measures. **Comments:**		✓
The organization is a member of the National Commission on Correctional Health. **Comments:**	✓	
There is a separate training or education division to provide ongoing training for employees. **Comments:**	✓	
Employee morale is generally rated as high or very high. **Comments:**		✓

Best Management Practices	Meets Target	Room For Improvement
The organization has well established policies. **Comments:**	✓	
The organization regularly reviews its policies and procedures to ensure current applicability. **Comments:** CHS is currently in the process of completing this review.		✓
The organization has an updated organization-wide strategic plan. **Comments:**		✓
Written policies and procedures exist for critical processes so that other employees can complete those functions if necessary. **Comments:**		✓
Recruitment and hiring processes are standardized. **Comments:** Generally, yes; however, there is room for improvement.		✓
Supervisors receive annual training on matters such as leadership development, harassment, workplace violence, and other high-priority topics. **Comments:**	✓	
Supervisors provide staff with professional development opportunities on an annual basis. **Comments:**	✓	
Management – Supervisory – Line employee chain of command and authority levels are appropriate. **Comments:** CHS should revise its organizational chart.		✓
Effective new employee orientation (NEO) occurs for all		✓

Best Management Practices	Meets Target	Room For Improvement
classifications. **Comments:** There are positive attributes to NEO; however, there is room for improvement.		
Health needs requests are addressed within 24 hours of receipt **Comments:**		✓
Medication passes are not missed. **Comments:**		✓
Employees are assigned goals and objectives for their annual performance appraisal and progress toward completing them are reviewed between employee and supervisor at least quarterly. **Comments:**		✓
Regular compensation and classification analyses occur. **Comments:**	✓	
Employee time sheets are completed timely and signed by both employee and supervisor **Comments:** Timely completion – yes; however, several are regularly not signed by either employee or supervisor.		✓
There is an established employee recognition program designed to recognize high-performing employees. **Comments:**		✓
The organization addresses both the physical and mental health of inmates. **Comments:**	✓	

Best Management Practices	Meets Target	Room For Improvement
There is an established procedure to screen inmates for potential medical needs upon their arrival to the correctional facility. **Comments:**	✓	
A mechanism exists to maintain communication between staff members regarding high-risk inmates. **Comments:**	✓	
Inmate grievances are addressed timely. **Comments:** Reports are that inmate grievances are sometimes delayed for weeks before responding.		✓
Health staff have ready access to clients when needed. **Comments:** While there is reportedly a very good working relationship between most MCSO staff and most CHS staff, there is room for improvement in this area.		✓
There are resources available to inmates as they are released to help them bridge the gap between correctional and community health services. **Comments:**	✓	
New employees have access to computer logins and appropriate facilities on their first day of work. **Comments:**		✓
Employees have an opportunity to provide input into a manager's annual performance evaluation. **Comments:**		✓
Employees working on project management have received project management certification. **Comments:**		✓

Best Management Practices	Meets Target	Room For Improvement
There is a strategy for debriefing when a suicide occurs that includes ways to improve suicide detection, monitoring, and management. **Comments:**	✓	
The organization has plans in place to address women's health issues. **Comments:**	✓	
All new clinical staff receive similar training before being released from a "trainee" status. **Comments:** There is no formalized process followed by all trainers to ensure similar training occurs.		✓
Leadership training is offered to all new supervisors and managers within their first three months in a leadership position. **Comments:**		✓