

Virtual Nursing and the Future of Care Work: Job and Skilling Insights from Lee Health

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Executive Summary

In late 2023, Lee Health, one of the largest public health systems in Florida, began a virtual nursing pilot designed to understand the opportunities and implications of shifting this vital role into a virtual environment. For Lee Health, patient care comes first. The team responsible for the pilot saw opportunities to shift responsibilities, enabling virtual nurses to cover administrative and care tasks that often burden nurses' time, while freeing time for bedside nurses to continue providing exceptional care. The opportunity to improve job quality for nurses, especially as the field is struggling with staff shortages and burnout, was a priority, both for nurses themselves and for the system.

The pilot team – **Kim Gault**, MSN, RN, business system analyst for virtual health and telemedicine; **Max Rousseau**, supervisor of virtual health and telemedicine; and **Jonathan Witenko**, system director, virtual health and telemedicine – worked directly with nurses themselves to determine how skills and responsibilities would be shifted in this new model. Using existing technology and infrastructure and bolstered by investments in a downtime server to eliminate outages and interruptions for crucial services, Lee Health launched its pilot.

The following interview with the three pilot leads dives into details on program intent and design, describing why this approach was a priority for the organization, the considerations the team made, and the outcomes the organization is seeking.

Haley Glover: I understand you have been thinking about this shift for a while. What was the tipping point here – what were the pressures that made this a priority for your team? And what made you confident that you were ready to move forward with the initiative?

Kim Gault: We had staffing shortages that came with COVID and with the hurricane [Hurricane Ian devastated much of the Cape Coral and Ft. Myers area in fall 2022]. Our contract budget was through the roof. So, we had to think about ways to get things back to an even keel. We went to our nursing unit and did a survey, and elevated some strategies that would support the nurses, and they said this all sounds great but what we really want is for you to hire more nurses. Well, so does everyone else in the nation. We would love to hire more nurses, but where would we find them? Everyone else is experiencing the same issue, coupled now with difficulties in recruiting people here because of the hurricane.

Jonathan Witenko: Our nursing staff also suffered with burnout. Coming off of COVID, nurses were the easy button. Just add one more thing to their plate. When a hospital wants something else done – some other metric, compliance feature, hospital feature – the easiest thing to do is give it to a nurse. COVID has been a lot for nurses, but then you take the frustration they feel because they went to nursing school to care for patients, and they're spending so much time doing documentation. Nursing is also physically demanding – many of our experienced nurses toward the end of their careers

struggle to keep up with those demands. A lot of our nurses are leaving, too. We're layering on burnout, exhaustion, and it's a thankless job in many respects, so we felt compelled to remove friction from the role and help them focus, and to extend the lifecycle of the role.

And in the spirit of removing friction, we know that there are a lot of skills a nurse uses that aren't necessarily bedside activities. If we can carve those off and section them to a virtual nurse, that could remove some friction! Nurses want to care for the patient. If the patient is in pain or needs help, that takes priority rather than filling out compliance documents.

Kim Gault: There are a lot of compliance documents required by accreditors. If a system is missing required documentation, that gets fined. So, it's important that everything gets written down and that everything is by the book. But if you're staying overtime to document after every shift, you're going to get reminded that you can't do that, and there will be negative consequences because you're costing overtime, even if you're documenting. That just can't happen. And this allows nurses to go back to true bedside care.

Jonathan Witenko: There are patient care implications, too. When we're checking someone out, we confirm who is bringing the patient home, is the home ready for the patient? We go through prescriptions, care processes, follow-ups. When those things don't get done fully, or they get delayed because of other responsibilities, the patient has a higher propensity to return to the hospital. Plus, other folks who might need a bed are delayed. If we can do all of that stuff ahead of time or in parallel, it makes the whole process much more efficient and contributes to our bottom line, which is getting people well.

Max Rousseau: People on the floor are incredibly busy, so sometimes they take shortcuts. You have to be thorough. What this program does is allow us to prevent shortcuts. The tasks that were most prone to shortcuts are now remote.

We wrote last year about your implementation of the [virtual observer role](#). Did the success in that shift contribute to the organization's ability to make the change for virtual nurses? How are your hospital staff feeling about this change?

Kim Gault: The presence of virtual observers has helped. And there is only one piece of tech equipment for the virtual roles in the rooms – we have a mobile cart, and it stays in the rooms. Now that we're in there so frequently and engaging with the staff and clinical team, they understand the benefits. Everyone is hesitant to change – they initially thought we were making this change in order to increase their patient loads. But we're there to help with documentation and processes. Now that we've been on this campus, they see us [the telemedicine team] doing layers of things.

CNAs like it because we're doing some of their work, too. The virtual nurse lessens their load by giving them a heads-up and letting them prioritize their work. We have had no negative feedback from physicians. It's an additional layer to support the patient, family, and bedside team.

Obviously, patients can refuse. But we've only had two patients refuse virtual care. Patients sometimes feel like they're being watched, so we have a "doorbell" with the technology. We ring the doorbell to see if it's okay to enter the room. We've actually found that these nurses have developed better relationships virtually than bedside. When they go into the room, it's an intentional encounter. There are no distractions, no getting a lab stat, no physicians coming – it's an intentional interaction. And families appreciate that there is someone else watching their loved one, as well as going through the chart, looking at things that might be missed.

Jonathan Witenko: There was some initial reluctance on the unit when we introduced this, but once the team saw it, that skepticism went away, because it was nurses who they knew, who worked on the unit. It wasn't an outside consulting company, or outsourced nurses – this wasn't a ploy to take jobs away. In fact, the virtual nurses sit right down the hall. So, once we go through that, the staff and clinical teams recognized that this is someone who is going to help me do my job, someone who is here to make me successful.

Kim Gault: What that looks like is a program that is not taking away from bedside experience or nursing, but is lifting up the bedside nurse and giving them a second set of hands, providing the patient and family with a better experience during the inpatient stay. We're trying to elevate that aspect of us having limited resources by supporting staff at the bedside.

Jonathan Witenko: Using the existing technology and infrastructure made sense – our teams were familiar with our observation technology, and patients are becoming more comfortable with it as well. Any role in a healthcare setting is vitally important, especially one that interacts directly with patients. To avoid any interruptions in service, for any reason, we invested in a downtime server. This is a new feature to the tech industry that we've been working to develop with our partner, and it's just one more way that we're making sure that patients get the best care.

What kind of skills and attributes are you looking for in virtual nurses?

Kim Gault: Virtual nurses right now are nurses who have worked on the unit. We thought the relationship between the virtual nurse and the bedside team would be better because it wouldn't be strained, and they'd understand the existing workflow. And since we've piloted, we're looking to leverage staff who might have some physical issue preventing them from working on their feet. I've always said, anytime a nurse is injured or on light duty, we put them on filing, and that does not have nurses operating at the top of their licensure. So, how can we use this innovation to allow nurses to work at the maximum of their licensure?

We have a pediatric nurse who had some health issues. She was in and out of the hospital, has a young child, and her doctor wasn't going to release her to be a bedside nurse. She was panicked that she wasn't going to be able to work, and we were able to start utilizing her in this position. I have another very experienced nurse who has been practicing for more than 40 years, but she has a hard time standing. So, with this role, she is working on discharges. And she is very proficient at discharges, but is a wealth of nursing knowledge because she's been doing the job for so long. She keeps telling us how happy she is, like she's a nurse again, doing work she wasn't able to do before.

Jonathan Witenko: This is really interesting. From a diversity, equity, and inclusion perspective, nursing has been limited, but in this role, physicality is no longer a barrier to being a nurse. So, in a virtual setting, it's now fair game.

And as we're staffing, we're not going to target nurses just out of school for this role. They have to be seasoned and have quite a bit of experience, especially as the nurses on the unit might be very new. In fact, the virtual nurse can be a big asset, helping less experienced nurses in safe, comfortable moments.

From a skilling perspective, we had to do Epic [electronic health records] training. We recognized that early. For many of them, they learned Epic 10 years ago, so we wanted to make sure we erased any bad habits and got a fresh start. We also focused on multitasking skills – they're working off three monitors, one with records, one audio/visual, and another for alerts, calls, and requests. And there are a

lot of interpersonal skills that go into being a nurse, especially in a virtual environment – they need to break through the screen. We didn't do a lot of testing for that. It has happened organically, but what they've found is that they get to build relationships. They get to interact, pop in, and they've learned to make it their own.

Kim Gault: Being able to connect with people is so important. It's different because it's on camera, it's a different relationship. There is intent when they go in the room virtually – they're making eye contact, and they're not busy with something else.

Nurses have so many tasks and duties they're responsible for. How did you determine what responsibilities would be virtual and what would remain with the bedside nurse?

Jonathan Witenko: We had to take a hard look at all of the things nurses do on a daily basis and assess what must be done at the bedside and what can be done virtually.

So, we built a change coalition. We did a multiday whiteboarding session, Vegas rules, and sat a bunch of nurses down and they went through the list of responsibilities, built on it, and really defined it. As a group, they drew the line about what they thought made sense. We asked them to think differently. We asked them to think about the job, about the unit, and about the whole system. Where are skills the same and different? Where are they translatable?

Day one, our team wasn't in the room – we wanted them to dream. On the unit, you're not allowed to dream, but in this room, we wanted them to think and challenge the status quo, get out their magic wands. We then came in on day two and worked through things with them.

You're currently piloting virtual nursing in a single unit, testing the approach and collecting data. What outcomes are you looking at, and how are you thinking about success?

Kim Gault: We're working right now on a 30-bed, predominantly cardiac unit. It's a high patient turnover floor. We felt like this would be ideal. Admission and discharge processes take up to an hour depending on the complexity of the patient's condition, so we were looking at significant amount of time with nurses doing something with one patient that doesn't allow them to do anything else. We'll likely expand to two more nursing units, bigger units, over the next several months that will allow us to collect even more data.

Feelings of satisfaction are important to us, but they're the hardest pieces to measure financially. But if we decrease nursing turnover and decrease our utilization of contract nurses, those are hard returns. That is our end goal – we want to retain who we have, put them back at the bedside doing the things that got them into the job in the first place, the patient care that they love, and take away some of the paperwork. If we can retain nurses, keep the satisfaction numbers up, help with travel and contract nursing use, that will be a win.

We're also looking very closely at readmission rates – one week and 30-day readmissions. That was a big piece, determining how we can package things up better for discharge. We're working on "meds to beds," trying to get patients' medications to their room before they leave the hospital. If they need home health, we get it set up. Get their oxygen before they leave. Getting all those details finalized so we don't have to see them again.

Jonathan Witenko: There is always a percentage of patients who come back, and it's generally a factor of "what we gave you didn't stick." The goal is lowering that number.

From the nursing side, we are looking to ensure that nurses are happier, that they're less likely to quit, less burned out. And from the system perspective, we want to reduce nursing turnover, and decrease the time it takes us to turn over a room so we can help the next patient.

Financially, we're looking to determine whether this is a cost to the system or are we generating true value. We don't have the numbers yet.

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