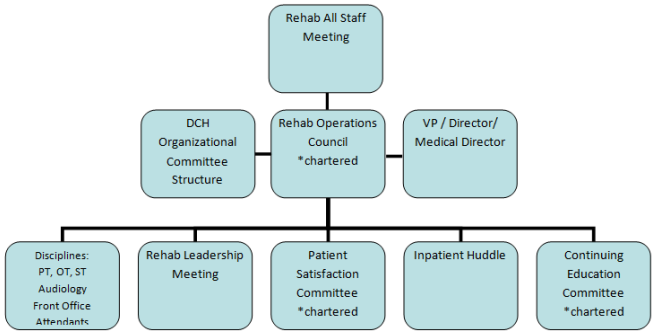
Thank you all for sharing the variety of Shared Governance Models from your various programs. Below is a summary of emails and discussions shared to best understand that there is a variety of Shared Governance Models throughout the country as our various locations. Our hospital is trying to implement an Interprofessional Shared Governance Model under the Patient Care Services Umbrella. This has been historically a nursing model with some influences with pharmacy, labs and IT. We are now hoping to expand with many representative services that surround the patient during their contact with the hospital. I will send out the summaries below and hope to be able to share how our model goes in months and years to come…. Thank you all for sharing.

Hospital Name	Model of Shared Governance
ORG A	Our acute care therapists very occasionally, may be better stated as "rarely", participate in the unit council meetings that occur on the patient care floors of our hospital. They do not participate in any of the other shared governance committees. I participate in the System Education Council meeting which meets every other month. Our pediatric rehab outpatient departments started moving to a shared decision making model in Jan '16 with the initiation of unit councils. Still very much a work in progress as this is a great change for all, but we are hopeful it will improve staff engagement and patient care as they (and their managers) become more knowledgeable and competent in this methodology. We will extend this model to include other supporting councils as the unit councils mature.
ORG B	Director is on a shared governance committee with ambulatory clinic coordinators as a subgroup of Specialty Care Services larger group. I've made 2of 4 meetings. One project was very burst: weighting protocols. Now we've moved to developing mentors beyond the nurse educators. The good thing in this discussion is more training in mentoring/educating new staff or new procedures. We think this model can be used in our therapy areas as well. Our Nicu therapists have tried to participate in shared governance on that unit. Good projects were proposed but fell apart as leaders left or didn't follow through on communicating and regularly scheduling meetings: often forgetting to include us. The main projects were for parent support and toy cleaning/organization.
ORG C	We are just venturing into our first experience with this. We formed an inter-professional practice council for shared governance this past summer. The team is made up of reps from many depts. – clinical and support services. We have PT, OT, SLP, RN, nurse tech, nutrition services, housekeeping, security for example. I have not been the administrator sitting in on the group, so I'm not sure what I could share at this early stage with our experience. One of their first projects was to re-design the whiteboards in patient rooms – space where IDT notes key patient specific info for primary benefit of patient, but also useful to staff responding to call lights, etc. Our shared governance team is too new for us to offer tips, pitfalls or keys to success.
ORG D	We have quite a robust shared governance system for our inpatient rehab and therapy programs, and partially implemented on our outpatient side. Our shared governance is totally integrated with therapies, psychology, therapeutic recreation, nursing, social work, physicians, etc. we have had this for about 5 years at this point I think. Some highlights • We are more successful in accomplishing improvements that are meaningful and truly last than we ever used to be. This is because it comes from the staff, not necessarily from leadership

	• Engagement of staff is very high. This is because they are involved in leadership opportunities and drive improvements. They also truly understand how they fit in the big picture of goals and strategic plan because this is built into the structure (each person knows how they contribute and how they matter) • Staff run many of the meetings, with leadership there on a consultative basis rather than driving the meetings Some of the pitfalls • Time for improvements. Because our staff now drive much of this work, we need to help them with prioritization because there is so much they want to do. Having them involved in this prioritization has helped, but still there is never enough time. We are now trialing each council having 4 hour blocks for improvement work as they have larger projects come up and have a formal request process for them to request this. If allotted, the leadership establishes coverage for them. • Sometimes it has taken a long time to get things done. Moving to a "just do it" identification of some projects has been helpful, but still takes longer than I would sometimes like • You have to have full leadership buy in, this means physician leadership as well. We worked intentionally on this and it has made a significant difference as many times the things the therapists want to work on improving have a large physician component to the work and you need to address all areas. I would say the major 2 key points are have a clear structure and processes (this is really key!) and involvement at all levels with everyone is they reason we are successful.
ORG E	Several members of the Rehab staff currently participate in Shared Decision making councils on a unit level and in hospital wide councils. Our councils (Shared governance) are also primarily nursing based. In fact, the office holders (chair and co-chair) must be nurses and the councils are required to have a higher nurse to ancillary staff ratio. Many councils have ancillary (non-nursing) staff which are considered ad hoc members, who only attended when a topic is specifically related to their discipline. 1. What were 3 keys to success? 1. Having a council that is open to the opinions of "non-nursing staff". 2. Having an OT/PT that is well known to the council nursing staff and who is familiar with the inner workings of a department. (Helpful if this person is a unit primary). 3. Having a therapist with experience in many units of the hospital to give input about how different units perform the same tasks. 2. What were 3 pitfalls or words of wisdom? 1. Because the councils are primarily nursing driven, the meeting times are based around nursing schedules. Many meetings are at night or "after hours" which require therapists to use their own (off the clock) time to attend. 2. Many council topics are very nursing oriented. There are many topics which do not directly pertain to the therapy staff. Even though we may have input into these topics, our opinion is not always given full consideration. 3. Several therapists who have been on councils in the past report that it was "a waste of time". The therapists involved should be committed to making things better for the unit/hospital as a whole and be willing and educated to give input on things which are not therapy specific.
ORG F	We have had a share governance structure system for a long time, it is interdisciplinary and we just did a redesign.

ORG G	We do have a shared governance structure that covers all of rehab. It is a bit of a hybrid – as the traditional nursing driven structure doesn't work for us. We have work group teams that organically will meet (SLPs, PTs, Leadership, Inpatient, etc.). But the core of our shared governance are our 3 chartered committees that cover both IP (med-surg/critical care not acute IP rehab) and OP. Those 3 committees are 1) CE committee, 2) Patient Sat committee and they all roll up to 3) Rehab Operations Council. We report out to hospital committees when appropriate and up to our all staff meeting. I included our committee structure.  Size wise we are a staff of 72 and include Audiology, PT, OT and ST. Both IP and OP services. One primary OP clinic with satellite coverage – not daily but a reduced, scheduled frequency (supporting specialty physicians) at 4 rural clinics. We do participate in the Clinical Operations committee (really about processes in the hospital), Clinical Excellence (education: from competencies to training) and the Multidisciplinary Advisory Group (service delivery) – all are a part of the nursing shared governance structure and we have asked for a seat at those tables as decisions are made that impact the rehab staff. The Clinical Ops I attend, Clinical Excellence is attended by a rehab manager and MAG is attended by a front line staff member. All are heavy, heavy nursing. Rehab leadership attends 2 of those 3 because we have found that front line staff don't always draw the parallels between what the nursing group is planning/discussing and the downstream impact on rehab – we can catch issues in those meetings and influence the end result. MAG is a decision making group of front line staff and it works for a staff PT to be there.