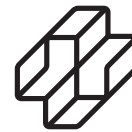


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Navigating the Muddy Waters of Labor Relations

by Carolyn Roe, MSM, BSN



Regardless of your personal beliefs about unions, you automatically assume a responsibility for your employer's fiscal health—in addition to the well being of your patients and staff—when you assume a management position. Statistics show that unionization can increase hospital costs by 17 percent to 21 percent (Permanent Solutions Labor Consultants). In some cases, these cost increases may be warranted. However, in other cases, the additional expense can be avoided or minimized when nurse leaders proactively address the issues that draw employees to unions in the first place. Here is one scenario. → →

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COMING IN JULY

Visit www.hfma.org/boc for additional resources on labor relations, medical homes, and helping the uninsured. Plus, peruse back issues for cost-reduction tactics that can help your organization in these difficult economic times.

The Business of Caring is now available to everyone for free at www.hfma.org/boc. The next issue (Summer 2009) will be posted on the web site in July. See page 7 for more information about this change.

The Business of Caring

May 2009

Volume 4, No. 5

The Business of Caring is co-published by the Healthcare Financial Management Association and the American Organization of Nurse Executives.

Presorted standard postage paid in Chicago, IL 60607. ©2009 HFMA.

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ISSN#: 1934-7502

Thirty plus years as a nurse executive and leader has led me to conclude that the frontline manager or director plays the most significant role in establishing and maintaining healthy interpersonal relationships. The following real-life scenario demonstrates how a frontline manager can influence positive relations in a unionized or a nonunion environment.

The Situation

A renowned hospital affiliated with prestigious medical and nursing schools had multiple issues in its cardiovascular service line, which comprised seven departments. Two departments, the ICU and cardiovascular (CV) step-down, had 35 percent staff turnover. There were several major contributors to the high turnover:

- > An inadequate number of qualified, competent, and trained CV staff to care for a high volume of patients.
- > Behavior-related physician issues that affected outcomes and caused nurses to feel devalued by the medical staff
- > Patient flow and throughput inadequacies that led to quality issues

Exacerbating the already volatile situation, the leaders of these two departments were ineffective. Staff had voiced their frustrations and concerns, but there had been a lack of action by senior leadership to resolve burning issues. Staff had a deep distrust of management. They did not feel listened to by their leadership and felt disrespected by the organization.

There were no unions and no obvious signs of intent to organize the RN or support staff. The possibility of unionization, however, was present. Staff was desperate for resolution to the staffing and patient care issues they faced daily. A smart, professional union organizer could easily have obtained card signing

by 50 percent of staff in this facility to be represented by a union. If the proposed federal card check legislation (i.e., the Employee Fair Choice Act, which has been reintroduced in Congress) had been the law, this facility would have been unionized without an election.

Interpersonal and working relationships will disintegrate when turnover is high, particularly in a division that provides a significant percentage of a health system's bottom line. (The service line at this hospital generated about 35 percent of revenue for a three-hospital system.) Disrespect and inattention to staff concerns are primary reasons staff seek representation by organized labor or file grievances and even lawsuits against an employer.

The Resolution

The right director came on board and resolved the major issues in a few short months. Here are some of the strategies she used to stabilize relationships in this service line with over 200 employees.

Walk in the shoes of staff. The director visited with the majority of employees, on all shifts, including weekends, in each of the service line's seven departments. She observed the care and interactions of staff, physicians, and patients.

Hold one-on-one conversations. The director talked one on one with 50 percent of the specialty ICU staff to diagnose the causes of high turnover and other issues. She listened, made notes, and communicated that these observations were for diagnosing strengths, weaknesses, and opportunities for improvement—not to threaten staff.

Build trust and respect. The director promised staff that she would share information with others only when the employee had given his/her permission,

and after verifying that the director had accurately heard what the employee had to say.

Take timely action to remove barriers impeding professional practice. For example, the director placed the two ineffective department leaders on action plans, and taught each manager how to assess the effectiveness of his/her leadership. The director also applied discipline fairly and consistently, quickly intervening when staff members did not follow policy or best practice.

Address the major issues. The director involved the medical and nursing staffs in prioritizing the critical issues that were hurting the service line. Within two weeks of assuming her new position, the director had empowered staff to address the most pressing issue: disrespectful relationships and behaviors between medical and nursing staffs in the critical care units.

A nursing and medical staff communication council was formed for the ICU. The council includes medical intensivists, anesthesiologists, surgeons, internists, seasoned staff nurses, and a charge nurse. The service line director serves in an advisory capacity.

The actions taken by the council included developing a code for professional behavior and communication that physicians and nurses agreed to follow. Infractions on either side were brought

Hospital leadership must develop a means to be visible and accessible to staff. Most important: Staff's legitimate concerns regarding patient care and safety must be addressed.

to the council. Council members also role modeled giving and receiving care recommendations, which seemed to be a stumbling block for many nurses who were afraid of being criticized or made to feel stupid by senior staff and physicians. In addition, a letter of praise and recognition for achieving good outcomes during an extremely busy, high-census period was written and signed by each member of the council. These letters (along with movie tickets) were hand delivered by council members to all staff in the ICU, including physicians.

Within four weeks, great strides were made in changing behaviors on both sides. Within three months, ICU vacancy was reduced from 17 to 3 FTEs.

Forgo the negative and pass praise. The director expected herself and her staff to achieve positive outcomes by focusing on what is right rather than what is wrong. She brought out the best in staff. When a good outcome was achieved, the director redirected praise to staff members critical to the resolution of the concern. She gave public praise and private criticism. She also taught staff how to solve peer conflicts positively, not allowing "he said, she said" communication.

Advocate for quality care. The director made it clear that patient care quality was a priority by addressing patient care issues promptly with the medical staff. Other examples: She personally spoke to top leadership regarding inadequacies in the new service line tower being constructed, and involved medical and nursing staff in redesigning the nursing station and equipment areas to improve work flow and safety.

Be Visible and Accessible

The crisis at this hospital is over for the moment. Great expense, time, and effort would have been expended on

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Managing in a Unionized Hospital

Visit www.hfma.org/boc for a second labor relations scenario. Carolyn Roe, MSM, BSN, discusses the use of situation and resolution in a multiunion healthcare system.

unionization, defending lawsuits and resolving grievances, yet the issues with quality, staffing, medical staff relations, and ineffective leadership would still have existed. It took the leadership skills of one frontline director to give employees what they truly wanted.

Regardless of the presence or absence of a labor union, staff will rebel if they are not listened to and will seek whatever means available to solve issues important to them. Hospital leadership must develop a means to be visible and accessible to staff. Most important: Staff's legitimate concerns regarding patient care and safety must be addressed.

Today's political and economic climate requires first-line managers and directors to exercise refined communication and relationship building skills to achieve safe and excellent care while surviving the financial hazards being faced. At the same time, senior leadership needs to recognize that they must provide critical support to remove barriers that prevent staff from making a difference professionally. Equally important for both senior leadership and front-line managers is demonstrating respect, honesty, and compassion in communications with staff. ☎



Carolyn Roe, MSM, BSN, is currently associated with Permanent Solutions Labor Consultants. Her background includes serving in chief nurse executive and vice president positions with health systems (carolynjroe@hotmail.com).

The Medical Home Model

In pilot and demonstration projects around the country, the patient-centered medical home is being tested as a possible remedy for poorly coordinated care that wastes money and harms patients. The medical home model seeks to transform care by focusing on a patient's total healthcare needs in a proactive fashion. The business theory: If patients receive appropriate outpatient care, their need for expensive interventions and inpatient care will be reduced.

What Is a Medical Home?

While the details of a medical home differ from one pilot project to the next, all emphasize the importance of primary care. The September/October 2008 issue of *Health Affairs* identifies seven essential components for a medical home:

- > An ongoing relationship between a patient and a personal physician
- > Physician-directed medical practice, in which a team of people share responsibility for patients' ongoing care
- > Whole-person orientation, meaning that the personal physician provides all of a patient's health-care services or coordinates care—including acute and chronic care, preventive services, and end-of-life care—to be delivered by other professionals
- > Care that is coordinated and integrated throughout the healthcare system and the patient's community; such coordination requires patient registries, health information exchange, and other tools and activities
- > Use of evidence-based decision support, active engagement in quality improvement activities, and other strategies to delivery high-quality care that ensures a patient's safety
- > Timely access to care and better methods of communication, such as telephone and e-mail contacts, between patients and professional caregivers
- > Payment that recognizes the added value of care provided through a medical home

Source: Rittenhouse, D. et al, "Measuring the Medical Home Infrastructure in Large Medical Groups," *Health Affairs*, Sep./Oct. 2008, vol. 27, no. 5, pp. 1246-1258.

A Sample of Medical Home Pilot Projects

- > The Centers for Medicare & Medicaid Services (CMS) is currently in the midst of selecting physician practices to participate in a medical home demonstration project that will begin in 2010. The project will be conducted in up to eight states and involve about 400 medical practices. (For more details, visit www.cmsmedicalhome.com.)
- > In 2008, Dartmouth-Hitchcock Clinic and Cigna launched a medical home pilot with about 19,000 Cigna members who receive care from Dartmouth-Hitchcock's 391 primary care physicians.
- > In 2008, Group Health and Health Insurance Plan of New York—two leading insurers in New York—announced a two-year medical home pilot involving about 20,000 patients.
- > UnitedHealth Group is conducting a medical home pilot program in Florida in conjunction with the American Academy of Family Physicians, the American Academy of Pediatrics, the American Osteopathic Association, and the American College of Physicians.
- > HealthPartners, a large Minnesota-based plan that is integrated with a health system, expects to start a medical home pilot in 2009.

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Working in a Medical Home Model

Read more about a nurse's role in a medical home model at www.hfma.org/boc. Kathleen A. Butcher, RN, CDDN, shares her experiences from Dartmouth-Hitchcock Clinic's pilot program.

What It Means for Hospitals

The primary way that a medical home concept saves money is keeping patients with chronic diseases out of the hospital. For hospital providers, the evolution toward medical homes means there may be fewer acute care patients; but the ones who are admitted are likely to be sicker and more expensive to treat.

“The hospital has the opportunity to have sicker patients and more flow through than you would if you are readmitting patients because their underlying disease state is not in good control,” says Barbara Walters, MD, senior medical director, of the New Hampshire-based Dartmouth-Hitchcock Clinic, which is integrated with Mary Hitchcock Memorial Hospital. “You’ll be able to have your beds filled by the sicker and more complicated patients, and you’ll keep your revenue stream flowing that way.”

When Physicians Are Employed

For hospitals that employ primary care physicians, Walters offers the following advice.

Jump on board the medical home train. Educate your physicians about how the medical home model works and start developing the necessary infrastructure required for the medical home to succeed, ranging from electronic medical records to nurses who serve as health coaches.

Work to receive medical-home recognition from the National Committee for Quality Assurance (NCQA). “That appears as if it’s going to be the price of entry into the model,” says Walters. Since 2008, NCQA has been assessing medical practices that wish to serve as medical homes. To be recognized, a practice must demonstrate its ability to meet criteria under nine standards, such as care coordination and performance reporting.

Start studying the billing issues. In a medical-home arrangement, physician groups get paid for services—such as creating care plans—that do not involve face time with a patient. “A lot of the things that you bill for trigger an explanation of benefits and copayments,” says Walter. “Patients would have no idea why they were getting billed for work that a nurse in the background did to create care plans for them. It’s very challenging to figure out the way to not trigger that.”

When Physicians Are Not Employed

Hospitals that do not employ primary care physicians should be staying on top of medical home projects in their community. “This can change the case mix or the hospital services that they will provide, given what their physicians are doing in their catchment area,” says Walters.

What It Means For Nurses

The medical home model relies on nurses who get to know their patients well and plan and coordinate their care with the goal of delivering the right care at the right time in the most efficient way possible.

Take the medical home experience at Dartmouth-Hitchcock Clinic in Concord, N.H. The clinic reorganized its work so that patient care is provided proactively, rather than only when a patient calls for an appointment. Nurses develop care plans for patients with chronic conditions and serve as health coaches, making sure patients understand how to comply with physician orders. Nurses also track patients with chronic conditions via “registries” that show a patient’s health status and appointment history. “We know who our diabetics are and what all of their key indicators are, so we know who has good control and bad control and who has or hasn’t been seen,” says Barbara Walters, MD, the clinic’s senior medical director.

Another key change is preparing patients for a meaningful session with the physician. “We call them to say, ‘We noticed you haven’t been in here. I want you to get all these lab tests and come in to talk about your diabetes. Let’s set up an appointment,’” says Walters. “The patient shows up with lab values in hand, and the physician gets a patient who understands his or her disease and is prepared to discuss how to manage it.”

However, it *does* involve a different way of thinking. “You’re trying to really address the whole picture,” says Kathleen A. Butcher, RN, CDDN, a pediatric triage nurse at Dartmouth-Hitchcock. “For example, if you have a parent who says, ‘My child is in a wheelchair, and our dentist’s office is not wheelchair-accessible,’ the easiest thing would be to tell that parent to start calling numbers in the phone book. However, in a medical home, the nurse should know how to connect the family with appropriate resources.”

That puts a nurse at the center of a patient’s care, working proactively with a multidisciplinary team that crosses the healthcare continuum.

Business-Smart Strategies for Helping the Uninsured

Savvy healthcare providers are figuring out financially viable ways to provide needed care to the rising number of uninsured—and nurses are often the lynchpins to success. Access the full-text case studies at www.hfma.org/boc.

Case Study 1: Preventing Unnecessary Hospitalizations

The St. Vincent's Nurse-Managed Health Clinic, in Galveston, Texas, has a first-year expense budget of a mere \$225,000. But that is not the figure clinic director Kathryn Fiandt, DNS, FAANP, focuses on. Her sight is set on 20—as in preventing 20 unnecessary hospitalizations by August.

“If we avoid 20 hospitalizations in the course of a calendar year, we will break even,” says Fiandt. The clinic serves all uninsured adults who show up; however, its main focus is to provide intensive primary care to more than 200 chronically ill uninsured patients who average 1.75 hospitalizations per year at the University of Texas Medical Branch (UTMB). Each inpatient stay costs the hospital an average of \$13,000.

Fiandt is optimistic the clinic will meet its goal. Frequent and comprehensive contact with patients is key, she says. “These are *not* 15-minute visits,” she says. In fact, a typical appointment may last up to an hour at the beginning. “We

get a comprehensive picture of what the needs are in partnership with the patient and the nurse case manager.”



Interviewed: Kathryn Fiandt, DNS, FAANP, is associate dean for graduate programs and clinical affairs at the UTMB School of Nursing's Center for Nursing Practice Development in Galveston, Texas (kfiandt@utmb.edu).

Case Study 2: Providing Specialty Care

Project Access of Durham County, N.C., provides free specialty care to uninsured county residents. Together, hospitals, surgeons, and medical specialists (including Duke Health) have committed to voluntarily provide more than 2,800 episodes of care in their own facilities. An episode of care is a full range of services—physician visits, inpatient stays, procedures, images, etc.—incurred by a single patient during a three-month period.

The uninsured in Durham County may also access these business-savvy services.

Case management. Project Access patients who have chronic conditions, such as diabetes, are referred to Bettina Karpathian, RN, disease/case management provider for Project Access. Karpathian works with a multidisciplinary team at the Local Access to Coordinated Healthcare (LATCH) to address mental health issues, homelessness, and other problems that can exacerbate chronic conditions.

Patient navigation. LATCH—funded by Duke Health—provides patient navigation and other social services to uninsured residents. Specially trained patient navigators help patients circumvent the financial, logistic, and social barriers to using the healthcare system. LATCH staff help about 48 uninsured patients enroll in Medicaid each year—and they also cut the number of unnecessary ED visits.

Interviewed: Fred Johnson is director of clinical services for the Division of Community Health at Duke Health in Durham, N.C. (f.johnson@duke.edu). Bettina Karpathian, RN, is the disease/case management provider for Project Access (bettina.karpathian@duke.edu).

Case Study 3: Directing Patients to Needed Resources

“Our goals are to provide expanded access to primary care for the uninsured and provide community-based care management for the chronically ill uninsured,” says Kimberly Camp, RN, MSN, director of care management at CHRISTUS Health.

The CHRISTUS Health program helps uninsured adults with chronic conditions. Twelve certified community health workers—who are supervised by an RN—have helped more than 300 patients access primary care, obtain prescription medications, and connect with other social services. A recent analysis of data for 100 patients enrolled in care management shows the average cost of care has been reduced by 76 percent, and the return on investment is \$2.28 for each \$1 invested in the program.



Interviewed: Kimberly Camp, RN, MSN, is director of care management for CHRISTUS Health: Community Health in Houston, Texas (kimberly.camp@christushealth.org).

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Download Protocols

The CHRISTUS system has created pathways, or step-by-step protocols, that guide community health workers when addressing common issues with patients, such as screening for depression and obtaining prescription medication assistance. Visit www.hfma.org/boc to download the pathways.

Communicating Layoffs

Transparency and understanding will help your staff through a difficult time.

How can I best communicate upcoming layoffs and other cutbacks to my nursing staff?

Sanford: Nurses are not as susceptible to layoffs as other hospital employees, but nursing assistants and LPNs are often among those who lose their jobs when the economy falters. The work done by those people often gets shifted to RNs, so even if nurses aren't being laid off, they should still be included in the communication process.

Layoffs can be very emotional for staff, even those who are keeping their jobs. This is particularly true in economic times like these: People are nervous about their personal financial situations and when they suspect cutbacks are coming, they are less trusting of the leadership who will be implementing them.

As a good manager, you probably already have good relationships with your staff, but layoffs mean that you must work to maintain their trust. The most important thing you can do in this case is communicate, communicate, communicate. Be as transparent as possible and scrupulously honest. When you have information you can share, let your staff know right away. If you have news that must be confidential, tell staff that you cannot share the information at the moment, but will do so as soon as you are able.

Once you know who is being laid off, the way to communicate this depends on how many people will be leaving. If it's just a few staff, you should sit down with each person individually before talking to the larger group. If there will be big layoffs, the best thing to do is to communicate this at a large group meeting, then meet with individuals one on one as soon as possible.

When discussing layoffs with a group, you need to make them understand the rationale. Many organizations make the mistake of assuming

that staff know why layoffs are occurring (i.e., that the economy is slow, that the patient census is down, that costs are up, that personnel is the biggest budget item). But these issues need to be detailed for the group, along with how they affect the margin, why the hospital needs to maintain the margin at a certain level, and why it is important to have capital for the future. You should also talk about how the layoff decisions were made—employees need to understand the decision-making process.

The next step is to meet with the individuals being laid off. When you have these meetings, you need to have the information on their last date of employment, severance (if there is any), re-hire rights, and whether there are other positions in the hospital for which they might be qualified. Also, be prepared to again discuss the hospital's rationale for the layoffs. Be sure to make it clear that the decisions were financial, not personal.

When laying people off, it's OK to show sympathy, as long as you remain straightforward and

business-like. Some believe that you need to be unemotional, but it can help the person to know that you feel bad about laying them off and wish it didn't have to happen. If the person is an especially good employee, you should offer to provide a letter of recommendation, and let him or her know that you can be called upon as a reference when they interview for other jobs.

Finally, have plans to address survivor guilt. People left behind after a layoff may become less productive, or they may leave their jobs because their friends were laid off. Talk to human resources staff and social workers to develop strategies to deal with survivor guilt, which can last for up to a year.

These are difficult economic times for everyone, and no one wants to lay off staff. However, transparency and solid communication can help ease the process for all employees involved. ☞



Kathleen D. Sanford, RN, MA, DBA, FACHE, is past president of the board of directors of the AONE and senior vice president and chief nursing officer of Catholic Health Initiatives. Do you

have a question for Kathleen? Send it to kathyaone06@yahoo.com.

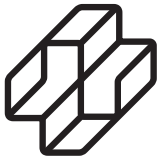
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