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The High Road to Better Care (and Stronger Unions)

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The conventional wisdom among most hospital managers is that unions have very little to offer when it comes to improving the quality and efficiency of patient care. In fact, many believe that unions just get in the way. However, that may be changing.

For the past several years, we have been studying, and in some cases assisting, unions that are actively mobilizing their members to improve the quality and efficiency of patient care. Those efforts have come in all different shapes and sizes. In one Massachusetts hospital, the union approached management about working with a unit to improve its patient satisfaction scores, and ended up boosting the scores on that unit from worst to first in the hospital. In hospitals in Pittsburgh and Vermont, union leaders are going unit by unit through the hospital mobilizing members to remove obstacles to achieving excellence in patient care. In New York City, the union has partnered with the hospital association on a campaign to reduce hospital acquired infections in hospitals throughout the region, and is involved in performance and quality improvement projects in many hospitals across the city. And in one of the largest health systems in the US, the union is working with management to establish structures to improve patient care at the unit level in every facility nationwide.

Although these efforts take many different forms, they have three key elements in common:

- The unions involved are focused on meeting the needs of patients – not just responding to the needs of union members
- The unions involved are taking the initiative to improve patient care -- not just reacting to what management is doing or not doing
- And the union leaders and members involved are getting smart about hospital operations, performance improvement, and change management – not just collective bargaining and contract administration

Adopting this approach can be a big stretch for union leaders. But our experience shows that there are big payoffs for unions that are willing to try. We are finding that members who have never been active in the union before are often eager to get involved in this new sphere of union activity, because the main drivers of hospital staff satisfaction are the ability to provide high quality care to patients and having a say in how that care is delivered. In addition, recent research suggests that gaining a greater voice in decisions that affect patient care is a critical determinant of nurses' commitment to their union.¹ As a result, these efforts are expanding both the number of activists and the level of union activity.

There are also big payoffs for hospitals. Mobilizing front-line staff to improve the quality and efficiency of patient care is not only an effective way to make sustainable improvements -- it may, in fact, be central and critical to the improvement process.² In addition, unions can play an important role in spreading improvements by helping communicate lessons learned from one department to another within an institution. And unions can help sustain improvements by incorporating those improvements into collective bargaining agreements, making it easier to stay on track through periods of crisis and changes in leadership. In several states, unions have also helped leverage state, federal, and foundation funding for training, backfill to enable staff to participate in improvement activities, and new technologies, all of which directly support hospital improvement efforts.

The Quality Imperative

Conditions are very favorable for more healthcare unions to adopt this approach right now, because hospitals are under the gun to improve the quality of patient care. Both their funding and their reputation are on the line.

For the past several years, there has been a big push to get hospitals to report to the public on the quality of care they provide. The Centers for Medicare and Medicaid Services (CMS) has launched a website – www.hospitalcompare.hhs.gov -- that contains data voluntarily reported by hospitals on 24 measures that are associated

¹ Paul F. Clark et al, "The Role of Nurse Voice in Influencing Member Perception of Union Instrumentality and member Commitment," Paper presented to the 60th Annual Meeting of the Labor and Employment Research Association, January 4-6, 2008.

² Draper, Debra A., Laurie E. Felland, Allison Liebhaber, and Lori, Melichar, "The Role of Nurses in Hospital Quality Improvement," Center for Health System Change, March 2008. Tucker, A. L., and A. C. Edmundson, "Why Hospitals Don't Learn from Failures: Organizational and Psychological Dynamics that Inhibit System Change." *California Management Review*, 2003.

with high-quality care. That list is expanding to 27 measures during 2008, including patient satisfaction scores.

Since July 2007, hospitals have been required to submit results from patient satisfaction surveys to receive their full annual payment update from CMS. Beginning in 2008, the results of those patient satisfaction surveys have been posted publicly on the Hospital Compare website. Hospitals that choose not to submit and publicly report their results will be reimbursed at a rate 2 percentage points lower than their peers. On the other hand, hospitals that publicly report poor results could find doctors referring their patients elsewhere.

Public reporting of results is intended to introduce competition into the health care system. Proponents believe that as consumers become more informed about care options, quality, and costs, providers will face pressure to adopt new competitive practices based on improved care and customer satisfaction.

But the government isn't relying entirely on consumers to hold hospitals accountable for higher quality. Since 2005, CMS and other payers have been experimenting with new pay for performance schemes that offer financial incentives to hospitals to hit certain quality targets. Hospitals that perform well get a reward, while hospitals that perform poorly lose out.

The number of quality measures is growing, and so is support for making this system mandatory for all hospitals. Four fifths of the health care opinion leaders recently surveyed by the Commonwealth Fund and Modern Healthcare magazine believe that more widespread public reporting of results will stimulate higher quality care.³

Along those lines, a growing number of states now require hospitals to publicly report medical errors and hospital-acquired infections. And CMS recently upped the ante with the announcement that they will no longer reimburse hospitals for the treatment of ten preventable errors, injuries, and infections that occur during a patient's hospital stay. The major insurance companies are following suit.

Union Quality Agenda

This changing environment creates an opening for unions to work with hospital management to improve the quality of patient care. So far, however, the union

³ K. K. Shea, A. Shih, and K. Davis, "Health Care Opinion Leaders' Views on the Transparency of Health Care Quality and Price Information in the United States," The Commonwealth Fund, November 2007

quality improvement agenda has focused almost exclusively on demanding better nurse staffing ratios and eliminating mandatory overtime, with the argument that these changes lead to better quality patient care.

Indeed, there is a growing body of research that shows a strong positive relationship between nurse staffing levels and patient outcomes. And in hospitals with chronic staffing shortages, better staffing ratios are a precondition to providing better care. But higher staffing ratios alone are not sufficient to achieve excellence in patient care in most hospitals, or in the healthcare system as a whole.

It's not clear that more staffing necessarily leads to better outcomes for patients -- the research is inconclusive. The research does show that higher levels of staffing are associated with better outcomes for patients, but it doesn't show a clear causal relationship. That was the conclusion of a meta-analysis that the Agency for Healthcare Research and Quality (AHRQ) did of 94 studies of staffing and patient outcomes conducted between 1990 and 2006.⁴

One possible explanation is that **what people do** may be more important than **how many people are doing it**. Currently, most hospital staff spend their days working in systems that are broken and that get in the way of consistently delivering high-quality care. According to one study of 36 hospitals,⁵ nurses spend only one-fifth of their time providing direct care to patients. They spend the rest of their time trying to keep up with paperwork, tracking down missing meds and supplies, tracking down doctors, and coordinating care with other departments.

The main effect of adding more staff into broken systems is to make it possible for more staff to work around more problems to get patients what they need. In fact, that's just what researchers at Harvard found when they shadowed nurses on the job.⁶ When the nurses ran into a problem, they came up with a quick fix to get around the problem 92 percent of the time, because they didn't have the time to resolve it. As a result, the same problems remained for them and others to run into again and again.

A more effective approach would be to fix the broken systems that plague most hospitals. And the best way to do that is to start at the point of care and

⁴ Robert L. Kane, et al, "Nurse Staffing and Quality of Patient Care," Evidence Report/Technology Assessment Number 151, Agency for Healthcare Research and Quality, March 2007.

⁵ Ann Hendrich, et al, "A 36-Hospital Time and Motion Study: How Do Medical-Surgical Nurses Spend Their Time?" *The Permanente Journal*, Summer 2008, Vol. 12, No. 3.

⁶ Anita L. Tucker, et al, "Front-Line Problem Solving: The Responses of Hospital Nurses to Work System Failures," *Academy of Management Proceedings*, 2001.

systematically eliminate whatever is getting in the way of consistently delivering excellent care. The experts on how to do that are the people closest to the point of care – the front-line staff.

Taking the Initiative

That creates an opening for unions that represent front-line staff to mobilize their members to improve patient care. And some are seizing this opportunity. However, they are finding that they need a new mindset, new skills, and new language in their collective bargaining agreements to do so.

Traditionally, most healthcare unions have tended to be reactive, rather than proactive, when it comes to hospital improvement initiatives. (The same is true of unions in other sectors of the economy.) The conventional mindset is that management acts, and the union reacts. And that is particularly true when it comes to hospital improvement initiatives.

One reason is because past re-engineering initiatives left such a bad taste in their members' mouths. However, the approach that many hospitals are now taking to improving performance is different from re-engineering. Most hospital reengineering efforts typically took the people out of the system first, and then rearranged the work to fit the remaining people. The approach that many hospitals are now using focuses on taking the non-value added work out of the system first, and then rearranging the people to fit the remaining work. That results in staff spending more time delivering care to patients, which is very satisfying, particularly when the staff are the ones making the changes.

Another reason that unions tend to be reactive when it comes to hospital improvement initiatives is because most union leaders lack the skills or experience necessary to be proactive in this arena. Most unions train their staff and local leaders in how to organize new members, negotiate and administer a contract, and conduct political action campaigns. They don't usually train them in how to launch, manage, sustain, and spread improvements in hospital operations and the quality of patient care, how to redesign work, and how to work together with management in that process.

A third reason that unions tend to be reactive in this arena is because they don't have language in their collective bargaining agreements that gives them a seat at the table. In fact, managing hospital operations is a right typically and often expressly reserved by hospital management in most agreements. Without a clearly

defined role in decision-making, union leaders have often seen their suggestions for improvements rejected or ignored without any justification, which has made some of them wary of getting involved in improvement initiatives.

However, many unions are starting to put language into their collective bargaining agreements to support union involvement in improving the quality and efficiency of patient care. Some internal union training programs are being expanded to teach the skills union staff and leaders need to be proactive in redesigning work and improving quality. And the joint training funds that a growing number of unions are establishing are being used to support the training and development of front-line staff to participate effectively in, and even lead, improvement efforts.

Partnership Structures

When it comes to working with management, there are many examples of unions successfully partnering with management to pursue common objectives. Those partnerships have reduced the number of grievances that need to be processed, prevented strikes, improved employee health and safety, expanded training opportunities, solved problems, and reduced conflict in the workplace.

In the past, most labor-management partnerships have focused mainly on improving labor relations and increasing employee satisfaction, and have tended to operate outside the operational mainstream of the organization. However, some unions have begun expanding the scope of their partnerships to also make improvements in the quality, safety, and efficiency of patient care.

Most unionized hospitals have had hospital-wide labor-management committees in place for a number of years to improve nursing professional practice. Similar structures are now being used to improve patient satisfaction and to reduce hospital-acquired infections, and those structures increasingly include non-nursing staff.

In our experience, however, these hospital-wide committees by themselves have had mixed results, and they have proven hard to sustain. So, the focus has increasingly begun to shift to the unit and department level, where the emphasis has been on engaging front-line staff in problem-solving and improvement activities. These efforts have usually taken the form of discrete projects focused on issues that are specific to the unit or department. In some cases, more permanent unit-based structures are being established to support the improvement process.

And in a few cases, those unit-based partnership structures are replacing more traditional management structures.

Our experience with these unit-based structures over the past several years suggests that they can play an important role in maintaining stability in hospital operations, making it easier for staff to get their work done and, thus, provide better patient care. In doing so, they create the conditions for fixing broken systems. But, while staff at the unit level are in the best position to identify where systems are breaking down, they are not in a position to fix the broken systems that are causing most of their problems, because those broken systems usually cut across multiple units, disciplines, and departments.

In response, some hospitals have started organizing multi-disciplinary, cross-functional teams to fix these broken systems, and these teams often include front-line staff. But, they rarely involve the union, mainly because management perceives that the union has little to contribute to these efforts, and in fact, is more likely to get in the way. In those cases, hospital management is going directly to the front-line staff and bypassing the union.

The Challenge

If healthcare unions continue to sit on the sidelines while management scrambles to improve patient care, or if unions take potshots at management efforts without doing anything on their own, the management perception that unions have little to contribute will harden, and this window of opportunity will close. But that doesn't have to be the case. Unions can be credible, responsible, and contributing partners in these strategic, cross-functional, systemic improvement efforts. They already are in some cases. And in a few cases, the union has even initiated and led these efforts.

The unions that are taking this high road are charting the course into a new frontier of union activity. The conditions are favorable, and the payoffs are significant in terms of stronger unions, healthier patients, and higher performing hospitals. It's possible that some day, the new conventional wisdom could be that "union care" really is "better care."