

STRATEGIC ALLIANCE REPORT 2007

Creating Competitive Advantage in a Changing Health Care Environment Through Worker Participation



ABSTRACT

The Maimonides Medical Center Strategic Alliance, which brings together labor and management to address issues of mutual interest, is a testament to the power of collaboration. Health care institutions today face mounting pressure to provide the highest quality care while controlling costs and meeting increasing regulatory requirements. To tackle this difficult task, the Alliance created hospital-wide and Departmental Labor Management Committees empowered to analyze problems and to develop, implement, and sustain solutions designed jointly by union and non-union employees and hospital managers. During the past 10 years, such collaborations of union and management groups have improved productivity and patient care throughout the institution, and have helped Maimonides to thrive in the ever-changing health care environment.

SUMMARY

For nearly a decade, the unions and management at Maimonides Medical Center (MMC) have been engaging in joint labor-management activities to further the strategic goals of

- clinical excellence.
- humane, respectful care.
- community engagement.

This organizational priority, known as the Strategic Alliance, is grounded in the belief that fostering respect among employees and supervisors, promoting rank-and-file leadership, encouraging broad workforce participation in problem-solving and decision-making, and developing a true partnership between unionized workers and management are all essential to the Medical Center's success.

Senior management and union leadership from 1199SEIU United Healthcare Workers East (1199), the New York State Nurses Association (NYSNA), and the Committee of Interns and Residents (CIR) have joined together to design, support, and structure worker participation programs. Workers and managers now meet regularly in highly organized settings to solve problems, hire managers and supervisors, and redesign work in order to further the hospital's strategic goals.

TRAINING IS ESSENTIAL

It was recognized early on that the Strategic Alliance's success would depend on participant training, leadership development, and staff support that go beyond traditional approaches to workforce development. External consultants were retained from the 1199SEIU Employment, Training and Job Security Fund and from the Cornell University School of Industrial and Labor Relations. Innovative programs on conflict resolution, team building, work redesign, and interest-based problem-solving have been developed to prepare all levels of the workforce for participatory decision-making. After experimenting with several approaches, a successful model was developed and implemented through the Medical Center's Labor Management Council (LMC) that oversees the Strategic Alliance. At both the hospital and departmental levels, labor-management committees have been formed to work on quality of care and patient satisfaction issues, as well as issues related to employee needs of respect and input into decision-making.

These internal committees are assisted by internal consultants—Developers and Coaches—who, as experienced advocates from either the unions or management, help ensure committees have needed resources and help guide problem-solving and decision-making activities so committees are efficient and obtain results in a timely manner.

All participants receive training on how to identify and reframe problems to address each party's interest, craft mutually agreeable solutions, and implement and evaluate joint decisions.

With this support and training, Departmental Labor Management Committees (DLMCs) have become the preferred structure for resolving outstanding employee/employer issues that are neither grievances nor disciplinary issues, and they are increasingly used to redesign work.

These labor-management activities have achieved impressive results:

- Joint hiring of new managers and supervisors is now routine and, as of June 2007, has been used to fill more than 70 management positions. While it is difficult to quantify the benefits of joint hiring, several departments have improved performance markedly under joint-hire managers and two such managers have been promoted to department heads.
- Formal grievances and arbitrations have become less frequent, with reductions in formal grievances from 103 in 1994 to 38 in 2006.
- Work has been redesigned in many departments throughout the Medical Center:
 - Patient transport turnaround time has been reduced in the Radiology Department with ER waiting times for radiology services declining by 40%.
 - Engineering Department staff are being reassigned more quickly after completing jobs, thanks to an improved job completion reporting system.
 - Ambulatory Health Services work was redistributed among the department's nine sites to equalize the workload.
 - Finance and Patient Accounts staff are completing Medicaid questionnaires more fully and effectively as a result of improved training and collaboration with information technology staff.
 - Food and Nutrition staff have redesigned the preparation and delivery of special dietary meals following a department-wide workflow analysis and retraining program. The percentage of meals delivered on time is now in the high 90s.
 - Health Information Services staff have expedited the filing of reports and retrieval of patient records, reduced the percentage of uncollected accounts, and improved the processing and completion of medical records.
 - The Laboratory management and staff have jointly developed and implemented a reorganization plan to redeploy staff flexibly and reduce turnaround time.

When NYSNA temporarily left the Strategic Alliance in 2002–2004 during a labor dispute, parallel labor-management activities in nursing were undertaken and also made impressive improvements in the quality of nursing care at the hospital:

- Patient falls hospital-wide have been reduced by nearly half, while the use of restraints has decreased.
- More elderly patients are being immunized against pneumonia and other bacterial infections.
- Fewer patients who are at risk for pressure sores are developing them.

With all three major unions now working within the Strategic Alliance, highly functioning labor-management committees are taking work redesign projects to a new level.

With all three major unions now working within the Strategic Alliance, highly functioning labor-management committees are taking work redesign projects to a new level. More than ever before, workers are leading the process.

- The Environmental Services Study Action Team has launched an ambitious Hospital Cleanliness and Orderliness Project to improve the cleanliness of the entire hospital as one of the many activities to maintain continuous readiness for surveys by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO).
- The Cardiology DLMC has established changes in procedures and communications that, as a crucial quality of care issue, have reduced the response time to cardiac monitor alarms to less than one minute. Attending physicians, nurse practitioners, and physician assistants have been part of these activities.
- Employee wellness has become sponsored as a Strategic Alliance project to improve each employee’s physical condition by increasing physical activity, improving nutritional habits, and reducing stress levels.
- An Employee Communication Work Group has been established to improve communication not only about labor-management activities, but also about other important hospital news, as reflected in expanded coverage in the Medical Center’s internal newsletter, *Ear to the Ground*.

The Strategic Alliance is deeply embedded in the Medical Center as an experienced partnership between the three unions and management.

With this strong record of success, the Medical Center’s labor and management are committed to broadening and deepening the Strategic Alliance. New joint labor-management activities continue to be developed. Today, the Strategic Alliance is deeply embedded in the Medical Center as an experienced partnership between the three unions and management. Participatory problem-solving and decision-making are becoming the norm, and Maimonides Medical Center is even more strongly positioned to reach its strategic goals as the leading tertiary care center and health care employer of choice in Brooklyn.

Participatory problem-solving and decision-making are becoming the norm.

INTRODUCTION

The health care environment is complicated, competitive and constantly changing. Hospitals and other health care institutions are expected to provide quality patient care, operate efficiently, serve nearby communities, and generate adequate revenues. Meeting these disparate and sometimes inconsistent objectives requires leadership, teamwork, and innovation, as well as a satisfied and productive workforce, all of which are often difficult to achieve under the high pressure of a complex medical center environment.¹

For nearly a decade, Maimonides Medical Center (MMC) has been engaging in joint labor-management activities to further the strategic goals of clinical excellence; humane, respectful care; and community engagement. This organizational priority is grounded in the belief that fostering respect among employees and supervisors, promoting rank-and-file leadership, encouraging broad workforce participation in decision-making, and developing a partnership between unions and management so as to design work in a way that improves quality of care and patient safety are all essential to the Medical Center's success as the leading tertiary care institution in Brooklyn.

Beginning in 1997, 1199SEIU United Healthcare Workers East (1199), the New York State Nurses Association (NYSNA), and senior hospital management created a Strategic Alliance “to work together in defined areas of shared interest, while understanding that each organization will at times work independently in other areas.” Today, the Strategic Alliance also includes the third union at Maimonides—the Committee of Interns and Residents (CIR).

As expressed by Maimonides President & CEO Pamela S. Brier, the Strategic Alliance reflects a joint commitment to “improve our ability to provide the highest quality patient care and remain an employer of choice in Brooklyn and the five boroughs as a result of systematic and leveraged use of worker participation activities.” Rhadames Rivera, Vice President of 1199SEIU, has stated, “Our union sees it as critical for us to participate in decisions that affect patient care and patient satisfaction. It is our responsibility, too, to insure patient care is excellent.”

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*—Rhadames Rivera,
Vice President of 1199SEIU*

¹ Physicians, nurses, patient care technicians, mental health workers, pharmacists, social workers, housekeepers, clerical and IT staff work side-by-side despite great differences in licensure and credentialing, power, status, and salary. Hospital work continues 24 hours a day, seven days a week, while three shifts come and go. A myriad of departments with disparate functions—from the laundry to the laboratory to patient accounts—are expected to coordinate their activities and meet high standards of service delivery. Emergencies and patient care imperatives are constant.

IMPRESSIVE RESULTS

The Medical Center's labor-management activities have achieved impressive results. Unionized staff and administrators now jointly hire new managers. Formal grievances are less frequent as a result of preventive problem-solving activities. Productivity and quality of patient care have improved because unionized workers, managers, nurses, and doctors are working together in structured ways to solve problems and redesign work.

Over the years, there have been some setbacks and some projects that did not achieve the desired results. Initiatives have stalled and then have been resuscitated. Less effective activities have been transformed into learning opportunities. At times, there have been problems sustaining changes once "solutions" have been implemented. Through it all, the joint labor-management commitment to the Strategic Alliance has been maintained and even strengthened. More and more, units within the hospital are making decisions with staff participation in joint labor-management teams. Pamela Brier proudly acknowledges, "It is becoming the way we work."

In 2007, it is possible to look back over the past decade to trace this progress and highlight important achievements for both patients and staff. It is also possible to look forward to the broadening and deepening of the Strategic Alliance between labor and management at Maimonides Medical Center.

THE STRATEGIC ALLIANCE'S HISTORICAL CONTEXT AND FRAMEWORK

In 1994, the collective bargaining agreement between 1199SEIU and the League of Voluntary Hospitals and Nursing Homes expanded the Job Security Fund and the Training and Upgrading Fund to include the “Labor-Management Project.” This initiative was established to support new ways for labor and management to work together to meet challenges in the changing health care environment. Not a replacement for contractual rights through collective bargaining, it was—and still is—an agreement to work cooperatively within defined areas of shared interest.

In 1997, Maimonides formed a hospital-wide Labor Management Council (LMC) to oversee and structure an organizational process fostering mutual respect, trust, effective communication, and the active participation of staff in departmental and unit decision-making. The LMC is made up of senior management, including the President & CEO, and union representatives, and it is staffed by internal consultants (Labor-Management Developers).

1199SEIU has been active from the beginning. The New York State Nurses Association (NYSNA) was an original member of the LMC, withdrew in 2002 over a jurisdictional conflict with 1199, and formally rejoined in 2004. The Committee of Interns and Residents (CIR) became recognized and joined the LMC in 2004.

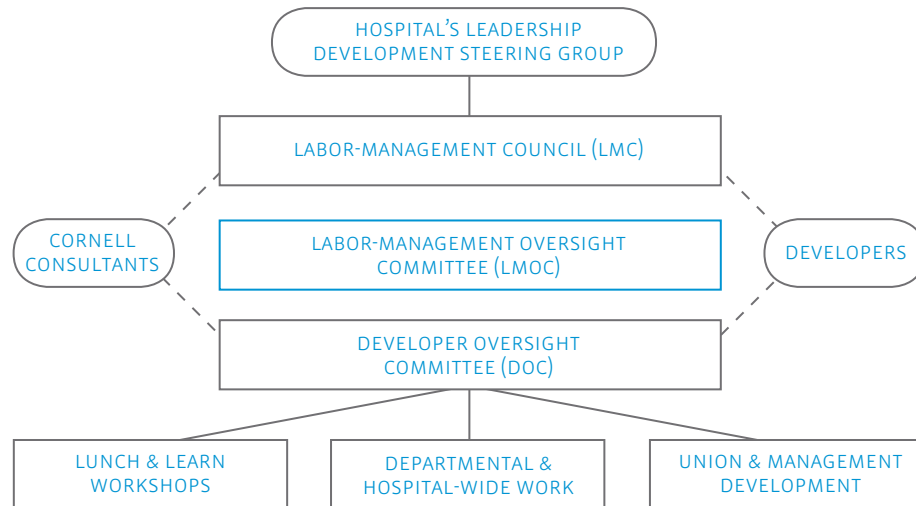
The LMC meets regularly and is facilitated by labor and management co-chairs. The LMC is charged with guiding the Strategic Alliance and meeting the critical goals of the Medical Center as well as of the unions.² Weekly supervision and leadership are provided through a Labor-Management and Developer Oversight Committee (DOC) that reports directly to the LMC.³

It was recognized early on that success would depend on participant training, leadership development, and staff support. External consultants were retained from the 1199SEIU Employment, Training and Job Security Fund and from the Cornell University School of Industrial and Labor Relations, and they have continued to provide important expertise in organizational change and joint labor-management activities.

² MMC's overarching strategic goals are clinical excellence; humane, respectful care; and community engagement. Labor-management activities to develop rank-and-file leadership and employee satisfaction are key strategies to reach these goals. The union goals are to provide workers with greater input into decisions that affect their work; increase the number of union members (especially active members); reduce unnecessary grievances and arbitrations; support the union's political agenda at the community and state levels; increase training opportunities for members; gain access to information on the hospital's economics, strategic plans, and quality evaluations; sit on important hospital committees; continue to meet with management on a timely basis to address problems early; and gain community support.

³ The Developer Oversight Committee (DOC) consists of the three Developers, the Vice President and Assistant Director of Human Resources, the Vice President of 1199SEIU, the union representative for NYSNA and the senior consultant from Cornell University.

STRATEGIC ALLIANCE STRUCTURES



FIRST STEPS

Initially, departmental and hospital-wide committees were provided conflict resolution training. This training was intended to create new methods to resolve conflicts at a departmental level and avoid formal grievances and disciplinary actions by offering a timely, structured, preventive problem-solving process.

This approach was a significant focus of work from 2002 to 2005, requiring substantial resources and training of large numbers of managers and union leaders. Trainees were released from their normal work responsibilities for off-site training in conflict resolution skills and, in selected departments, managers and supervisors as well as union leaders also received several days of leadership development workshops. However, participants found it difficult to apply these lessons once they returned to the workplace and conflict resolution training turned out to be insufficient to help workers and managers problem solve and redesign work.

DEPARTMENTAL LABOR MANAGEMENT COMMITTEES ARE BORN

In order to focus more specifically on problem-solving closer to service delivery and on engaging larger numbers of employees, the LMC decided to accelerate work at the departmental and unit levels through Departmental Labor Management Committees (DLMCs). In 2005, during the second phase of the Maimonides Strategic Alliance’s development, greater emphasis was placed on problem-solving skills training, union and management leadership development, and continuing conflict resolution. Departments that were selected during this phase were assigned a Developer who coached DLMC

co-leaders and members in order to improve effectiveness of departmental committees and project teams.⁴

A series of trainings have been conducted over the years for managers and union representatives (both separately and together), as well as for internal resources that support the Strategic Alliance (e.g., the Developers, HR staff, and union representatives). HR staff, union organizers, and the hospital's Chief Learning Officer at times serve as Coaches to union and management leaders, and participants on DLMCs and project teams.

Union leaders and HR staff are paired to work with specific departments, as well as assigned to work with specific staff to help ensure that workers are consulted when changes are taking place, and that the ideas and both strategic and day-to-day concerns of workers and management are shared at monthly DLMC and LMC meetings. The HR-union teams also ensure that co-leaders receive support to develop meeting skills and ensure that solutions are sustained. They also work to develop fully functioning DLMCs to serve as a forum for sharing information, identifying problems to be solved, and overseeing the implementation of appropriate solutions. The hospital's Developers (internal consultants) work with co-leaders of each DLMC and project team to improve the effectiveness of these groups.

DEVELOPING EFFECTIVE DLMCs—IMPROVING WORKER PARTICIPATION ACTIVITIES

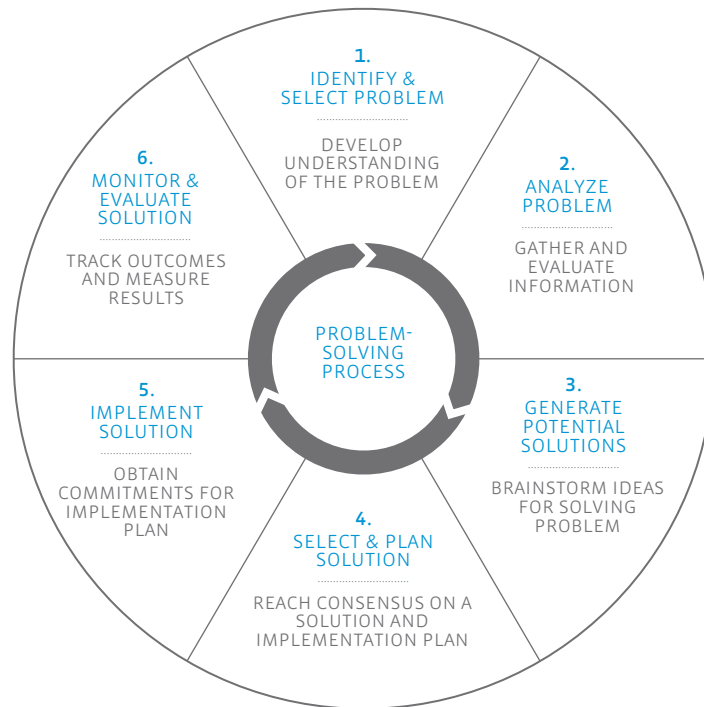
To date, 13 DLMCs have been formed, with members who are chosen trained in interest-based problem-solving, work redesign practices, and the worker participation principles that are the foundation for the Strategic Alliance.⁵ The DLMCs provide a forum for labor and managers to come together and work on areas of mutual interest and need. The emphasis is on interest-based problem-solving—a structured approach involving six steps:

- identify and select the problem.
- analyze the problem.
- generate potential solutions.
- select and plan solutions.
- implement solutions.
- monitor and evaluate solutions.

⁴ Subcommittees in departments were assigned specific problems to analyze and for which to develop solutions.

⁵ The first round of projects started in Medical Records, Food and Nutrition, and the Laboratory. Once this work was under way, it was recognized that department-level work needed more support. A DLMC toolkit was created along with defined roles for Coaches and co-leaders. By 2002, the original projects had been restructured and additional DLMCs formed in the Blood Bank, Environmental Services, Engineering, and Patient Accounts. By 2005, Ambulatory Services, Cardiology, Case Management, Health Information Services, Radiology, some Medical Units, and Finance had also formed DLMCs.

SIX STEPS OF PROBLEM-SOLVING



Departmental Labor Management Committees use this six-step process to develop, implement, and sustain mutually agreeable solutions to issues they want to address.

All newly-chartered DLMCs start by identifying outstanding issues that are creating conflict and dissatisfaction in a particular department. Once trust and respect issues are addressed, the group focuses on departmental projects to improve performance using interest-based problem-solving and other analysis and decision-making tools.

Developers, Coaches, and consultants, as well as the union and management co-chairs, have all played key roles in supporting these departmental activities and advancing the Strategic Alliance objective—improving patient care by increasing worker participation. With assistance from Developers and Coaches, DLMC members and project work teams use the appropriate tools and approaches for problem-solving, implementing, and sustaining solutions. All work of the Strategic Alliance is based on the 12 principles of the Strategic Alliance.⁶

⁶ See Appendix A for the 12 principles of the Strategic Alliance.

LEARNING BY DOING

In many cases, issues were resolved simply by putting them on the table. In other cases, resolution has required developing team projects, collecting data, creating workflow charts, redefining roles and responsibilities, training and retraining staff, and providing follow-up monitoring and ongoing compliance efforts. Some issues have been addressed with available resources while others have required budget approval and union-management agreement on job title changes through the collective bargaining process. As Maimonides has gained experience, the Medical Center has learned that significant time and resources are necessary to fully engage labor and management in team-based activities.

Even with the support of the LMC and interventions by Coaches and Developers, the process has not always been easy and there have been barriers to success along the way. It has sometimes been difficult to get broad departmental representation, especially in multi-site departments. In the face of other work pressures, it has sometimes been difficult to schedule meetings and ensure attendance, especially in areas where there are multiple shifts. Obtaining consistent physician, resident, and intern involvement has also been a challenge. Over time, however, there has been a shift in these dynamics with an increasing recognition of the benefits of joint work.

In many cases, it has been possible to resolve issues simply by putting them on the table.

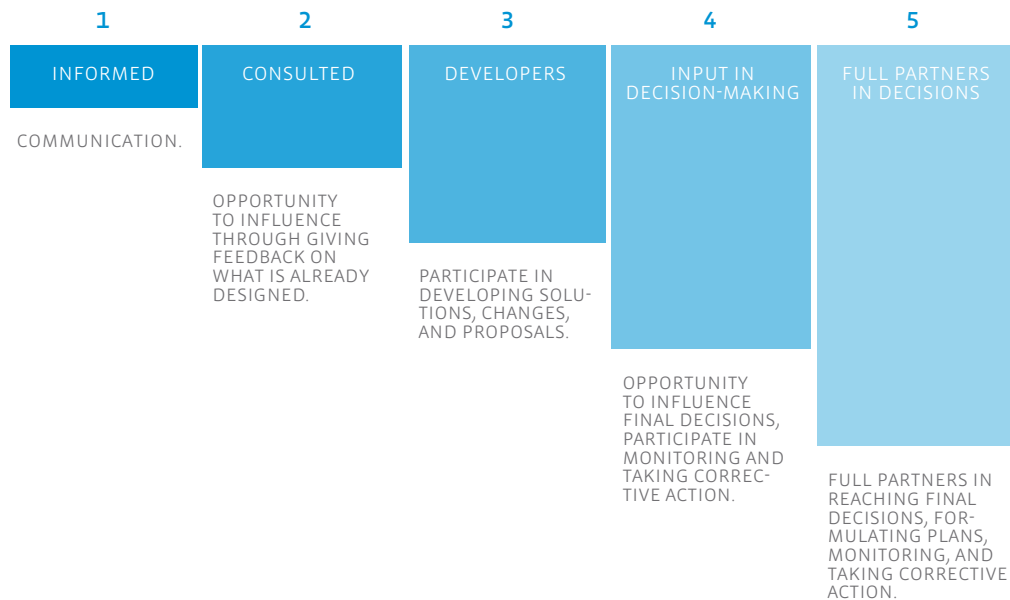
PROGRESS DESPITE DISCORD

In 2002, NYSNA withdrew from the Strategic Alliance as a result of a jurisdictional dispute with 1199SEIU. During this period, the Nursing Department initiated parallel labor-management activities. The Nursing Performance Improvement (PI) projects, as they were called, were used to continue NYSNA involvement in participatory approaches to problem-solving and joint decision-making on all nursing units. Because NYSNA was not then a part of the Strategic Alliance, this activity developed a separate organizational context to move forward.

The PI projects were chartered by a nurse steering committee instead of the LMC and aligned with the Medical Center's performance improvement structure. Rather than creating labor-management co-chairs, a nurse manager served as the team leader with responsibility for guiding the problem-solving process, thereby ensuring that critical baseline data was collected, preparing for and conducting team meetings, and coaching team members. Despite the differences in structure, Strategic Alliance core principles of staff participation and team decision-making were adhered to, and unit-based nursing teams included all staff: RNs, patient care technicians (PCTs), nurse managers, clerical staff, information specialists, physicians, pharmacists, and PI specialists. Each team established a specific project goal, (e.g., reducing patient falls by 50%), met weekly for three to four months, engaged all staff in the analysis of a particular problem, obtained agreement on the solution, and oversaw the implementation and solution maintenance process.

When NYSNA rejoined the Strategic Alliance in 2004, the PI projects became incorporated into the work of DLMCs, which were aligned and integrated with the Medical Center’s PI functions and structures. Tools used in the “PI nursing process” have proven to be very useful and have become an integral part of Strategic Alliance activities. DLMCs have been taking on increasingly ambitious projects that have direct impact on the quality of patient care.

LEVELS OF INVOLVEMENT BETWEEN LABOR AND MANAGEMENT STRATEGIC PARTNERS



For each project, the Departmental Labor Management Committee (DLMC) selects the level of its involvement in decision-making. Experience has shown best results when this is decided at the outset of the process. The goal currently is to have DLMCs participating in projects at levels 4 and 5.

THE MANY SUCCESSES OF THE STRATEGIC ALLIANCE

1. JOINT HIRING OF NEW MANAGERS AND SUPERVISORS HAS BECOME ROUTINE.

Joint selection of most new department heads and supervisors, including those in all departments with a unionized workforce, was one of the first hospital-wide labor-management projects undertaken at Maimonides and has gradually become a standard practice. This is now viewed as an important opportunity to hire for the new competencies needed to address labor relations issues, promote employee participation in decision-making, share quality and efficiency data, and foster respect and trust.

In those departments that decide to establish a joint hiring process, a joint selection committee is established. Both labor relations staff and union organizers work with the appropriate DLMC to select committee members. Typically, the selection committee includes a management representative, a union organizer, a human resources representative, and departmental employees from a cross-section of different job classifications. The level of this committee's decision-making is determined by discussions among the labor and management coaches and the manager of a particular department. Decision-making authority has ranged from providing input to deciding who should be hired.⁷

Committee members are trained in interviewing techniques and candidate assessment. They review job descriptions, share concerns, and align management and union expectations. Most important, the committee sets the criteria for candidate selection. As joint hiring has become common practice at the Medical Center, there have been increasing opportunities to build better understanding among managers and workers. Senior management increased efforts to inform the DLMCs about issues of confidentiality and privacy regarding personnel issues that remain solely within the confines of the Human Resources Department. An environment in which union employees feel safer participating in interviews with a candidate who eventually might become their supervisor has been encouraged. Over time, as the benefits of joint hiring have become apparent, joint selection committees with hiring authority are becoming the norm, and that is quite rewarding.

Seventy management positions have now been filled through joint labor-management hiring since 1997.⁸ The Medical Center has found that jointly hired managers are more likely to support and sustain joint labor-management activities, work effectively with the union for timely resolution of labor relations problems, practice participative management, and receive immediate staff support as they transition into their new jobs.

⁷ See accompanying chart for information about different levels of decision-making.

⁸ The following positions are among those filled utilizing the joint labor-management selection process: VP and AVP, Human Resources; Assistant VP, Psychiatric Services; Director, Food and Nutrition (twice); Director, Medical Records (twice); Director, Engineering (twice); Director, Ambulance Services; Director, Environmental Services; Director, Nursing Medicine; Director, Nursing Recruitment; Director, Perioperative Services; Business Manager, Perioperative Services; Nurse Manager, Pre-Admission Testing; Administrative Director, Ambulatory Care Network; Site Administrator, Ambulatory Health Network; Business Manager, Ambulatory Health Network; Assistant Director, Radiology; Training and Development Specialist; and three Developers.

2. INTEREST-BASED PROBLEM-SOLVING HAS BECOME THE PREFERRED METHOD FOR RESOLVING OUTSTANDING ISSUES AND CONFLICTS.

The first phase of the Strategic Alliance's establishment of DLMCs included the following departments: Medical Records, Food and Nutrition, and Laboratory. Substantial attention and resources were devoted to training members and Maimonides Developers, designating management and labor Coaches, defining the scope of work through each department's charter, and developing an appropriate way to release staff to attend DLMC and team meetings without disrupting patient care.

Starting in 2000, a "Lunch and Learn" series was developed for managers to enhance skills needed for successful Strategic Alliance work. Topics ranged from participatory management practices to reading and communicating budgets to staff and learning techniques for joint problem-solving.

There were also workshops provided for union delegates (union representatives) to learn how the Strategic Alliance works and to learn and practice interest-based problem-solving skills—a method to solving problems jointly with management and with each other. These workshops used situations and examples specific to Maimonides and included topics pertaining to more traditional union roles, such as investigation techniques, methods for informally resolving grievances and other problems, interpreting key sections of the contract, running effective meetings, and ways to communicate with members.

This delegate training expanded the "toolkit" for union leaders and was used to help build their confidence to participate in problem-solving and decision-making with management. In 2002 and 2003, more than 350 labor delegates, staff, middle managers, and supervisors attended separate and joint educational workshops on interest-based problem-solving, communications and engagement skills, and fast cycle/breakthrough project development.⁹

In addition to training, each DLMC was assigned a union and human resources Coach. Intensively trained and supervised by outside consultants, each Coach was prepared to work with the labor and management co-leaders and DLMC members to approach workplace issues in an open, non-judgmental manner using interest-based problem-solving techniques. Despite the Coaches' challenges of having multiple roles (union Coaches are also organizers and advocates; management HR Coaches also hear grievances), experiences with the Coaches have also increased the level of trust between labor and management.

⁹ Phase One training (September 2002) was provided to DLMC members in the Blood Bank, Engineering, Environmental Services, Food and Nutrition, and Health Information Services DLMCs. Phase Two training (June 2003) was provided to DLMC members in the Ambulatory Health Services Network, Laboratory and Pathology, Nursing-Medicine, and Radiology. Phase Three training (December 2004) included DLMC members in Case Management, Patient Accounts and Cardiology.

Through this joint labor-management process, conflicts have been addressed regarding vacation schedules, dress code, job responsibilities, parking, shift-to-shift reporting, management communication, physical space, work stations, and many other job-related issues and concerns. As interest-based problem-solving has become more common, formal grievances and arbitrations have become less frequent.

The tables below offer evidence that the Strategic Alliance work has resulted in a trend away from reliance on grievances, arbitration, and disciplinary action to resolve disputes. It also can be inferred to have had a beneficial effect on union membership enrollment.

CURRENT GRIEVANCES AND ARBITRATION INFORMATION

	1994	1995	1996	1997	2002	2003	2004	2005	2006
1199SEIU GRIEVANCES	72	41	35	31	5	11	12	15	26
1199SEIU ARBITRATIONS	14	17	13	20	1	1	0	2	6
NYSNA GRIEVANCES	14	17	4	14	2	6	2	0	5
NYSNA ARBITRATIONS	3	12	5	4	1	0	2	0	1

DISCIPLINARY ACTION

	1994	1995	1996	1997	2002	2003	2004	2005	2006
1199SEIU	220	201	162	159	159	164	170	106	200
NYSNA	43	47	41	29	22	33	23	5	20
TOTAL	243	248	203	188	181	197	193	111	220

UNION BUILDING OUTCOMES - 1199SEIU

	2002	2003	2004	2005	2006
NUMBER OF MEMBERS	2,422	2,602	2,267	2,175	2,569
CONTRIBUTION TO PAC	58%	65%	71%	83%	84%
NUMBER OF DELEGATES	23	35	61	67	84
HOLDING REGULAR DELEGATES MEETING/ASSEMBLY	20	45	55	47/60	50/67
ATTENDING POLITICAL RALLIES	—	—	622	925	0
GRIEVANCES/ARBITRATION	1	1	1	1	2
DELEGATES TRAINING	1	2	2	1	2
UNION SKILL BUILDING (INDIVIDUAL SKILLS)	—	—	—	2	2
DELEGATE/MEMBERS RATIO	—	25/1	25/1	20/1	18/1

3. LABOR-MANAGEMENT COMMITTEES HAVE BECOME INVOLVED IN REDESIGNING WORK AT THE DEPARTMENTAL LEVEL.

As the Strategic Alliance has matured and broadened its representation (with the return of NYSNA and the inclusion of CIR), departmental labor-management activities have moved beyond resolving outstanding issues and conflicts to solving systems and operational problems.

DLMCs are increasingly focused on the broader goals of quality of care and workforce productivity. Successful projects are being replicated in other departments and emphasis is being placed on hospital-wide approaches that strengthen and coordinate the various departmental labor-management activities, as well as integrate this work with the other leadership, quality of care, and patient satisfaction activities. The partial listing of DLMC projects below shows the impressive range and scope of labor-management activities that have been undertaken in various departments.

RADIOLOGY

The first major work redesign project in Radiology was an emergency room patient transport turnaround time reduction initiative. X-ray technicians were spending an inordinate amount of time locating and transporting patients from the Emergency Department and this, in turn, reduced the time available for X-ray procedures.

DLMC data collection found that the X-ray technicians were taking an average of 25 minutes to locate each patient. After analyzing this problem and identifying solutions, the DLMC established the goal of reducing patient transport time to 15 minutes. The Radiology DLMC then created a Patient Transport Turnaround Time (PT3) team to analyze and then suggest needed changes in the flow of patients and the work of staff to reduce patient wait time to 10-15 minutes.

The PT3, in consultation with all employees in their department, developed and proposed a better system for locating and getting patients X-rayed. The committee's analysis also revealed the need for a new position of Imaging Assistant who would be responsible for transporting patients whenever necessary and, between trips, making sure that the procedure rooms are clean and that X-ray films and charts are up-to-date and complete. The team presented these changes to their DLMC and obtained support for all of their recommendations, including hiring a new imaging assistant. As a result of tracking and monitoring these activities, eventually two additional full-time and one part-time imaging assistants were hired.

ENGINEERING

This DLMC initially focused on improving communication and procedures in order to reduce work order backlogs. One of the critical priorities was to find a way to expedite the reassignment of employees after an assigned job had been completed. The DLMC's analysis of the delays indicated the importance of increasing job completion call-ins so that the Medical Center's computerized tracking system could assign staff to the next jobs.

While calling in job completion is mandatory, there were significant inconsistencies in compliance. Once trust was established regarding the use of data to address this as a systems issue, there were significant improvements in the level and timeliness of calls. DLMC Coaches were assigned to help keep job completion call-ins on track when compliance levels began to decline after the initial improvements. Now, 98% of job completions are called in on time and the department is starting to use the lessons learned to redeploy resources and improve the preventive maintenance program.

AMBULATORY HEALTH SERVICES

The initial project for this DLMC focused on improving communication between ambulatory care sites, radiology, and the laboratory. A directory of services was produced for each of the sites, along with a quarterly newsletter specifically for the ambulatory care network. This provided employees at all nine network sites consistent information about the management, services, and hours of operation of each location, as well as details concerning billing, insurance, and patient-related matters.

The DLMC then developed a document for distribution to patients answering common questions on insurance, managed care, and physician participation, again providing all parties with consistent information.

With increasing support from staff in this multi-site department, the DLMC has been able to take on more ambitious projects such as redistributing work and centralizing some functions in order to avoid layoffs and equalize clinic workloads. When a few ambulatory sites in the Maimonides network experienced declines in visits, instead of layoffs or transfers to other departments, a redeployment plan within Ambulatory Health Services was developed. Work was reassigned; employees at one site were given additional billing work, and staff at other sites took over responsibility for case closings and charge postings for all sites. This plan not only avoided layoffs, it increased the overall efficiency of the network.

Another project involved the DLMC assessing the benefits of a centralized appointment system in order to avoid delays caused by patients contacting incorrect sites for appointments. After analyzing baseline data on the time spent on referral calls, the DLMC decided that implementing a centralized system was not the best solution.

FINANCE

An important project in this department has been to reduce errors resulting from incomplete information in Medicaid questionnaires that are used to measure recent patients' health care experience. Once trust was established regarding the use of data to address this as a systems issue, analysis of incomplete information revealed error patterns by payer, department, and employee. Then, all employees and supervisors were retrained in the proper procedures. Weekly reports monitored progress and identified continuing issues, which in turn led to further retraining. Equipment and software problems with scanners and computer screens that interfered with data migration were also identified and systems were changed to correct these problems. This project has significantly reduced errors and incomplete information, thereby improving cash flow.

FOOD AND NUTRITION

This DLMC identified the need to improve the accuracy and timeliness of patient meal delivery, particularly for those with special dietary needs. Following meetings with food service employees, nursing staff, and dietitians, an analysis of the entire meal cycle from ordering through preparation and delivery was conducted. In addition, all job descriptions were reviewed.

The analysis and problem-solving work of this DLMC resulted in a new delivery schedule that more adequately meets nursing staff requirements, the creation of new menu items to meet the needs of patients requiring special meals such as soft foods, and an intensive retraining program for all 120 food service workers. The on-time meal delivery percentage has moved from the 80th percentile to the high 90th percentile as a result of the changes made through this collaboration.

HEALTH INFORMATION SERVICES

This DLMC initially focused on improving productivity and employee satisfaction by:

- redesigning the workflow, which reduced unfiled reports by 75% and uncollected accounts by 75%, and achieved an almost 100% record retrieval rate for clinic patients.
- conducting a medical records training program as part of the transition to computerized medical records.
- improving workplace conditions that were identified in an employee survey and then prioritized by the committee. Chairs and broken tiles were replaced, walls were repainted, and staff were relocated to free up additional space for the coding clerks.

As the DLMC gained experience, projects moved beyond complaint resolution to work redesign. A project was recently completed to improve processing and completion of medical records. A forum was developed for health information technicians to discuss mutual issues and concerns. These technicians are responsible for the maintenance and management of patient records.

Through a joint fact-finding process, the group identified the patterns and sources of missing information. A standard reporting form was created and provided to technicians, and nurses and physicians were retrained to improve clinical documentation. To monitor compliance and provide feedback, weekly reports were generated and recurring patterns identified. The error rate was reduced from 26% to 2%.

Most recently, the DLMC implemented an education project on JCAHO readiness specifically related to privacy and confidentiality of health information. Employees participated in tracer activities to assess and understand JCAHO survey processes. Feedback to staff was timely and opportunities for continued training and education were identified. A follow-up survey recorded 100% compliance.

NURSING/MEDICINE

The Nursing/Medicine DLMC's initial focus was on issues involving the patient care technicians (PCTs) represented by 1199SEIU.¹⁰ PCTs assist nurses in delivering direct patient care, (e.g., help patients with tasks of daily living, assist nurses and physicians with treatments and diagnostic procedures). The initial project addressed PCT concerns about having time to wash up at the end of their shifts and management concerns about PCTs stopping work early, with cleaning left for the following shift even though "wash up time" is not included in the workday.

The process of interest-based problem-solving concerning the needs and issues of PCTs led to focusing on improving PCT-to-PCT communication, particularly between shifts.

A PCT report was developed with an itemized cleaning and servicing checklist for each patient room. After training and staff education, a pilot project was initiated. Compliance proved difficult and further discussions led to more redesign.

A PCT was then designated for each shift to monitor the implementation of the PCT-to-PCT report. This greatly improved daily use of the report. After the pilot period was completed, this procedure was implemented on all Medicine units.

¹⁰ When its work began, NYSNA was still outside the Strategic Alliance. When NYSNA rejoined the Strategic Alliance, the committee was expanded to include all nursing staff, not just those represented by 1199.

The PCT reporting project was initiated prior to the Joint Commission's announcing its National Patient Safety Goal pertaining to shift-to-shift handoffs, thereby putting Maimonides ahead of schedule in meeting this national goal.

The Nursing/Medicine DLMC also tackled the problem of making sure that clean linen is on hand when it is needed. Patient washing is delayed when clean linen is not available, and PCT and nursing time is required to track down linen, creating tension between nursing and laundry staff.

Working collaboratively with laundry staff, flow charts of the laundry delivery process were developed and data collected. These showed a need for improved inventory control, which was implemented. All units are now working with Laundry Services to improve linen management.

CASE MANAGEMENT

The Case Management DLMC began working on outstanding issues regarding vacation self-scheduling for social worker assistants. With the assistance of labor and management Coaches and Developers, the DLMC has helped the social worker assistants overcome their resistance to creating a vacation schedule coverage process and an arrangement was made for peers to cover assignments. Additional coverage concerns among clerical staff were addressed through cross-training and work re-assignment, a process that continues to be monitored and improved. The results of these efforts have been that productivity remains stable when staff is out.

The DLMC also moved to address employee morale. A questionnaire was developed to identify specific areas where communication can be improved and where ongoing education or additional training is needed. Forty percent of the departmental staff responded anonymously. Subcommittees consisting of union and non-union employee and management representatives were formed following the survey and have initiated improvements in departmental workflow, communication, and training. Their work is ongoing.

LABORATORY AND PATHOLOGY

As the first project sponsored by the Labor Management Council, the initial focus was on increasing the flexibility of the Laboratory and its staff to meet the changing demands of the field and to reduce turnaround time. The joint committee worked on redesigning the physical plant so that the Laboratory took up much less space. Workstations were consolidated and job descriptions changed. Phlebotomy was moved from the Laboratory to the patient's bedside as part of the implementation of a new patient care model with new responsibilities for nursing attendants. Cross-training enabled laboratory staff to perform a wider range of tests. Retraining and redeployment were used to avoid layoffs wherever possible as, for example, when six laboratory staff were retrained as respiratory technicians. When retraining was not possible, several of the staff were transferred into other departments. Later, new positions – Technical Specialists and Point-of-Care Technologist – were created to assume some of the responsibilities for the daily laboratory operations.

4. THROUGH PERFORMANCE IMPROVEMENT, NURSING CARE HAS SYSTEMATICALLY IMPROVED, WITH MEASURABLE RESULTS FOR PATIENTS AND STAFF.

Parallel labor-management activities in nursing were undertaken in 2002-2004 when the New York State Nurses Association temporarily left the Strategic Alliance during a labor dispute with 1199SEIU. Twenty-nine unit-based performance improvement (PI) projects were initiated throughout Nursing over the three-year period. Project areas were selected by staff of each unit with input from the Nurse Manager Steering Committee, which tracked and monitored all PI work. Input from each nursing unit included RNs, LPNs, PCTs, and Health Information Technicians.

PI Projects were launched using a “Breakthrough Strategy” involving results-focused, rapid-cycle projects (two-three months or less) designed to improve performance, utilize new methods to accomplish and sustain results, and develop new skills to be used in subsequent PI work. This approach challenged staff to seek significant changes with measurable results, using a six-step process similar to the interest-based problem-solving process used by the DLMCs.

DECREASING PATIENT FALLS

Nurses on a cardiology unit were particularly concerned about patient falls since cardiac treatment often includes medication that causes disorientation and drowsiness. In addition, studies show that one of every three Americans over 65 fall each year, with 10% of fatal falls occurring in health care facilities.

Using a customized fall prevention risk assessment tool, data was collected to identify high-risk areas within the unit. Based on this analysis, an action plan was developed.

Patient slippers were changed to non-slip socks. The pharmacy was asked to label medications that increase the risk of falls by causing drowsiness or lack of motor control. Fall prevention activities were included in the shift-to-shift written report. Peer re-education was conducted during chart reviews to ensure compliance with a new protocol. Reminders were posted and staff participated in the National Safety Awareness Week.

After months of intensive focus, the unit was able to achieve its goal of reducing falls by at least 50%. Based on this unit's success, their model fall prevention program was implemented hospital-wide and the average number of falls has been reduced by nearly half.

INCREASING PNEUMOVAX IMMUNIZATION AGAINST PNEUMONIA AND OTHER BACTERIAL INFECTIONS

To improve the consistency of administering pneumovax immunization, a unit PI team decided to address both systems and cultural issues. These included that the vaccine was not routinely available on the floor and had to be specially ordered from the pharmacy, nurses forgot to vaccinate patients in the midst of other discharge tasks, and staff did not fully understand the importance of the vaccine.

Process improvements were initiated to have the vaccine routinely available on the unit, revise the computerized discharge screens to include vaccine administration as a check-off item, and launch a Pneumovax Education and Awareness Campaign.

Tracking data on compliance registered steady monthly increases until high levels of compliance were reached. With this unit-based success, the model pneumovax program was successfully implemented throughout the hospital, including all outpatient clinics, as a result of collaboration among the clinics and the information technology staff to place vaccination status on the on-line patient information sheet.

REDUCING STAGE II DECUBITUS ULCERS (SERIOUS BED SORES)

As in most hospitals, serious bed sores were a problem at Maimonides, and one unit selected this as the focus of its performance improvement process. Baseline data collected during weekly skin care rounds identified that one in three inpatients was either at high risk or had pressure ulcers. Ongoing review revealed that nursing staff often did not have current orders for the management of decubitus ulcers from physicians, usually because interns and residents were unaware of the need for proper orders. Additionally, nurses were unable to articulate the level of specialty mattress needed to relieve pressure and did not consistently document the sizes or stages of the decubitus ulcers.

The team decided that timely physician orders were the most critical factor and, with the assistance of the Chief Hospitalist, a set of standardized orders for treating serious bedsores was developed for interns and residents. A weekly nurse review of at-risk patients was instituted and the need to obtain physician orders underscored with all nursing staff. In addition, a customized dressing cart was created to assure readily available dressing supplies at the bedside, and qualified PCTs were allowed to do dressing changes after an RN assessment.

High levels of compliance were reached and this successful model is being implemented throughout the hospital. A Skin Care Committee that includes nursing representation has been established.

REDUCING CALL BELL RESPONSE FOR ALL SHIFTS BY 50%

In satisfaction surveys, patients expressed frustration with delays in the nursing staff response to their calls. The Breakthrough Strategy was used to analyze the problem and develop an action plan to reduce response time by 50%, to within two minutes.

The PI team initiated a series of procedural changes. All nursing staff now had the responsibility of responding to the call bell, regardless of whose patient was calling. Responders were required to report the nature and resolution of the call. To reduce the need for patient calls in the first place, all nursing staff increased the frequency of patient rounds, created a checklist of critical patient needs, and routinely checked that those needs were met before leaving the room.

After six weeks, data found an average response time of 73 seconds. To measure the sustainability of these results, data was again collected after six months and, while it was not possible for the staff to maintain the original goal, there were still significant reductions over the original baseline data.

REDUCING PATIENT RETURNS TO THE CARDIOTHORACIC INTENSIVE CARE UNIT FROM THE NURSING UNIT FLOOR

Data was collected on the reasons patients were returned to intensive care, the goal was set to cut these patient returns by 50%, and a work plan was developed. Most of the unit nurses attended a detailed practicum in the intensive care unit to advance their clinical skills in pre- and post-op care, including ambulation, chest physical therapy, and respiratory care. A four-bed room (the Annex) was earmarked for more acute patient care on the unit, with more intensive coverage for these more seriously-ill patients. Two additional RNs were assigned to the night shift and a respiratory therapist was designated for the unit as part of increased involvement by the Rehabilitation Department. Interdisciplinary teaching rounds were conducted each day along with cross-training for the team. RNs were rotated through the CTICU and Annex.

This project reduced patient returns by 39%, and while this did not fully meet the goal, it nonetheless represented a significant achievement. Moreover, it reinforced the critical importance of interdisciplinary support and motivation as key factors to achieve and sustain the improvement.

IMPROVING PAIN MANAGEMENT FOR SURGICAL PATIENTS FROM THEIR ADMISSION THROUGH THE EMERGENCY DEPARTMENT TO DISCHARGE

Patient satisfaction survey data indicated that 14% of adults and 10% of pediatric inpatients did not feel that the hospital had done all it could to control their pain. Self-reported ratings of pain by inpatients indicated that 21% of adults and 22% of children experienced severe or moderate pain after medication. After examining this evidence and the literature on pain management, the PI team determined that it could reduce and maintain pain scores by 30%.

To understand the existing process for pain management, the interdepartmental team developed a detailed flow chart. This analysis brought to the fore a number of issues that impacted staffs' ability to promptly and effectively address pain throughout the surgical patient's stay.

In the Emergency Department (ED), pain medication was inconsistently administered after triage. It was sometimes difficult to find a surgical resident to prescribe the medication, physicians had different comfort levels in pain management, and nurses weren't consistently following the timetable for reassessment. Patients were being transferred to inpatient units without a standing pain management order and access to the "narcotics key" was sometimes a problem. When patients arrived at the unit, nurses weren't always available and PCTs weren't always aware of their responsibility to alert the clinical staff. There was inconsistent reassessment and documentation after the administration of pain medication.

A work plan was developed and implemented that addressed many of these issues. The plan included increased communication between the ED triage nurse and primary nurse, instruction of surgical residents on staying in touch with primary nurses in both the ED and nursing unit, the addition of a Pain Alert Timer to remind nurses when reassessment is necessary, physician rounds and resident re-education on pain management, structuring access to the narcotics key to assure its availability to qualified staff, re-education of nursing staff about the "gatekeeper" function, and better tracking of patient pain score reports throughout the process. Pain scores were improved for 20% of patients, with significant improvements over the baseline.

PREPARING 60% OF ELECTIVE C-SECTION PATIENTS WITHIN 45 MINUTES OF REGISTRATION

Patients were complaining that they were unable to have their C-section at the scheduled time. Baseline data showed that it took anywhere between 15 minutes and 2 hours and 25 minutes (with an average time of 1 hour and 6 minutes) to register and prepare patients for this elective surgery.

After data collection and analysis of the reasons for delay, the Breakthrough goal was chosen and an implementation plan developed. The location of the initial patient assessment was changed from the Triage area to the Holding area and new protocols were developed to streamline the process. These changes in work flow reduced the variation in preparation time to between 25 minutes and 1 hour and 20 minutes (with an average of 51 minutes).

5. WITH ALL THREE MAJOR UNIONS NOW WORKING WITHIN THE STRATEGIC ALLIANCE, HIGHLY FUNCTIONING LABOR-MANAGEMENT TEAMS ARE TAKING WORK REDESIGN PROJECTS TO A NEW LEVEL.

With the return of NYSNA and the addition of CIR, the hospital is now positioned to take joint labor-management work to a new level. Clinical and non-clinical staff are working together. Work redesign is focusing more on quality of care issues. The projects in Environmental Services and Cardiology provide good examples of this new phase of labor-management activities in the Medical Center.

ENVIRONMENTAL SERVICES

In 2005, the DLMC instituted the Standard Equipment Project, following an Environmental Service employee survey that indicated a critical lack of cleaning equipment at the beginning of shifts. At the time of the survey, employees were using an average of 45 minutes at the start of their shifts just to gather necessary supplies and equipment.

After analyzing this problem, a pilot project was developed to ensure that staff have the appropriate equipment to begin their work promptly. Changes that have been implemented as a result of this project include the installation of new locks on the equipment closets and the development of a sign-out sheet for both staff and supervisors to ensure closets contain standardized sets of equipment.

Now, when a member of the housekeeping staff comes on duty, a key to the closet is issued along with a beeper and a checklist of cleaning equipment that should be in the closet. The checklist must be filled out before starting work and again at the end of the shift before turning in the closet key and beeper. As a result, there is 100% availability of standard equipment on all floors of the pilot building. This project is being carefully monitored and expanded to the entire hospital.

In August 2005, the Environmental Services DLMC launched an ambitious project designed to improve the cleanliness of the hospital so as to maintain continuous readiness for unannounced JCAHO surveys. This initiative reflects a conscious decision to give unionized workers a leadership role alongside management to drive this process. While managers and supervisors were part of this process, the President & CEO wanted worker recommendations for staffing, skill deployment, and equipment. The project was kicked off with a large and enthusiastic meeting in the hospital auditorium and follow-up sessions were held with the rank-and-file leadership and the President & CEO.

Because of the significance of this project, the Environmental Services DLMC created a Study Action Team (SAT) consisting of five environmental services workers and one supervisor.¹¹ Members of this full-time project team were released from their job responsibilities to work on this project for three months. The responsibility of the SAT was to analyze current practices, learn about best practices in the industry, meet with staff to obtain their suggestions for changes, and then develop recommendations and a plan for implementing needed changes.

Based on individual interviews with housekeeping staff, the SAT first identified critical equipment needs and developed recommendations for staffing and supervisors. The SAT also recommended a team-based approach to cleaning rooms regularly, created a quality assurance survey to track and monitor the safety, orderliness and cleanliness of rooms, and created weekly rounds so that all staff would help evaluate the “cleanliness” of a unit and areas for improvement.

The SAT and departmental supervisors developed and conducted training for all Environmental Service employees that incorporates both current procedures and new approaches. This training is given to all incoming employees. The recommendations of the SAT are currently being tracked and monitored by their DLMC.

¹¹ The Study Action Team (SAT) is a joint labor-management approach that has been highly successful in other industries to achieve needed changes in organizations when significant changes were needed.

CARDIOLOGY

This DLMC is a reflection of the growing acceptance of labor-management activities as a critical way to resolve patient care issues. A project to reduce the response time to cardiac monitors and alarms to less than 60 seconds was initiated.

A comprehensive analysis was conducted by a joint labor-management committee consisting of RNs, PCTs, health information technicians, physician assistants, nurse practitioners, attending physicians, nurse managers, and a Developer. This group was assisted by staff from Performance Improvement and Risk Management departments.

This committee reviewed current literature about responses to alarms and monitors on cardiac units, identified potential systems failures, broke these down into discrete issues and assessed the level of risk. An extensive process of analysis was followed by in-depth unit-based meetings with staff, to get input about potential solutions. Finally a comprehensive list of recommendations was developed, along with a specific process for implementing and monitoring suggested changes. The Cardiac DLMC accepted all recommendations for changes, including:

- A Clinical Alarm Protocol Policy for the care of telemetry patients was created based upon a patient acuity assessment developed by the group, and staff training was conducted on the new protocol.
- Protocols were standardized for individualized alarm settings, parameter adjustments, and checking of alarm settings at the start of each shift.
- The bedside monitor manufacturer provided special instructions on use of the features available for remote monitoring.
- A logging system was created for tracking equipment breakdown and repair.
- In-service training was conducted on the use of pulse oximetry prior to triggering a cardiac alarm.
- Staff were provided additional in-service training on the proper use of Powerheart® bedside monitor defibrillators.
- Protocols for monitoring patients leaving the unit were standardized.

Continued monitoring of results reveals consistent achievement of responding to alarms and monitors in less than 60 seconds and a series of clinical procedures to more effectively monitor the care of cardiac patients.

6. WITH THIS STRONG RECORD OF SUCCESS, LABOR AND MANAGEMENT ARE COMMITTED TO BROADENING AND DEEPENING THE STRATEGIC ALLIANCE.

New joint labor-management activities continue to be developed:

- All staff are participating in a variety of continuous readiness activities for surveys by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO), including Environmental Services' ambitious Hospital Safety, Orderliness and Cleanliness project to improve the cleanliness of the entire hospital.
- Based on the New York City Department of Health's survey of employee needs, the Strategic Alliance is sponsoring an employee wellness project to improve each employee's physical condition, starting with three challenges: walking, healthy breakfast, and smoking cessation.
- An employee communication work group has also been established to improve communication about labor-management activities and other important hospital news, including expanded coverage in the Medical Center's internal newsletter *Ear to the Ground*.
- A project is underway to survey employee satisfaction throughout the hospital—quantitatively with a questionnaire and qualitatively through focus groups—as part of an overarching priority to evaluate the effectiveness of the labor-management projects more systematically.

The Strategic Alliance continues to align and integrate its expanding work into the routine operations of the Medical Center. Trust, respect, and mutual purpose have grown through this 10-year initiative into an experienced labor-management partnership. This alliance has become a cornerstone of the success of Maimonides, the quality of care delivered to patients, and the pride of those who work here.

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MEETING FUTURE CHALLENGES

The myriad of challenges facing health care institutions will continue into the foreseeable future. Modern science has extended the lives of many. While this is a welcome achievement, it means that people are living longer and not always in the best of health. Patients will continue to be older and sicker.

Additionally, our lifestyles have given rise to obesity and diabetes, conditions that contribute significantly to poor health. Lower income and under-insured citizens represent a large percentage of the population affected by these diseases, making the financial burden of their care difficult.

Add to this scenario lingering shortages of key health care workers, such as registered nurses, as well as the need for teaching hospitals to remain current technologically and the continuing uncertainties regarding health care financing, and it is easy to see why new approaches to coping with these issues are imperative.

BLAZING A NEW TRAIL

Maimonides Medical Center is known historically as a center of innovation. The commercial pacemaker was developed here. Maimonides was the first hospital to offer outpatient chemotherapy and to implement an electronic ordering system for medical orders, such as lab tests and prescriptions. We also pioneered the use in New York City of hospitalists, also known as inpatient physicians, a trend that has proven to result in better care and reduced patient stays.

It is no surprise then, that in seeking ways to remain competitive while continuing to provide the highest quality care, we turned to an important problem-solving approach: the Strategic Alliance process¹² —engaging labor and management in strategic as well as daily problem-solving challenges.

“When we began this journey of labor-management collaboration a decade ago,” recalls Pamela S. Brier, President & CEO, “it was in the firm belief that workplace problems are solved best by those who perform the work. Our instincts were correct, and we’ve gained much more than productivity and patient care improvements. We’ve learned how to approach problem-solving for the long term, and that is the true value.”

“We’ve gained much more than productivity and patient care improvements. We’ve learned how to approach problem-solving for the long term, and that is the true value.”

*— Pamela S. Brier,
President & CEO*

¹² This approach has been highly successful in other industries.

FINDING COMMON GROUND

Keeping the Strategic Alliance alive and well has not always been simple. But, through experience, we learned that the department-level teams known as Departmental Labor Management Committees (DLMCs) were the most effective forums for open discussion and solution design.

“All of us from the CEO to the unions and the caregivers, want the same thing – excellent patient outcomes,” says Veronica Richardson, a DLMC resource person representing the New York State Nursing Association, “and the DLMCs are the perfect places to work together and get things done.”

The Strategic Alliance is shaping organization-wide understanding of the broader issues both inside and outside of Maimonides. “We all have overlapping interests in health care today, and we are informed and educated,” says Cecile Charlier, a union organizer for 1199SEIU. “Through interdisciplinary projects, everyone begins to understand why things are done a certain way and how their work impacts that of others.”

The ability of the Strategic Alliance collaboration to broaden discussions between labor and management is also a great benefit. “We have been able to move on to work floor-related issues, not just contractual ones,” says Andrew Greenberg of the Committee of Interns and Residents. “That is the value of the Alliance,” he adds.

A FORCE FOR CHANGE

The DLMCs have served as a step in changing the culture of our organization to one in which everyone who works here feels they can participate. Such culture change is an ever-evolving process, and we are making progress.

“Staff have taken notice of the fact that the administration is willing to listen and learn from them,” says Sondra Olendorf, Senior Vice President, Nursing and Hospital Operations. “This, in turn, helps us to be seen as a health care employer of choice in the New York metropolitan area, thereby improving our ability to recruit the very best people and provide the very best care.”

We face our future optimistically because the Strategic Alliance provides a way for us to tap into the wealth of knowledge and ideas of those who work here. “When all the stakeholders can come together, voice their concerns, and find mutually acceptable answers to our challenges, we have a blueprint for success,” says Pamela S. Brier. “The people who work here are what make it possible every day for Maimonides to live its credo: Passionate about medicine. Compassionate about people.”

ABOUT MAIMONIDES MEDICAL CENTER

At almost 100 years old, Maimonides Medical Center is a thriving non-profit, non-sectarian hospital that is the pre-eminent treatment facility and academic medical center in Brooklyn—and among the best in the United States.

Serving people of all faiths and backgrounds from the incredibly diverse population of Brooklyn, the Medical Center has 705 beds, a staff of renowned physicians and more than 70 primary care and sub-specialty programs. In 2006, the Medical Center serviced more than 80,000 emergency room visits, received more than 210,000 ambulatory care visits, and delivered over 6,700 babies – more than any other hospital in the state of New York.

As one of the largest independent teaching hospitals in the nation, Maimonides trains more than 400 medical and surgical residents annually. As a premier academic medical center, it is devoted to educating health care professionals, patients, families, employees, and the communities it serves. Widely recognized for its major achievements in medical technology and patient safety, its Stroke, Cardiology, and Critical Care divisions are rated among the top 5% in the United States.



Created jointly by Maimonides Medical Center, 1199SEIU Healthcare Workers East (1199), the New York State Nurses Association (NYSNA), and the Committee of Interns and Residents (CIR).

GLOSSARY

BREAKTHROUGH STRATEGY: problem-solving process developed by Robert H. Schaffer and Associates and used by MMC nursing staff to tackle rapid-cycle (2-3 months) projects in a modified six-step approach: select the improvement opportunity, organize the project team, carve out the breakthrough goal, create the project work plan, manage progress toward the goal, and summarize the results and plan for expansion.

COACHES: experienced advocates from either union or management, who are specially trained and paired to guide labor-management departmental and hospital-wide problem-solving and work redesign activities.

DEPARTMENTAL LABOR MANAGEMENT COMMITTEES (DLMCS): departmentally based work groups containing representation from employees, unions and management who come together to discuss areas of mutual interest and need and implement improvements. DLMCs are the preferred forum for resolving conflict and redesigning work.

DEVELOPERS: internal consultants who serve as resources to the Strategic Alliance.

INTEREST-BASED PROBLEM-SOLVING: a technique based on six steps: defining the problem; identifying each party's interests; reframing the problem to address the parties' interest; generating options; crafting a solution that meets all parties' interests, and implementing and evaluating that solution.

LABOR MANAGEMENT COUNCIL (LMC): a hospital-wide committee that oversees and structures the organizational processes fostering mutual respect, trust, effective communication, and the active participation of staff in departmental and unit decision-making. The LMC is composed of senior management, including the MMC President & CEO, and representatives from the hospital's three unions, and it is staffed by internal consultants (Developers).

STRATEGIC ALLIANCE: the official name of the hospital's initiative to foster respect among employees and supervisors, to promote rank-and-file leadership, to encourage broad workforce participation in decision-making, and to develop a partnership between unionized workers and management in order to meet the organization's strategic goals.

APPENDIX A

PRINCIPLES FOR HOW WE WORK TOGETHER

The Maimonides Medical Center community adopts these 12 principles as manifesting mutual respect for each other, our patients, and their families. These principles enable our delivery of high-quality and affordable services.

1. Patients, their caregivers, and visitors should be treated with respect and dignity at all times, even when their demands might be difficult or unrealistic.
2. All employees should treat each other with respect and dignity, affirming each individual's value through positive language, nonverbal behavior and gestures, even when someone's behavior or attitude seems problematic.
3. All employees should engage in their work in ways that achieve quality and affordable care and will work together to take corrective action when possible to improve that care.
4. All employees should always demonstrate cooperation and two-way communication with other staff, using listening and understanding skills before speaking.
5. All employees should provide one another prompt, direct, and constructive feedback when concerns or disagreements arise and all should be open to this feedback.
6. Labor and Management should work together to provide employees a safe place to work.
7. Management and supervisors should consult with CIR, NYSNA and 1199SEIU leaders to learn staff perspectives before developing changes that affect patient care.
8. All employees should be consulted through appropriate labor-management groups or task forces before clinical or procedural changes are implemented.
9. Union and management should use interest-based problem-solving processes to examine work related issues and seek solutions that incorporate the issues and needs of all parties. If problems can't be resolved at a departmental level, appropriate union and management leadership will be asked to assist with resolving the issue(s).
10. All employees should be receptive to and constructively participate on departmental as well as hospital-wide committees to improve patient care and address departmental performance and quality issues.
11. Union and management leaders should use group and individual activities as opportunities to learn from each other.
12. Jobs should be designed so that all staff have "quality work" in which each staff member is responsible for multiple tasks, contributes to a "whole process" as much as is possible, receives timely feedback, is acknowledged for his or her important role, and is able to make decisions on how to do the work.

