Washington Healthcare News®

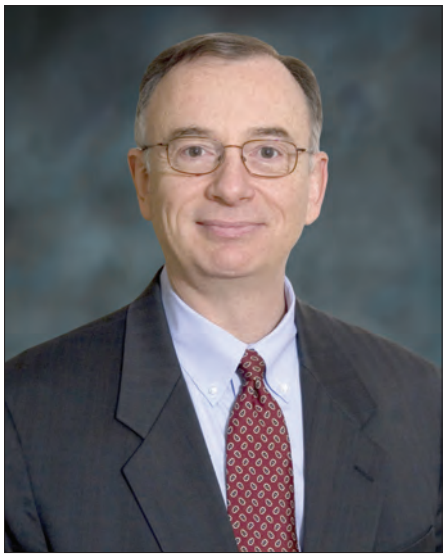
wahcnews.com

Articles, Interviews and Statistics for the Healthcare Executive

VOLUME 6, ISSUE 12 DECEMBER 2011

Changing the Rules: The Federal Government Makes Union Organizing Easier

By Timothy J. O'Connell
Partner
Stoel Rives LLP



Non-unionized health care employers – especially clinics and other non-hospital employers – may feel like the government has made them a target. Reacting, some pundits think, to Congress's failure to pass the so-called "Employee Free Choice Act," in recent months the National Labor Relations Board has taken several steps to make it easier for unions to organize new workplaces. These new regulations, proposed regulations and new decisions will change decades-old legal principles.

Free Advertising: Posting Advice About Unions.

The first of the Board's new requirements is a regulation that obligates all employers covered by the National Labor Relations Act – essentially, all private sector employers except for very small businesses – to post a notice reciting employees' rights under the NLRA. The notice seems designed to increase employees' interest in unions: it is a large, multi-colored poster that discusses employees' rights without addressing any of the drawbacks of unionization. The poster is especially troubling for health care employers because it does not describe any of the rules specific to the health care industry.

The Board's new rule purports to make it an unfair labor practice for an employer to fail to post the notice – and a knowing refusal to post the notice could support a finding of unlawful motivation in other unfair labor practice proceedings. Worse, the Board claims that if the notice is not posted, the six-month statute of limitations mandated by the NLRA will never even start to run.

Changing the Rules: Who Gets to Vote?

As if it that were not bad enough, the Board is also altering its policies to make it easier for unions to win elections. One way of doing so arises from a recent decision by the Board. In union elections, the preliminary dispositive issue is determining who gets to vote – or, in NLRA terms, what is the appropriate "unit" of employees? In the *Specialty Healthcare* case, the Board faced a petition for a union election in a very narrowly defined

Please see> Rules, P4

Inside This Issue

Washington Healthcare News
wahcnews.com | *Articles, Interviews and Statistics for the Healthcare Executive*

Publisher and Editor
David Peel
Managing Director
Elizabeth Peel
Contributing Editor
Nora Haile
Advertising
Jennifer Sharp
Business Address
631 8th Avenue
Kirkland, WA 98033
Contact Information
Phone: 425-577-1334
Fax: 425-242-0452
E-mail: **dpeel@healthcarenewssite.com**
Web: **wahcnews.com**

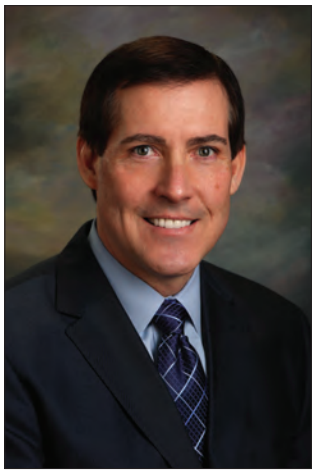
TO GET YOUR COPY

If you would like to be added to the distribution, go to our web site at www.wahcnews.com, click on the "subscribe" tab at the top of the page and enter all information requested. Be sure to let us know whether you want the hard copy or the web version.

LETTERS TO THE EDITOR

If you have questions or suggestions regarding the News and its contents, please reply to dpeel@healthcarenewssite.com.

Letter from the Publisher and Editor



Dear Reader,

Magazines publish editorial calendars so writers can focus their articles around a theme and advertisers can select editions with content most likely to interest buyers of their products. We've been publishing editorial calendars since 2006 and have fine-tuned them to focus on what our readers like to read.

After careful review of what's worked well and what hasn't, we've finalized our 2012 editorial calendar. In a nutshell, we're not changing much from 2011.

Of our 12 editions in 2012, 5 will have a hospital theme, 4 will have a clinic theme, 2 will have a human resources theme and 1 will have an insurance theme. The only difference from 2011 is that we had an ASC theme in February 2011 and will change that to a clinic theme in February 2012.

Thanks for supporting the Washington Healthcare News over the years and we wish you happy holidays and a prosperous new year.

David Peel, Publisher and Editor

< Rules, from P1

unit, consisting of only the nursing home's CNAs. The nursing home, in contrast, claimed that the appropriate unit was all service and maintenance employees. Rejecting decades of precedent, the Board held that the narrow unit sought by the union would be allowed, despite the Congressional direction to avoid fragmentation of bargaining units in health care facilities. In an even more dramatic change, the Board concluded that if an employer believes the appropriate group of employees is broader than the proposed unit, the employer must demonstrate that those additional employees share "an overwhelming community of interest" with the employees in the proposed unit.

Under *Specialty Healthcare*, unions will be able to target small groups of disgruntled employees, and the employer will have to prove that the "micro-unit" is inappropriate. The likely outcome is obvious: employers will face a proliferation of small units, with increased exposure to disruptive small strikes, not to mention increased expenses attributed to negotiating multiple contracts. All these considerations seem secondary to the Board's objective of increasing union representation.

Changing the Rules: How Long to Decide?

Worse still, the Board has proposed radical changes to the rules regarding union elections, dramatically shortening the time between the union's filing of a petition and the holding of the election. Even under current rules, union elections happen quickly. The Board's statistics demonstrate that currently an initial election is held within a median of 38 days from the filing of a petition, and more than 95% of elections occur in less than two months. Not content with these speedy results, the Board seeks to eliminate several steps in the current process, in order to have an election in perhaps as short as *10 days*.

The Board would accelerate elections by requiring employers to identify all issues with the proposed unit at the "pre-election conference," held within seven days of the filing of the petition. Even if the employer could hire legal counsel and identify all the possible issues within a week, the employer's concerns may not be addressed unless the positions at issue equal 20% of the proposed bargaining unit. If the employer's

Please see > Rules, P6

< Rules, from P4

concerns involve less than 20% of the unit, those issues would simply be ignored, and an election would be directed as soon as possible. Moreover, the employer would be required to quickly produce contact information about all employees in the proposed unit, including the employees' home telephone numbers and personal email addresses.

The Board's proposal causes alarm on several levels. Within one week, an employer would be required to identify all of its concerns about the unit proposed by the union and be prepared to actively litigate any disputed issues. Moreover, because the Board would refuse to decide issues pertaining to less than 20% of the bargaining unit, an employer would face dramatic uncertainty about how to get its message out. For example, one routine issue that a health care employer may dispute in a union election is whether charge nurses are supervisors. It is unlikely that charge nurses would make up 20% of the bargaining unit. Thus the employer would go into the union election campaign not knowing who its supervisors are. The Board's new rules not only shorten the time the employer has to communicate its message, but also place roadblocks on how an employer could do so.

Where Can You Get Advice?

The final major effort to help unions organizing is not from the Board – it is a proposed regulation from the Department of Labor, which enforces the Labor-Management Reporting and Disclosure Act. The LMRDA requires detailed reports from individuals who communicate with employees about the disadvantages of unionization – so called "persuaders." For decades, rules interpreting the LMRDA made clear that the reporting requirements did not apply to professionals who merely advise the employer about strategy and the legality of dealing with an organizing campaign.

Earlier this year, however, the Department proposed new regulations that would virtually eliminate this "advice" exception. Under the proposed rules, professionals who give advice to an employer facing a union organizing drive would have to file reports with the government about that work – even attorneys giving legal advice to their clients.

The effect is obvious. By requiring reporting of activities that could invade the attorney-client privilege, the Department would limit the resources currently available to employers. Tellingly, the American Bar Association – by no means a right-wing organization – has condemned the Department's attempt to pry into attorney-client advice.

Conclusion: What Is an Employer to Do?

The labor law changes that have been implemented or proposed will dramatically change the landscape for union organizing. The watch word must be *preparation*. An employer that pays no attention to union avoidance until the union files a petition for an election will find the rules stacked against it, with little time to respond and fewer resources available. Any employer that hasn't consulted with counsel to review its vulnerability to union organizing efforts, and how it can respond, should do so – and soon.

Tim O'Connell is a partner of Stoel Rives LLP. His practice includes representing healthcare providers in NLRB and PERC proceedings, labor arbitrations, equal employment and discrimination cases before administrative agencies and courts, wrongful discharge litigation, wage-and-hour counseling and litigation, and general personnel management. Contact Tim at tjoconnell@stoel.com or 206-386-7562.

Good Medicine Has Its Rewards: $207 Million

10% dividend for Washington members in 2011

We have returned $207 million to our members through our dividend program.

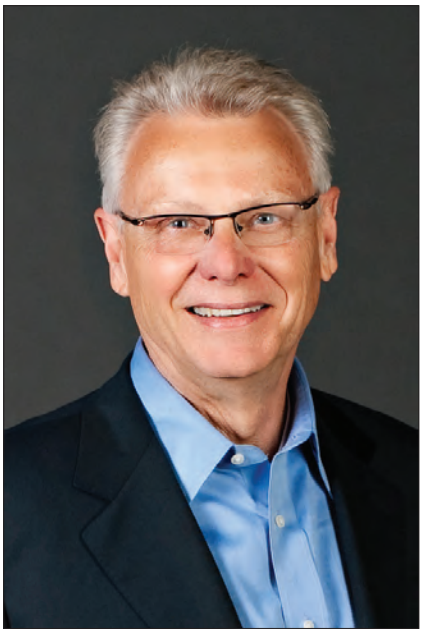
The 2011 dividend is made possible by the excellent claims experience of our members in Washington. As a leading carrier in the state for more than two decades, The Doctors Company is strong. This strength allows us to deliver on our promise to defend, protect, and reward the practice of good medicine.

To learn more about The Doctors Company's medical professional liability insurance program in Washington, including the member dividend, call our Seattle office at (877) 673-2101 or visit us at www.thedoctors.com.

THE DOCTORS COMPANY

In the Belly of the Beast - Why Projects Succeed

By Darryl Price
Healthcare Practice Leader
Slalom Consulting



This column's focus on trends and opportunities underscores that, as an industry, we are facing a wide array of opportunities and challenges.

During my twenty plus years in the belly of America's healthcare system, I've learned what it takes to execute on an opportunity. From building a new business unit to enterprise-wide large system and process change, I have seen firsthand the impact projects have on organizations.

The difference I am seeing today is volume and velocity. Our industry has kicked into overdrive. So before launching into the next game changer, let's get grounded in what it takes to successfully execute on one of these opportunities.

Roger Kastner, one of Slalom Consulting's leaders in Project Management, writes a blog series and teaches a course entitled "Why Projects Succeed" based on years of experience leading major projects and working with leaders across a wide variety of industries, including healthcare.

Darryl Price: Roger, why do some projects succeed? Are there consistent success factors?

Roger Kastner: Every project is different, but time and time again, I find Executive Sponsorship, Project Leadership and Organizational Change Management are the top three success factors. With those three highly functioning together, the likelihood of success increases dramatically.

DP: Roger, we've all heard these words before. It's obvious these are not just words to you. What do they mean and why is Executive Sponsorship at the top of your list?

RK: Sure, they appear to be pretty simple, but common sense is not common practice. I advocate that leaders create and make visible a list of success factors tailored to their projects and environment, and start with these three which I've found to be the most important.

Strategically, Executive Sponsorship is at the top because it drives all project actions, decisions and outcomes. Sponsors articulate the vision, define clear objectives, and establish a culture of accountability. Their vision inspires and connects people to the work. Their objectives inform the decisions and define progress. And a culture of accountability enables a higher level of execution.

Tactically, Sponsors actively engage stakeholders, stay on top of project progress and challenges, and remove barriers that threaten success.

DP: How do you contrast that with "Project Leadership"?

RK: Project Leadership is project management on steroids. It sets, manages and delivers on expectations by focusing on the project's return on investment. Organizations only invest resources in a project based on the expectation of a certain return, right?

Project Leadership ensures that these expectations are appropriate-

ly set through clear requirements gathering and risk management, tightly managed through proactive issue management and thorough change control, and accurately delivered by ensuring expectations are met and approved by sponsors. Lastly, Project Leadership fosters the behaviors that drive the culture of accountability that the Sponsor creates.

DP: OK, so I now know where I'm going, how success will be measured, and I have resources to manage the project's challenges. Explain Organizational Change Management (OCM) and why is it so important to project success?

RK: OCM focuses on aligning people with the vision and engaging them in the solution in order to embrace adoption. Without adoption, a project cannot successfully achieve its objectives. Regardless of how well the project's scope, schedule, or budget is delivered, without the users adopting the solution, the project fails.

OCM engages stakeholders throughout the project lifecycle, involving them not only in the rollout but also in the design and build phases, creating advocates for the change along the way.

Finally, OCM identifies where resistance in the organization exists and provides strategies to help users through the transition.

DP: How can these three success factors support healthcare transformation?

RK: Large, transformative healthcare projects have very similar success factors as their smaller counterparts. Managing expectations of scope, schedule, and budget are a challenge regardless if you are building a fence, a 787, or a new claims system. Though every environment will have some variances, the top three factors should undoubtedly remain the same.

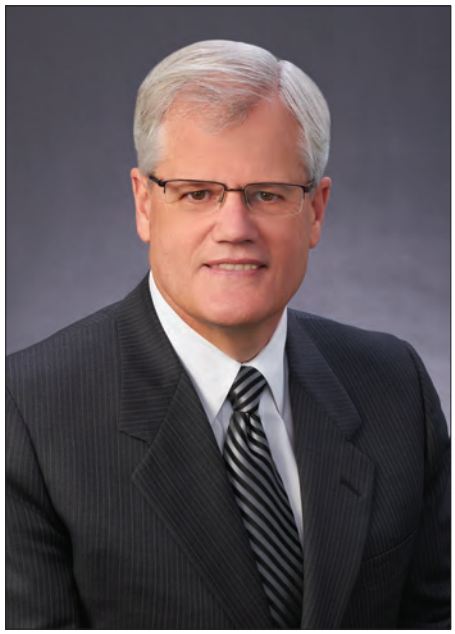
DP: Any last bit of advice of the leaders of Healthcare transformation initiatives?

RK: Yeah, eat your Wheaties. A 2009 Standish Group study illustrated that only 32% of IT projects are successful as measured against their original scope, schedule, and budget. Not great numbers. Developing and using a highly visible and actionable checklist of project success factors, starting with the three I've outlined here, plus hard work can propel your project towards that 32% success category.

Please see > Projects, P14

Rural Health Care at Risk: Protecting an Essential Community Resource

By Scott Bond, FACHE
President and CEO
Washington State Hospital Association



Washington's State's budget outlook is grim. With a $2 billion budget hole and several all-cuts budgets already enacted, there are few, if any, palatable places left to make reductions. But the answer to the state's budget woes cannot be to cut away the remaining health care safety net.

Elimination of essential health insurance programs in current state budget proposals would endanger the health of our most vulnerable residents. Enrollees in Basic Health and Disability Lifeline have nowhere else to turn for the care they receive. Their access to care will deteriorate, and their health will suffer as a result.

There is another significant – but little-understood – cut being proposed that will destabilize Washington State's health care system by gutting our rural hospitals and health care providers.

Washington State has a network of 38 Critical Access Hospitals. The goal of the Critical Access Hospital program is to ensure the stability of hospital safety net services in small, rural areas. It was created in recognition of the cost of providing health care in rural areas, the central role hospitals play in the rural health care system, and the importance of assuring their long-term viability. "Critical Access" designation is a lifeline that provides cost-based reimbursement for Medicare and Medicaid patients. Medicaid and Medicare make up a significant portion of rural residents' health coverage. These programs typically pay hospitals well below the cost of care.

The Governor's budget roadmap includes the elimination of cost-based reimbursement to Critical Access Hospitals for their care of Medicaid patients. The move would save the state roughly $22 million, or about one and a half percent of its total spending on Medicaid. It's a small number for the state, but has a huge impact on these hospitals. On average, their Medicaid payments will be cut in half.

Moreover, the numbers provided by the state reflect only state dollars and do not include the impact of lost federal matching funds. The true impact on Critical Access Hospital payment would be close to $70 million. Many rural hospitals will lay off staff, cut services, and possibly even close altogether.

Even with cost-based reimbursement, these hospitals survive on a very small margin. Twelve hospitals are already operating in the red and less than a handful achieved margins in the last year above the five percent mark. Should these cuts become reality, a full 33 of the state's 38 Critical Access Hospitals would operate in the red. Absorbing these cuts simply is not sustainable for Washington's smallest hospitals.

These small hospitals are hubs for health care in their communities, often providing care from birth to the nursing home. They also are important bridges within Washington State's health care network,

stabilizing patients for transport to larger facilities.

Our state benefits from a strong network of hospitals working together to ensure appropriate care for every patient. The loss of these hospitals would leave enormous gaps in our health care system. Rural residents would have to travel further for care and arrive sicker at the next hospital.

Beyond the implications for health care, the economic impact on our rural communities will be enormous. Rural hospitals, and the clinics and nursing homes they run, are often the largest employer in their communities. Making these cuts will lead to people losing family-wage jobs and pain in rural economies.

To ensure access to care across our state and to maintain a strong health care system, Critical Access Hospitals must remain financially viable. This cut seems shortsighted with relatively little gain for the state's budget. The Washington State Hospital Association is working to inform legislators about this important resource that is critically at risk. We hope you will also lend your voice to this cause and urge your own senators and representatives to protect funding for Critical Access Hospitals.

More detailed information, including hospital specific impacts are available on the WSHA website, at http://www.wsha.org/rural.cfm

Scott is the president and CEO of the Washington State Hospital Association, a position he has held since April 2011. Prior to joining the Association's leadership, Scott served as an at-large member of the WSHA board, a member of the WSHA executive committee 2002-2004, and chair of the WSHA board in 2004-2005. He also served on numerous WSHA board committees and led special projects at the request of the WSHA executive committee.

For more than 25 years, Scott worked for the Providence Health System. Most recently, he was Chief Executive for the Providence Health & Services, Southwest Washington Service Area. He was also administrator of Providence Hospital, Everett.

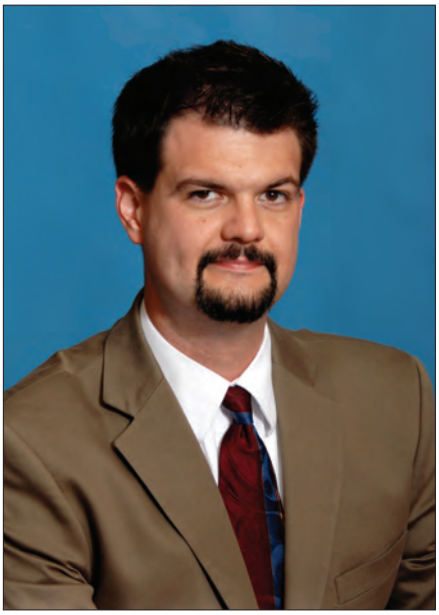
***

The opinions expressed in this article are not necessarily the opinions of the Washington Healthcare News.

Special to our Readers from the California Healthcare News (cahcnews.com)

Sociocultural Considerations in Mass Decontamination

By Jeremy Stacy
Disaster Preparedness Coordinator
Good Samaritan Hospital
Los Angeles, CA



It is an unfortunate reality of our era that health systems will have to deal with the stresses of patient decontamination. Whether the result of terrorism or the byproducts of industrialized society, the potential for radiological, chemical, and biological contamination is all around us. Hospitals must be prepared to deal with the operational and safety issues posed by decontamination, an issue that has been largely addressed through the allocation of government funding towards the development of guidance, training, and equipment purchasing throughout California. However, one of the most complicated aspects of decontamination operations is crowd control and one of the best ways to maintain crowd control is to take a "community-care" approach.

How does this community-care concept differ from how first responders and health systems currently deal with decontamination? It's primarily a matter of objectives. First responders have public safety as an objective – making sure the contaminated victims have the best chance at survival while containing the danger posed to the public. Hospitals similarly have the safety of their staff and patients as their primary objective. While critical, this may prove counter-productive if not balanced with consideration for the contaminated victims. Community-care is realizing that some steps mitigate harm while other steps do more harm than good.

One example of poorly executed community-care is the pesticide release incident in Earlimart, CA. In 1999 a release affected around 250 people. First responders forcibly stripped victims and sprayed them down in a field while the media cameras watched. Victims described feeling as if they were sexually assaulted, there was a massive backlash against the department by the community, and new legislation was enacted to prevent this kind of incident from recurring.

First responders have learned from these lessons, but hospitals are still struggling because of inexperience. The idea of receiving large amounts of contaminated patients is daunting enough for most hospitals that they take a very rigid approach – everyone strips all the way down, everyone gives up his/her personal effects, and anyone who doesn't cooperate gets turned away. In practice, this kind of hard-line approach may well lead to chaos.

From a practical perspective, if you remove victims' adaptive devices, such as canes, glasses, hearing aides, etc. you've further impaired your victim population. The subsequent increase of special-needs victims is now a larger strain on your hospital resources. From an emotional perspective, controlling victims in a panicked state is a difficult proposition. Compounding that by taking their wallets, removing their wedding rings, and stripping their children in public could well turn a panicked victim into a violent assailant. The victim does not share

Please see > Considerations, P14

< Projects, from P9

As you wrap up 2011 and prepare for a successful 2012, have a safe, healthy holidays. Thanks for all your work, you make it better.

Darryl Price is the Healthcare Practice Leader for Slalom Consulting. With twenty plus years of executive experience in healthcare, Darryl brings a keen understanding of the healthcare business and the technology solutions that drive success. Darryl can be reached at darrylp@Slalom.com.

Roger Kastner's "Why Projects Succeed" is available by going to http://blog.slalom.com and click on Roger's blog series. Roger can be reached at rogerk@Slalom.com.

Slalom Consulting is a business and management consulting firm that helps companies drive enterprise performance, accelerate innovation, enhance the customer experience, and increase employee productivity.

< Considerations, from P12

your objective of protecting your staff and patients.

Community-care aligns the objectives of the victim with the objectives of the health system without compromising either. Looking at the patients, staff, and victims together as a community means pragmatically tailoring objectives in ways that make sense. If the ultimate goal is to protect the current patients and staff while providing care to the victims, then reasonable measures can be taken to reduce danger to patients and staff without increasing danger by agitating and/or further impairing the victim population.

History offers some great perspective on the risk / benefit analysis in situations like this. Recently the TSA discovered something important related to their full-body scan technology – people don't like to be seen naked, even if it's for their own safety, virtual, and viewed remotely. Boycotts at airports clogged up travel and people protested angrily. In October the US Supreme Court upheld a Muslim woman's right to sue Orange County because deputies jailed her and forced her to remove her hijab in the presence of men.

On the other hand, OSHA found that incidences of hospital staff being injured by contaminated patients are very low. A review of more than 2,500 hazmat incidents from the Agency for Toxic Substances and Disease Registry (ATSDR) Hazardous Substance Emergency Events Surveillance system shows that hospital workers were only injured in 0.2% of incidents and that none of those injured needed hospitalization. Even though 640 patients entered health systems without being decontaminated during the 1995 Tokyo sarin gas incident, all of the exposed health care workers were able to continue their duties.

This isn't to say decontamination should be avoided or done incompletely. It is merely to say that consideration should be given to the level of risk posed by the contaminant versus the level posed by violating social and cultural practices. Privacy, communication, and care are all critical components of a balanced and effective decontamination response.

Jeremy Stacy is the Disaster Preparedness Coordinator for Good Samaritan Hospital in downtown Los Angeles. He is also a Hazardous Materials Emergency Response instructor through CSTI's Outreach program. He teaches classes in Emergency Management and Patient Decontamination and recently participated in a research program on developing guidelines for victim decontamination being done by the Division of Medical Countermeasure Strategy & Requirements (MCSR) Office of Policy & Planning (OPP), the Office of the Assistant Secretary for Preparedness and Response (ASPR), and the U.S. Department of Health and Human Services (HHS).