

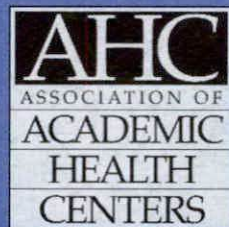
# Proceedings

## 8<sup>th</sup> CONGRESS of HEALTH PROFESSIONS EDUCATORS

June 4-5, 2001

Washington, D.C.

**Solving the  
Workforce  
Crisis: Lessons  
from Clinical  
Practice and the  
Corporate World**



Proceedings  
8th Congress of Health Professions Educators

# Solving the Workforce Crisis: Lessons from Clinical Practice and the Corporate World

Elaine R. Rubin

Editor

June 4–5, 2001

Washington, DC

Association of Academic Health Centers

The Association of Academic Health Centers (AHC) is a national, nonprofit association dedicated to improving the health of the people by advancing the leadership of academic health centers in health professions education, biomedical and health services research, and health care delivery.

The AHC represents more than 100 institutional members in the United States that are the health complexes of the nation's major universities. Academic health centers consist of an allopathic or osteopathic school of medicine, at least one other health professions school or program, and one or more teaching hospitals. These institutions are the nation's primary resources for education in the health professions, biomedical and health services research, and many aspects of patient care.

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1400 Sixteenth Street, N.W.

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Voice 202/265-9600

Fax 202/265-7514

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## PREFACE

*Solving the Workforce Crisis: Lessons from Clinical Practice and the Corporate World* is a compilation of the papers presented at the national 8th Congress of Health Professions Educators. Sponsored by the Association of Academic Health Centers (AHC), this year's congress reflected the concerns of the public, associations, and health care institutions across the nation with health professions shortages and the resulting impact on the effectiveness and quality of health care. Recognizing that the health care field needs to find ways to respond to a growing crisis, the congress was dedicated to highlighting strategies, programs, and initiatives that are beginning to resolve the health workforce crisis.

The papers that follow analyze and debate such critical issues as the declining interest in health careers, along with the need to take into account professional relationships, diversity, student and staff recruitment and retention, applicant pools, leadership, quality, public perceptions, the media, and the effect on academic health centers as they outline opportunities for improvement, innovation, and change.

Dr. Bentley presents an overview of the challenges facing all health professions today, noting how shifting demographic, market, and socioeconomic forces are creating new career opportunities in the workplace at the expense of the health professions. In the face of these developments, Bentley provides useful insights on how to change negative perceptions and environments to benefit health professions education and practice.

The papers by Dr. Rogers, Dr. Cohen, and Ms. Thode provide examples of ways in which institutions, health professionals, and health care providers can enhance the workplace environment. The authors describe those major elements of the workplace, ranging from ergonomics to physician relationships to participation in governance and decision-making, that workforce programs and policies must address. What emerges is a picture of changing attitudes, expectations, and life styles in the workforce that are transforming institutional and corporate cultures in the United States but have not yet been fully factored into educational and labor practices in health care settings.

Yet another paper also delves into some of the most intractable and troubling problems confronting health professions educators. Drs. Davis and Jenkins present a unique perspective on diversity, and show that ways exist to ensure that the health professions of the future mirror the diverse patient populations to be served. Determination, hope, and faith in themselves and each other are part of the odyssey of these two men who, together with a good friend, triumphed against overwhelming odds to become doctors serving the community.

where the three spent their boyhood. Their story clearly reveals that the rhetoric of diversity cannot become reality without money, time, and people dedicated to students.

Dr. Johnson-Pawlson tells how Partnerships for Training, a Robert Wood Johnson Foundation-funded project at the Association of Academic Health Centers, is changing both the education and practice worlds through technology and distance education.

The papers by Dr. Heller, Dr. Valachovic, and Dr. Cerra were catalysts for discussion at workshop sessions carrying out the how-to theme of fixing workforce problems. Heller outlines a broad spectrum of nursing alliances and initiatives at the University of Maryland, Baltimore, that have proved successful in recruiting, retaining, and replenishing the nursing workforce. Valachovic points to strategies for educating nonhealth organizations, policymakers, and the public about the health workforce situation today. Cerra describes how academic health center leaders are creating structures to change academic cultures and promote interdisciplinary activities, crucial complements to other strategies for improving work environments.

Significant case studies of institutions that have found answers to workforce challenges make up two papers. Ms. Beeth points to an evergrowing shortage area—home health aides—and relates how Fairview Health Services in Minnesota is meeting this need through a wide range of programs within the institution itself. Ms. Poyser and Ms. Warren address welfare-to-work partnerships, showing how new populations can enter and make valuable contributions to the health care workforce. The lessons garnered from their experiences can translate to many health care and educational organizations.

The final paper by Mr. Berens brings to light public perceptions of the health care world through the media's lens. In the process, this reporter also offers a glimpse into what nurses think—and are beginning to articulate—about the effect of the nursing shortage on their work.

We hope that this book will serve as a useful reference for anyone interested in understanding, addressing, and resolving the difficulties and complexities of health professions shortages, in particular, and workforce issues more generally.

More important, we hope it will stimulate dialogue and collaboration among health professionals, institutions, policymakers, and the public to work together to find solutions that ensure a quality health care workforce for the future.

The Association of Academic Health Centers would like to thank the many people and organizations whose support and work contributed to the success of this year's congress. The Congress of Health Professions Educators is a major activity of the Center for Interdisciplinary, Community-based Learning, which operates under a cooperative agreement between the Association of Academic Health Centers and the U.S. Health Resources and Services Administration (HRSA). We thank HRSA for its ongoing support and collaboration. We also thank members of the Federation of Associations of Schools of the Health

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—ERR



## CONTRIBUTORS

Laura Beeth is director of workforce development and career and placement services at Fairview Health Services, Minnesota.

James Bentley, PhD, is senior vice president for strategic policy planning at the American Hospital Association.

Michael Berens is a staff writer at *The Chicago Tribune*.

Frank B. Cerra, MD, is senior vice president for health sciences, University of Minnesota.

Jordan Cohen, MD, is president of the Association of American Medical Colleges.

Sampson Davis, MD, is a founder of The Three Doctors, Newark, New Jersey.

Barbara Heller, EdD, RN, FAAN, is dean and professor at the School of Nursing, University of Maryland.

George Jenkins, DMD, is a founder of The Three Doctors, Newark, New Jersey.

Jean Johnson-Pawlson, PhD, NP-C, RN, FAAN, is director of Partnerships for Training at the Association of Academic Health Centers.

Tracy R. Poyser is director of employer and industry relations, Office of Applied Innovations, DePaul University.

Bonnie Rogers, DrPH, COHN, LNCC, FAAN, is associate professor of nursing and public health and director of the occupational health nursing program at the University of North Carolina, Chapel Hill.

Elaine R. Rubin, PhD, is vice president for program, Association of Academic Health Centers, and acting director of the Center for Interdisciplinary Community-based Learning.

Mary Ann Thode is chief operating officer of Northern California, Kaiser Permanente.

Richard Valachovic, DMD, MPH, is executive director of the American Dental Education Association.

Charlotte Warren is staff specialist for professional services at Northwestern Memorial Hospital.

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# I. OVERVIEW

# 1

## **CAN A HEALTH CARE PROFESSION BE THE #1 CAREER CHOICE?**

James Bentley, PhD

The present workforce situation in which the hospital community finds itself can be attributed to five issues. First, the annual turnover for hospital employees is roughly 20 percent per year. Second, the hospital is an institution with a predominantly female workforce. Precise national data are not available, but somewhere between 75 and 85 percent of hospital employees are women.

Third, hospitals have stratified diversity. That is, if employees of most hospitals were standing on a lawn and we asked the people with relatively low pay rates to line up at one end, and the people with higher pay rates to line up at the other, we would find that the side with the relatively low pay rates had substantial diversity. The side with the higher pay rates would be primarily Caucasian male and female.

Fourth, the hospital is the factory of the health care system. It works 24 hours a day, 365 days a year. Clearly, not all portions of the hospital work to that degree. The outpatient clinics often are only open Monday through Friday, perhaps ten to twelve hours per day. The institution itself, however, never closes. Also, as in a factory, the hospital workforce is highly guild-based. A hospital organization chart does not look like the traditional pyramid seen in most businesses. Rather, it looks much more like a comb in which a variety of personnel and occupations make up the separate teeth.

Fifth, licensure and regulation underlie and build in, through practice acts and other licensure specifications, many of the features of that guild activity.

### **FACING LONG-TERM SHORTAGES**

Although the nursing shortage has attracted a lot of press, the fact is that hospitals are experiencing a shortage of everyone: pharmacists, lab techs, food service workers, information technologists, coders, et cetera. Furthermore, this is not the first shortage of nurses or other health care workers. A shortage occurred in the 1960s, followed by a particularly bad one in the 1980s, and then by a light shortage in the 1990s.

In the past, shortages generally occurred when, like now, the economy was at relatively full employment. Whether people chose to work fewer hours or had a broader selection of career opportunities, hospitals found recruiting difficult, especially for night and weekend workers.

This does not appear to be what hospitals face today. Certainly, part of the personnel shortage may be a function of full employment and broader labor force opportunities. But, an additional and major factor is the long-term shortage that will come about as baby boomers move into retirement.

Data suggest that this wave of retirements will happen before the baby boomers turn sixty-five and qualify for Social Security. Retirement savings programs, such as the 401(k), 403(b), or individual retirement account (IRA) savings, have allowed people to accumulate enough money to either retire early or move into what has been called a bridge job: a part-time job between full-time employment and full-time retirement.

Behind the baby boomers are two smaller demographic groups, Generation X and Generation Y. If hospitals simply recruited the same proportion of people into health care or hospital careers from these generations, we would still not have enough people to replace those currently employed.

Baby boomers do not just retire and disappear; they retire and move into the age groups that place the highest level of demand for service on both the health care and hospital systems. Thus, as demand for services grows, smaller cohorts will be trained to care for them.

## **UNHAPPY EMPLOYEES**

Another factor complicating hospitals' ability to attract and retain workers is employee discontent. Indeed, according to the American Society of Healthcare Human Resource Administration (ASHHRA), the level of dissatisfaction among health care workers is atypically high. ASHHRA is a unit within the American Hospital Association (AHA) that has been working for two years with Aon Consulting's Loyalty Institute in Ann Arbor, Michigan, on America at Work, a set of projects focused on learning about people's attitudes to their jobs. Aon currently collects these data in the United States, Canada, Scotland, and England. Compared with other industries, the dissatisfaction level of health care workers has been found to be the highest.

This poses a major challenge because an employee will often leave one of our institutions, go out into the community, and say, "If I had it all to do over again, I wouldn't become a nurse, a pharmacist, a physical therapist," or, "I wouldn't work at the hospital." At the same time, people in the health care field tend to identify with their profession, occupation, or discipline more than with their employer. While the average employee in the United States, when asked where he or she works, will give the company name on the paycheck, health care people will name their discipline: I'm a nurse. I'm a pharmacist. I'm a lab tech.

The dissatisfied health workers willing to move can continue their occupation or discipline while they change institutions. It appears that, if a person gets frustrated by the lack of upward mobility, sideways mobility is available.

## **NEW ATTITUDES ABOUT HEALTH CAREERS**

Complicating the scenario is that both Generations X and Y look at the health care field differently than previous generations. They have a less positive view of, and have different expectations from, health careers than their baby boomer predecessors. The baby boomers were raised by parents who came out of the Depression and World War II and who had a very different way of looking at work and the relationship between work and the rest of life.

Six factors contribute to the diminishing appeal of health-related careers to the younger generations, as discussed below.

First, thirty years ago, in what was a predominantly manufacturing economy, young people saw health care as high tech. In an information system economy, it is seen as low tech. It has been noted that hospital work has changed not so much from high tech to low tech, but from clean to dirty. A world where people get dirty, often with products from people, is not very attractive to a lot of young people who have the option of sitting at a desk in a business office. Hospitals may be losing the talent race for young people based on this perception.

Second, the health care field was seen as a very secure place to work twenty or thirty years ago. It had all of the positive characteristics of working for government and virtually none of the negatives. As a result of restructuring, reengineering, managed care, and the changes in the 1980s and 1990s, virtually no one sees the health care workplace as secure. In addition, we have broadened career options in health care for women, but not for men and minorities.

The fourth point has to do with the psychic rewards of health care. Several decades ago, a heart attack meant a four-week hospital stay; a gall bladder surgery required six weeks. Often on discharge, the patient left some flowers or plants at the nursing station, where they knew almost everyone's name. An attendant who had seen the patient over a number of weeks walked him or her to the door. This pattern provided a lot of psychic reward, even at a time when hospitals did not have to pay the minimum wage.

Today, many hospitals have an average length of stay of four days. The chances that a patient will see the same nurse twice on two shifts are substantially diminished. And psychic compensation for health care workers has been replaced by documentation and record keeping. A recent AHA study shows that for every hour a nurse is involved in an emergency room, there is an hour of paperwork to complete. As a result, nurses and others are not happy—and they tell young people about it.

A fifth difference is that the parents of baby boomers who lived, worked, or were unemployed through the Depression, or served in World War II were much more accepting of work shifts and encouraged young people to accept them.

Today's young people have the option of taking any number of college courses on the Internet 24 hours a day, 7 days a week, according to their own personal convenience and interest. Unfortunately, this is an expectation that a lot of young people have in terms of how their work life should be organized. But hospitals are not organized like that.

The final difference, which is more anecdotal than scientific, comes from simply listening to health care workers, nurses in particular. Nurses in their upper 40s or 50s report a change in how they feel about what they do for the patient. Many of them feel that they are torturing patients as a result of the current array of technology applied to the very ill. They also say they had a lot more to do before things were so high tech. And they remember having patients who were not as sick as hospital patients today.

## **THE AHA WORKFORCE COMMISSION**

The American Hospital Association has put together a commission to look at workforce issues in hospitals and health care systems. It is chaired by Peter Butler, the chief executive officer of Methodist Health Care in Houston. The commission has a number of representatives from the academic community and senior officials from academic health centers.

The commission has more outsiders: a foundation president; the president of the Service Employees' International Union (SEIU); the president of the American Nurses Association (ANA); and others not directly members but who are involved in some aspect of helping train, develop, or care about the health care system.

In a field in which upper levels are still dominated primarily by men, AHA has worked very hard to get more women, minorities, and younger people on the twenty-seven-member commission. One of the other things we are learning is the importance of how young people see health careers before they get out of high school.

### **The Pipeline**

The commission was formed to deal with five areas of interest: the employee pipeline; career development, work redesign, and workplace environment; and restructuring the hospital system.

First is the pipeline. In this regard, almost everyone is talking only about first employment. Look at the materials that come across your desk. If someone is older than twenty-five, the articles about the pipeline and workforce development doesn't include him or her. Yet we know that in the hospital and in health care, we have a large number of people who enter the field at midcareer, perhaps after having raised a family, or perhaps having tried something else and found that it wasn't attractive to them.

Think about the characteristics of a job that you were interested in when you were eighteen or twenty-two years old. Put those on one side of the page. On the other side, list what you are interested in now. Some people have some very

challenging ideas. Do you envision a work life in which work is made up of four-hour shifts, and in which everybody can decide how many four-hour shifts they want to work?

One of the things the commission is looking at, and will talk about, is broadening the view of the pipeline. We simply can't assume that if we don't get people by the time they are twenty-six, we are never going to get them.

Most of the literature on the employee pipeline discusses only first employment; articles about human resources development do not concern themselves with people older than twenty-four or twenty-six. Yet, in the hospital and health care systems, a large number of people enter the field at midcareer, perhaps after having raised a family or having tried something else.

The book *Working Through Demographic Change* shows that a great number of people in the fifty-five to seventy-five year age-range are interested in continuing to work. They look at work and work shifts differently, however, and health care employers will need to adapt to this group's expectations.

### **Career Development, Redesign, and Environment**

A second issue for the workforce commission is career development, or upward mobility. The educational system is less than helpful in this regard, particularly for people who work in the lower echelons of health care, such as kitchen servers, housekeeping staff, nurse's aides, or lab technicians. Often they see another career in which they have an interest but become discouraged when they realize they must go back to school to achieve it.

Third, hospitals also need to change their work design from a factory concept to one of greater employee autonomy. In the 1950s, physicians had one of the few health force occupations that required a university education. Diploma nursing programs or hospital-based programs provided training for other fields. Little has changed since then. Although students who graduate today expect to be participants, hospitals still do not have an environment that allows for employee autonomy or creates an organization with a systematic work life. Both worker satisfaction and productivity must improve.

Another issue for the commission is the workplace environment. A paper published by the Credit Union League lays out the fact that work is one of the few places in our society where people come together across generations. Work is the place where we still bring together the World War II, baby boomer, and X and Y generations, not to mention the soon-to-be-labeled next generation whose expectations of the workplace environment are very, very different. Yet, management tends not to respond to differences; rather it wants to homogenize, which the paper suggests is a major weakness in the workplace.

### **Restructuring the Hospital System**

A last question for the commission will likely be, "What if we started from scratch?" This fundamental, clean-slate approach to rethinking the system is an

issue we are going to try to grapple with. Whether we will be successful is yet to be determined. The AHA Workforce Commission will publish its report in April 2002.

## **EDUCATIONAL ISSUES**

Rural hospitals are very upset with the education structure in this country. For people to advance, they have to go school. Yet, most rural communities find that, if sent to the urban center to train, even full-time employees do not come back. Thus, there is a genuine need for distance learning.

Across the entire American Hospital Association membership, there are three concerns: educational inflation of careers, the lack of dialogue between the educational and service communities, and the possibility that education demeans patient service. In the first case, professions—on their own—are adding one, two, or three years so students can qualify for a different degree or different educational threshold.

The lack of dialogue between the educational and the service communities is an ongoing concern. When United Parcel Service (UPS) expanded its huge sorting facility in Louisville, it decided to hire college students as part-time workers. However, getting college students to work on the schedule the company needed required the colleges to shift their course schedules. It was a difficult negotiation, and many colleges and universities were not willing to adapt. What brought some of them around were brand-new dormitories and other facilities built on campus by UPS. In the end, that was the only way UPS could manage to get a school to change.

There is also concern that education demeans patient service. In a recent public radio broadcast, a nurse from one of the large academic health centers called to complain that we train “plainclothes nurses”; that is, nurses who have no interest in being where patients are and never want to put on a nurse’s uniform. They simply want to be behind a desk. In addition, there is the idea that if nobody else is here, a nurse will do it. It does not make any difference what the task is; the nurse on duty will fill in. This is the concept of fatal availability, which particularly applies to nurses.

For academic health centers, the same concept, never as well-labeled, also applies to medical residents. As we look at resident work hours and education requirements, we also need to look carefully at who we assume will fulfill the fatal availability requirement. Is the decision undermining to the resident or is it making the hospital a good place to work?

## **CONCLUSION**

Hospitals can indeed be employers of choice if their goal is to sustain a workforce of people who are caring, highly skilled, highly motivated, and highly productive.



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## II. CHANGING THE WORK ENVIRONMENT

## 2

### **RESPONDING TO THE CHALLENGES OF INJURY, STRESS, AND ERGONOMICS**

Bonnie Rogers, DrPH, COHN, LNCC, FAAN

This paper addresses the issues that face health care workers, particularly those related to injuries on the job, ergonomics, needle-stick injuries, and stressors. The Bureau of Labor Statistics indicates that health care workers are among the groups that have the highest risk of injuries (and now illnesses as well), particularly those providing direct-care services. How can you describe such a situation in ways that won't affect a person's decision to enter the health care field?

The only way to do that is to change the industry.

#### **INJURIES, ILLNESSES, AND OTHER RISKS**

In the past, if you, as a nurse, had exposure to blood, you felt it really was nothing. It was sort of a badge of courage. Basically, if you had blood on your uniform, they knew you were at work that day, and you almost attempted to get blood on your uniform.

When you look at the issue of illnesses and injuries, it's pretty amazing to think that hospitals and nursing personal-care environments have an injury or illness rate twice that of the general private industry—and lost work days to match.

Over a fifteen-year period, you see a doubling or even tripling or quadrupling of the types of injuries reported. Clearly, some of this is related to reporting. But in some instances, staff are more likely to underreport.

#### **Muscular-Skeletal Injuries**

The large portion of lost work days is related to the manual handling or lifting of heavy patients. Patients can be very heavy, particularly for a small health care worker, to lift. As a result, back injuries account for about 40 percent of the injuries that are reported in hospitals. And back injuries are an acceptable risk that one assumes as part of the work. So back injuries and ergonomics really do need to be a hand-in-hand item.

Looking at the incidence of days away from work, the Bureau of Labor Statistics reports that lifting is far and away the greatest cause of lost work time. Of the top ten occupations for muscular-skeletal disorders, Number One is made up of nurse's aides, orderlies, and attendants, and Number Six comprises registered nurses. Nurse's aides actually rank above truck drivers in terms of muscular-skeletal disorders.

Much of this is related to the heavy lifting, the twisting, the bending, the awkward postures, and standing for long hours at time. I remember days of standing pretty much for eight or ten hours a day. I still remember taking care of a patient with an abdominal wound that needed to be dressed, but the patient couldn't turn over. My job was to climb under the bed to change the dressing through the wires. They had actually cut a hole in the mattress so it would drain, but you had to change the dressing through the wires of the bed. These are some of the awkward postures that you have to be in along with the dust bunnies under the bed.

These are some of the physical environment stressors that people face including the compression that occurs from gripping tightly on handling devices, which decreases the blood flow.

### **Worker Status**

Are the health care providers in good health? Do they have any kinds of chronic disease that they bring with them that are likely to be compromised? Do they have immunosuppressive disease as well?

We also have an aging workforce, but the jobs are still designed for younger workers. Clearly, lifting equipment needs to be addressed in a better fashion, particularly in the health care industry, where you are dealing with humans, and not boxes of materials. A patient is very different from a chemical vat. It's not just a stationary object that you lift up.

### **Back Pain**

The common problem of back pain causes lost work time, and in terms of direct care costs alone, costs about \$50 billion annually in the health care industry. Back injury risk-factors include working in long-term care where patients tend to be more immobile. Another consideration is the severity of the health care provider's injury; a second injury clearly is a worse injury, with younger workers more likely to be injured acutely, and the older worker to have a chronic injury. Staffing ratios also come into play here: Does the provider do all the lifting him- or herself? It's important for people to actually practice proper body mechanics, but body mechanics cannot substitute for getting help when needed. It cannot substitute for an assistive device.

### **Other Considerations**

Patient factors also come into play: patients who may be obese, patients who may be comatose, patients who may be uncooperative. And what happens when

a patient resists? The provider tries to catch the patient falling out of bed, jerking his or her whole body in the process. Task demand and task repetition are also factors that create the environment in which we see back injuries.

Another factor is the physical capacity of the worker. When we speak about ergonomics, we are talking about matching the job to the worker, not matching the worker to the job. Each worker has to have some accommodations made depending on variations in his or her personal fitness, personal styles, and how he or she does a particular job. So we think about body mechanics in terms of its effectiveness as an adjunct, but not as a primary method of dealing with this problem.

The National Institute of Occupational Safety and Health (NIOSH) has lifting guidelines that can be used to determine how much weight a particular person can lift. But you have to also think about lifting in terms of how high that person can lift. What happens when somebody is falling off the bed? It doesn't account for those kinds of factors. It is an area that clearly needs more study.

There are six ergonomic elements that need to be incorporated in the industry: management leadership; employee involvement; hazard identification; hazard prevention; health care medical management; and training and education.

The employee needs to believe that management has a demonstrated concern for health and safety. It wasn't that way thirty years ago. It probably wasn't even that way twenty years ago, but you do see some changes and shifting in the attitudes about this today. However, little is done about home care in terms of looking at the hazards related to that health care worker. There are no assistive devices in a patient's home.

Safety and health should be viewed by management as important as any other policy in the institution, not as an adjunct policy, but right up there with all the personnel policies. There needs to be an institutional commitment to responsibility and resources, in other words, the institution providing the necessary dollars and labor. Once that is done, there has to be accountability.

Employees need to be able to recognize what and where the hazards are. I have been told by health care institutions not to tell them that the hazards are there, because they will leave. That whole approach needs to change.

In addition, employees need to feel they can report a problem, and that they are not going to be punished for reporting but rewarded. Employees also need to be involved in decisions; they need to sit on safety and health committees; they need to be involved in developing policies that relate to the whole health and safety aspect of that environment.

Looking at the record, like the Occupational Safety and Health Administration (OSHA) logs and insurance claims, can help reveal the real hazards that are there. What is causing them? Some departments and some jobs are more hazardous than others and should be prioritized accordingly. What are the risk factors that can be identified from watching people as they are doing their job? And then, how can that be changed?

It also takes looking at both low- and high-risk jobs, and then verifying, for example, that restricted duty or light duty or modified duty is, in fact, a low-risk situation.

## **INCORPORATING ERGONOMICS**

Job hazard analysis consists of breaking down the job by task, identifying the hazard, and then developing a solution for risk reduction. Take a look at all the steps in a simple bed-to-stretcher transfer:

1. Getting the stretcher to the room.
2. Positioning the stretcher.
3. Locking the wheels.
4. Aligning the stretcher with the bed.
5. Obtaining transfer aids.
6. Ensuring the proper slack of tubing for patients.
7. Getting the right number of staff members to assist when needed.
8. Asking the patient to align him- or herself if the patient can do so. If comatose, the patient will not be able to help with the alignment.
9. Leaning across the stretcher.
10. Pushing the patient toward the stretcher. When the patient is moved to the edge of the bed, what happens? The nurse climbs up on the bed to help complete the move!
11. Pushing the patient onto the stretcher.
12. Transporting the patient to the desired location.

All of these tasks are involved in just this one activity.

Hazard prevention and control consists of engineering controls, administrative controls, work practice controls, and personal protection controls. Engineering controls, in some cases, can mean redesigning the work station so that instead of the health care worker bending over, lifts bring the patient up. Do the equipment and tools fit the worker? Are they designed for both men and women?

Administrative controls means reducing lift exposures, rotating people through jobs cautiously so they don't have other exposures, and giving the health worker's muscles time to recover. Try to incorporate low-risk tasks, along with high-risk tasks, and make sure proper maintenance and housekeeping care is provided in terms of the equipment, et cetera.

Work practice and personal protection controls address body mechanics, mentoring, and monitoring so that people actually know what it is they are

supposed to be doing on their job and that somebody watches them to make certain that they are doing it in a safe way.

Health and medical management provide early identification of signs and symptoms to prevent a back or muscular-skeletal injury from occurring.

Appropriate return to work means not returning the worker to a risky environment, reintroducing him or her to another injury, or complicating an injury that is already there. And then, clearly, there is follow-up to make certain that people are complying, and evaluation to determine that the treatment plan is, in fact, working.

To handle training and education issues, supervisors need to attend training sessions to identify risk factors and appropriate work methods, and then apply that information exactly to the work environment.

Last, effectiveness (reductions in injury, lost work time, health care costs) has to be measured to improve the work environment and quality of life.

## **PREVENTING NEEDLE-STICK INJURIES**

Legislation was recently passed that, it is hoped, will eliminate many of the problems caused by needle-stick injuries. More than 800,000 such injuries occur each year in the United States. They are costly in terms of the time and money needed to investigate the source of the exposure, postexposure care, lost work time and productivity, treatment and, the most important, workers' lives.

Needle-stick injuries occur mostly to nurses. They report about half the needle sticks because it's mostly nurses who handle needles. Next come physicians, followed by nurse's aides.

The essence of the new legislation is to look at design of safer devices, and not so much at work practices. Most needle-stick injuries occur in patient rooms, followed by operating rooms, emergency rooms, and then ICU departments. The tasks that most often lead to injuries are disposing of needles, administering injections, drawing blood, recapping needles, and handling trash and dirty linens. The law says we can't recap needles any more, but that's what is happening. Health workers still recap needles. When AIDS and HIV emerged, people stopped recapping, but we're seeing a reemergence of the practice. Upwards of 60 percent of health care workers in some institutions are recapping needles.

Needle sticks occur before and during use when, typically, the needle is not contaminated so it is not much of an issue. But 10 percent of them happen during and after disposal where housekeepers and laundry workers are getting stabbed with contaminated needles in the trash and dirty linens and don't know the source of the exposure.

How serious a threat are needle-stick injuries to health care workers? Up to 80 percent of all accident exposures to blood are caused by needle-stick injuries. And 16,000 of the estimated 800,000 needle sticks (about 2%) are likely to be contaminated by HIV. HBV, hepatitis-B, and hepatitis-C are more serious

problems than HIV because they are more transmissible. In all, more than twenty pathogens can be transmitted by needles.

Blunt suture needles and safe phlebotomy needles have been shown to significantly reduce the amount of needle-stick injuries. Blunt suture needles provide up to an 86 percent reduction and phlebotomy needles up to 76 percent.

The Needle Stick Safety and Prevention Act, which became law just last year, is a start in helping industries to begin to think about the best devices that can be used in this particular industry.

## **MINIMIZING STRESS**

Stress issues, particularly in the health care environment, are reported most frequently, but they are reported in different groupings. For example, ICU nurses or health care workers report death and dying as most stressful; so do pediatric nurses. When a person is stressed out on the job, nothing gets done. Some 70–80 percent of worker time is spent dealing with a particular stress issue; whether it's family or whether it's work, stress is there.

Floating from one assignment to another is very challenging and stressful, particularly for the health worker who is floating to an area where he or she has limited skills. It's pretty scary to be expected to perform when you don't have the skills.

Work overload, work environment, family issues, and role conflict between the different personalities and disciplines that are on the job are also stressful. There is a long history of physicians and nurses having conflict. Many issues relate to management and personalities while on the job.

In addition, you often have two or three managers, particularly in a metrics environment—for example, a nursing supervisor and a technical supervisor whom you have to satisfy at the same time.

And then there is shift work. Nobody likes it. In one of our hospitals in North Carolina, the policy is that everybody has to shift or rotate, even though some people like to work permanent nights. The Work and Family Institute reports that people are working very fast, very hard, and still don't have enough time to get the job done. There have been dramatic increases in this kind of situation in twenty years. This whole issue of stress clearly is being demonstrated not just in the health care worker industry, but the entire workforce in this country. One-fourth of employees view their jobs as the biggest stressor in their lives. Three-fourths believe that the worker has more on-the-job stress than a generation ago, and that problems at work are more strongly associated with health complaints than with any other stressor in their life.

Job stress is related to cardiovascular disease, muscular-skeletal disorders, and psychological disorders. We see that stress on the job is related to many of the health complaints—suicide, cancer, ulcers, and impaired immune function—that people are facing today. Related factors fall into six strategic areas: organizational, environmental, situational, personal, technological, and professional.

## CONCLUSION

To summarize, looking at management commitment, there needs to be training and retraining with technological job alteration. There must be ways for people to learn new tasks. There must be a communication channel overhaul so that employees are heard when it comes to decision-making. There has to be organizational upsizing, instead of downsizing. People should be involved in performance evaluation changes, not just recipients of the evaluation. And last, you need to have a culture that really does support occupational safety and health, and doesn't just pay lip service to it.



# 3

## INTERPROFESSIONAL RELATIONSHIPS: THE IMPACT ON THE WORKFORCE

Jordan Cohen, MD

Interprofessional relationships and their impact on the physician workforce is a topic with many different layers. Swirling around the issue are major concerns that cannot be compartmentalized without engaging virtually all of the other health professions.

The problems relate to the total supply of physicians for the future; the proportion of that supply that is going to be in one of the generalist disciplines, as opposed to the more specialized or subspecialized areas of medicine; and, finally, the redistribution of specialty services among medical specialties and among many other health professionals as well.

### THE PHYSICIAN SURPLUS?

First, with respect to future supply, the question is: Will there be a surplus of physicians? As recently as ten years ago, and perhaps even less than that, almost every scholar in the area of the physician workforce was predicting a large oversupply by the turn of the century. Many may remember Jonathan Weiner's article, one of the most influential on the topic. Dr. Weiner, professor of health policy in the Johns Hopkins School of Public Health, predicted that a surplus of 150,000–180,000 physicians would be among us in the year 2000.

The millennium came, but we did not see any doctors out of work. None were driving taxicabs, as far as one could tell. The prediction of an enormous oversupply, particularly of specialist physicians, clearly did not appear to be the case.

A number of reasons can account for this situation. As Weiner says, workforce projections are totally dependent on the assumptions one makes in the beginning about what kind of work is going to be done, what sort of employment arrangements are made, et cetera.

It turned out that some of the models of managed care in the early part of the 1990s simply did not sit well with the American public. The whole gatekeeper concept, which limited access to specialists, turned out not to be an economically viable model for managed care organizations. Thus, the projections made on the basis of this model proved to be totally incorrect. Nevertheless, there are

still some, including Jonathan Weiner, who believe that we are, in fact, going to be facing a surplus in the future relative to our needs.

Another body of opinion on physician supply, based upon some analytic work, is emerging. Again, one can quarrel with the methodology because it still is very much dependent upon assumptions. This work also suggests that we are facing a shortage of physicians. Indeed, looking at the anecdotal evidence, there are a lot of areas in the country that complain about the inability to attract sufficient numbers and kinds of physicians to meet perceived local needs.

## **TO PROJECT OR NOT TO PROJECT**

Given that workforce projections in this field have been uniformly wrong, a lot of people believe that we should not worry about trying to project physician supply. They also believe that it is inadvisable to try to modify the pipeline of physicians against these projections. They say we ought to forget about making projections and allow the marketplace to simply make whatever adjustments are going to be made. Clearly, this is the default position of workforce planning.

However, in thinking about how to best anticipate future requirements, the question is if we should base our projections on a need for physicians or on the demand for physician services. This fundamental philosophical difference leads to widely different results. If one tries to assess need on the basis of what is an optimal or better health care system, one comes up with a set of numbers that are quite different than if one assumes that the demand for physician services will continue to grow as the population ages and increases in size.

Other factors that affect demand include technology and the wealth of the nation. It has been shown that the demand for physician services tracks closely with the economic well-being of the United States, and of other countries as well.

Should we respond, then, to the need or to the demand? That depends tremendously on what we think future physicians are going to do. This controversial and divisive issue (whether current physician services are going to continue or not, and what physicians actually will do in the future) involves much uncertainty, conjecture, and opinion.

## **ENSURING A SUFFICIENT NUMBER OF GENERALISTS**

Another concern has been the number of generalists coming out of medical school. It clearly was a major issue in the early part of the 1990s. At the time, aggregate interest in generalist disciplines among graduating U.S. medical students fell dramatically to less than 15 percent, prompting worries not only because of expectations that managed care was going to need a huge supply of generalists, but also because many parts of the country were unserved by generalist practitioners.

For some time, the Council on Graduate Medical Education (COGME) has been promoting the concept that 50 percent of medical students should select a

generalist discipline. This is also the current position of the Association of American Medical Colleges (AAMC).

A tremendous amount of public debate and public policy considerations has focused on increasing the supply of generalist physicians to this magic number of 50 percent. We did encourage many, many medical students to pursue generalist careers, and the numbers most recently have come close to 50 percent of graduating U.S. medical students who, at least at that time in their careers, were planning to pursue one of the generalist careers.

Although few experts have been advocating that we need more than 50 percent, many believe we have yet to fill the pipeline adequately with generalist services to meet the public's need. Others still wonder whether this emphasis on generalist physicians was overdrawn, given that some of the anecdotal evidence, again coming from the marketplace, suggests that we may be reaching the saturation point in some parts of the country for generalist physicians.

This begs another question: How much primary care will other health professionals do? It is a huge issue with respect to trying to calibrate or predict what the generalist physician component of the future workforce is going to be. We must also consider the needs of this workforce. Until we answer the question of what other health professions are going to do (for example, osteopathic physicians, who traditionally have had more graduates entering generalist careers), we will not be able to project what the adequate supply of generalist physicians will be.

Additionally, advanced practice nurses are increasingly doing many of the things that historically were physician services. A number of alternative medicine practitioners, who are now claiming to be primary care professionals, are providing a great deal of first-contact involvement with the health care system. Certainly, interest among these non-MD health professionals in providing generalist services is going to increase sharply by every measure that one can assemble.

## **DISTRIBUTION OF SPECIALISTS**

With respect to the distribution of specialists, there is a great deal of uncertainty about where the boundary lines are going to be drawn between medical doctors and other providers of specialized services. Several examples follow.

For some time, there has been an ongoing, raging debate between ophthalmologists and optometrists about the scope of practice. It is an evolving, changing boundary, and optometrists are gaining much more through licensing and other credentialing activities; they are doing many things that ophthalmologists had been doing exclusively.

The same is true of psychologists and psychiatrists. In much of the country, psychologists are now getting prescribing privileges and are doing many of the things that have been the exclusive domain of psychiatrists. Within this very active, evolving interface, it is predicted that the distribution of these services is going to continue to evolve over time.

A last example is that of anesthesiologists and certified registered nurse anesthetists. A lot of change is occurring in traditional areas of responsibility. The impact that these and other evolving boundaries are going to have on the future physician workforce and its distribution is certainly difficult to predict.

In the final analysis, however, there are three major concerns about the physician workforce: whether the future supply is going to be sufficient; whether the 50 percent target for generalist physicians will be achieved; and whether there will be a stable or an evolving redistribution of specialty services. In each case, it is the interprofessional issues that are paramount when it comes to planning for or projecting the future.

## **INTERPROFESSIONAL MODELS FOR THE FUTURE**

Without better opportunities to come together as a broad group of health care professionals and think through some of these issues jointly, there is little hope of coming to any kind of consensus or rational judgment about the future workforce. Certainly, we want to try to do some planning to change the distribution of educational activities or mount different kinds of educational models. However, unless we can find ways to converse across historic disciplinary boundaries, we are going to be very hard-pressed to come up with any rational answers.

The next issue is how we can educate ourselves on the whole concept of team care. The very clear expectation is a health care system that is much more dependent upon teams of health care professionals as the unit of accountability, rather than having individual practitioners or small groups of like practitioners continue as the unit responsible for delivering quality health care.

A much better model for the future, one that we are still having difficulty creating, is a team model of health care that allows all health care professionals to do what they are trained to do in an optimal, coordinated, and collaborative way. With this model, we can deliver quality health care, particularly to increasing numbers of our patients who are suffering from chronic illnesses and disabilities.

The need to find ways to work across historic divides is real and will determine if the community of health care professionals will be able to meet the combined challenge of addressing the nation's future health care needs.

## **OTHER WORKFORCE ISSUES**

A few other physician workforce issues also come into play, although they are not as clearly involved in the interprofessional relationship issue.

### **Attracting Physicians to Underserved Areas**

A serious problem, one that has been around since the beginning of time, is the geographic maldistribution of health care services, in general, and physician services, in particular. We have tried to solve this problem by increasing the

number of doctors, particularly generalist and primary care physicians, but that has been proven over and over again not to be the way to solve this problem.

Physicians and other health care providers have many reasons for not migrating toward areas that are persistently underserved. The reasons include spouses who need career opportunities, professional isolation, and the difficulty of mounting a financially viable practice. They face other issues of a more social nature, such as limited educational opportunities for their children and the lack of cultural outlets.

Because people do not traffic in sufficient numbers to underserved areas, we need targeted incentives to allow this problem to finally recede. This strategy is better than trying, by mass action, to increase the number of people and hope that will lead to a diffusion of health care professionals into these areas.

One attractive solution is a major enlargement of the National Health Service Corps (NHSC), something the AAMC has been advocating for a long time. This is an approach to providing helpful services, albeit not in every instance, in lieu of permanent occupants of these locations. Yet this is a partial solution.

### **Underrepresented Minorities**

Another major physician workforce issue, one that is true of other health force professionals as well, is the paucity of minorities. We in medicine are facing a negative trend in this regard since the onslaught of antiaffirmative-action sentiments in some parts of the country. Medicine has taken a backward step in terms of the ability to attract physicians from underrepresented groups into the profession. This issue demands our vigorous attention. We are failing dramatically in our responsibility as custodians of the health professions unless we address what we know to be one of the most compelling needs of our future society, namely, an increasingly diverse America that will not be optimally served unless we can find ways to diversify our health care professions, particularly our physician workforce.

### **Medical School Debt**

Another problem facing medical education is the mounting medical student debt. More than 85 percent of graduates are in debt, with the average debt exceeding \$90,000. Many students are \$150,000–200,000 in debt just when they graduate. This has a tremendous impact on career choice and on the attractiveness of medicine in the first place. It is particularly true in the case of disadvantaged populations, who are not prepared to take on this financial burden.

### **Foreign Medical Graduates**

Substantial numbers of foreign medical graduates continue to come into this country. We have a much larger capacity in graduate medical education and teaching hospitals than we have graduates of U.S. medical schools. The differ-

ence, roughly, is about 16,500 graduates of U.S. medical schools each year but some 23,000-plus entry-level positions in graduate medical education. A large capacity is filled by foreign medical graduates. Depending on one's view about whether we are heading for a surplus or a shortfall of physicians, this situation is either worrisome or very good.

What is increasingly coming into play in this debate is that this disparity between the number of U.S. graduates and the capacity of graduate medical education, as well as the fact that twice as many applicants apply to medical school as are places for them, illustrates that most people who enter the applicant pool for medical school have already self-selected themselves for having sufficient academic credentials. They at least think of themselves as being potentially competitive.

Many students study medicine in one of the Caribbean schools or elsewhere outside the country. They then come back to the United States, along with many foreign students, to gain entrance to our graduate medical education. However, we are limiting opportunities for enrollment of U.S. students, either citizens or permanent residents, to U.S. medical schools as a consequence of this difference in capacity and the ultimate output of physicians from graduate medical education. The question is whether this situation ought to be part of our plan to expand capacity to meet marketplace demand.

### **Cultural Competence**

Additionally, there is the issue of cultural competence, which relates to our desire to provide a physician workforce that has a range of skills that very much includes the ability to manage, address, and relate effectively with a much more diverse patient population. It is perhaps arrogant to think that medical education in this country can address such issues more directly and more adequately by importing physicians from other cultures, even though they might not necessarily have the same skill sets as we might choose to imbue in our own students.

### **CONCLUSION**

All of these issues are relevant in thinking about the future health care needs of the nation. We know that interprofessional issues are paramount along with interprofessional relationships. The challenge is to find ways to resolve historic tensions and to build a skilled community of health care professionals to deliver expert quality care.

# 4

## **DOES A MANUFACTURING MODEL FIT THE HEALTH CARE WORKPLACE?**

Mary Ann Thode

The concept of a labor-management partnership started in industry and, to this day, most such partnerships focus on high productivity standards as well as quality and service. This paper describes the labor-management partnership as it has been applied to Kaiser Permanente, a not-for-profit health plan established in 1945.

Kaiser Permanente operates in eight regions, with 70 percent of the members in California. It's an old organization and, as with other old organizations, it has to deal with many traditions and history. Throughout the country, Kaiser has 29 medical centers, 17 in northern California; 90,000 full-time equivalent employees; and about 30,000 part-time employees. The organization has a number of affiliations as well, for example, with Group Health of Puget Sound in the Northwest.

### **MOVING TOWARD A PARTNERSHIP WITH LABOR**

Kaiser Permanente is the largest health maintenance organization (HMO) in the industry, with about \$18 billion in revenue. The enormity of managing such an enterprise, and then trying to fold a partnership with labor into it, is quite a challenge.

The labor-management partnership at Kaiser Permanente grew out of the tremendous labor strife that occurred between 1990 and 1997. At the time, Kaiser was also experiencing some severe financial losses, going through almost \$4 billion-plus in cash in 1996 and 1997. The balance sheet was beginning to look pretty dismal.

Dr. David Lawrence, Kaiser's chief executive officer, met with John Sweeney, president of the AFL-CIO. They discussed the fact that if something didn't change in the way Kaiser's workers and the rest of the organization worked together, Kaiser Permanente would probably go out of business.

Kaiser had a great reputation for clinical quality, but not for service. The labor-management partnership, when announced, had little substance. A period of negotiations then ensued, resulting in a formal agreement. Kaiser Permanente

established a partnership office at the program office level in Oakland, California. At the same time, the unions came together and appointed a president for the Coalition of Unions. The coalition consists of 55,000 AFL-CIO employees, 36 bargaining units, 25 unions, and 10,000 employees in non-AFL-CIO type unions.

## **Building Trust**

The first two years of the partnership consisted primarily of trust. Kaiser Permanente wanted to find out what would make the organization more performance-driven and provide a better work environment for employees. Facing the same health care shortages as other institutions, the Kaiser organization knew that it had to do something to make people feel good about working for Kaiser Permanente.

Kaiser also focused on a financial turnaround, engaging the unions very heavily in performance metrics and making sure that the workers understood their jobs and roles in the organization.

In northern California the registered nursing union, the California Nurses Association (CNA), chose not to become part of the partnership, holding that the partnership put a gag order on nurses when it came to making complaints about quality. (That wasn't necessarily true. The partners certainly came forward with many of complaints.) How to integrate nurses into decision-making still remains a challenge in northern California. In southern California, however, the two professional organizations for nurses became part of the partnership.

## **Going Into National Bargaining**

By April 2000, the partnership had moved far enough along to enter into national bargaining. At different times, between 200 and 400 employees, representing all the unions in the organization, came together and negotiated a national agreement covering 65,000 employees. This took fifty-five days.

## **A Task Force Approach**

The national agreement was ratified in October. The entire process was probably one of the most gratifying I have ever experienced as a health care professional. As the bargaining progressed and the employees became more and more involved, I could walk out of the room any time, and depend on a union partner to represent me—a big difference from the old adversarial attitudes. A number of task forces were established. People sat around tables. Everyone was free to talk about what they believed were the issues in the workplace.

## **Increasing Performance**

The Performance and Work Improvement Task Force was critical to this work. The partners reached agreement on issues important to increased performance, such as flexibility, crossing union lines, and crossing jurisdictional lines. In an



ambulatory care clinic, for example, people working in the back of the clinic would not come forward to help the receptionist when the reception line became very long. The receptionists were represented by Local 29, and the people in the back by Local 250. With the agreement, they were able to cross jurisdictional lines so they could fill in for others as needed.

Job security was another big issue. Kaiser Permanente had actually granted job security when the partnership first started. Instead of laying off people, Kaiser retrain. During negotiations, a lot more detail was built into this decision. Because the organization is so large, there is enough attrition to make this approach viable.

The partners also talked about life balance and workplace innovations and some of the things that could be done to improve the work environment. Even small things came up for discussion: concierge services, for example; a small place could be made available where employees could drop off and pick up their dry cleaning during the day.

The most negotiating time was spent on quality and service, Kaiser's service culture, and joint staffing. The result was that Kaiser Permanente signed one of the first agreements in the nation giving the unions the right to be involved in staffing—something seen as a big taboo in health care.

There was a lot of discussion about ratios. According to recent California legislation, minimum patient-provider ratios will be established for acute care hospitals. The partners, however, did not set ratios, but agreed there would be joint staffing teams in every medical center who would be part of putting the budget together for staffing. This didn't mean that labor would have an open checkbook. Instead, they would have to decide on the priorities for spending the money.

In preparation for joint staffing, a phenomenal amount of training and education was required. Probably the people most concerned about joint staffing were the physicians because they would have to go over decisions at all ambulatory care clinics. The physicians are critical to creating an environment that is team-oriented and truly involved with employees and in employee decision-making. Kaiser has done a lot of training with its physicians, for which they get administrative time. The eight days of partnership training was cut to three days for them because they cannot take more time out of their practice.

## **THE FINAL AGREEMENT**

The national agreement has two parts. The first is a traditional agreement covering wages and the benefits. (The unions got better retirement benefits.) The other part covers the privileges and obligations of partnership that apply to employees.

The privileges and obligations of partnership are very important because the unions are now looking at quality data, something that greatly concerned the physicians. Some information like peer review, for example, is privileged. But the unions are looking at incidents and all the reviews that take place when an incident occurs. Because they have tremendous access to confidential informa-

tion, all union partners participating in any privileged committee work must first sign a confidentiality agreement. There have been no problems to date with anything being revealed.

Kaiser employees received a great deal of employment and income security. They, in turn, had to give Kaiser more performance and more flexibility in the way they performed their jobs.

## **SOME PRELIMINARY RESULTS**

### **Performance-Sharing Plans**

Kaiser set up a new incentive plan for all employees in the partnership, and they are designing these plans together with management. This means that they must be committed to the quality and service and performance metrics.

In 1999, the year after the partnership was fully implemented, Kaiser moved from a negative 2.5 percent operating margin to a positive 2 percent operating margin. The next year, it was a positive 4.5 percent operating margin. The target for 2001 is about 4.8 percent.

California has legislation in the offing that will require Kaiser Permanente to rebuild 60 percent of its hospitals in northern California. Because capital needs between now and 2010 will be about \$8 billion, Kaiser is hoping to get the time period stretched out to 2013. Meanwhile, in terms of cash flow and what is needed to generate capital and build the facilities again, Kaiser is pushing on financial performance.

Kaiser also feels it has labor's tremendous commitment on quality, service, and performance. In 2000, it was the only health plan in California to get the blue ribbon award from the Pacific Business Group on Health (PBGH). Kaiser also received commendable accreditation, the highest accreditation for a health plan, from the National Committee for Quality Assurance (NCQA).

### **Participation in Governance and Decision-Making**

Governance is the most controversial issue. Labor is still not on the governing board; that is the next step. There is also a high-level group that comes together as part of governance—the KPPG, or the Kaiser Permanente Partnership Group—made up of the national leaders of Kaiser Permanente programs on the management side and leaders of the medical groups from all over the country. Labor does not have official representation yet, but they are beginning to attend the meetings. In the service areas, or regions, where a number of hospitals come together in ambulatory care centers, labor is sitting on the management committees and, in many cases, on regional management teams.

The National Labor-Management Partnership Strategy Group is the highest level of the partnership. It sets policy and deals with legislative issues. Given the size of both Kaiser Permanente and its labor force, the partnership can have tremendous influence on legislation in California. It sponsored and achieved

success with the safe-needle legislation, which also became part of some national legislation. It is very important to the employees to know they work in a safe environment.

The National Partnership Council, which is just below the strategy group, is a group of senior managers from all over the country who come together with labor leaders to address tough issues. It's not always pleasant, but it's where everybody is very up front about how the partnership is actually rolling out. Performance is the key.

### **The Bottom Line**

The partnership is really a business strategy for Kaiser Permanente. At one point, Kaiser was going to close one of its optical labs in California that was losing quite a bit of money. (Kaiser builds all its eyeglasses within the system.) Labor offered to help change the situation. A four-month analysis showed that, with some changes in productivity standards and skill mix (usually a negative factor with labor), the plant could be turned around. Kaiser did so in six months. Not only was the manufacturing of lenses improved, but the delivery of service also improved; Kaiser sold more glasses and got them to members on time.

In another lab, the laboratory scientists took on the job of increasing the amount of referral volume coming into the lab by marketing outside the lab. Kaiser turned that situation around, too.

### **LESSONS LEARNED**

The first lesson that Kaiser Permanente learned is that traditional behavior is hard to change. In a traditional union environment, it is difficult to get people to understand that you are moving out of a direct kind of control model, for example: "Here is the union contract, here is what it says, and you have to follow it to the letter of the law."

It's difficult for physicians to operate in this model because they like to be autonomous. That's the way they learn, and that's why they go into practice. Bringing a team of people together to make decisions is very hard for them.

Meanwhile, the union doesn't have enough people in leadership roles who can interact with leadership on Kaiser's side. Kaiser is spending a great deal of money on building union leadership and helping union leaders understand the business so they can understand how to lead and facilitate groups.

In aligning labor with management, Kaiser Permanente has also instituted some more visionary practices, for example, a no-cancellation policy for nurses. Previously, if there were not enough patients, the nurses would go home and still be paid. That policy was discontinued in some service areas, and the money put into new graduates. Kaiser is also encouraging a work environment where more senior nurses can take on special projects, and younger nurses can continue to take care of patients because that's what they need to do.

## CONCLUSION

Traditional behavior takes a long time to go away. Over the last three years, about 40 percent of Kaiser's employees have been trained, and more will be trained every year over the next ten years. When you look at some of the companies that have done what Kaiser is doing, one can see that it can take twenty to twenty-five years to transform a corporate culture.

Many of the changes that Kaiser Permanente put in place align with what labor wanted, and were critical to creating a better, more productive work environment. I don't know that you need a labor-management partnership to accomplish this. Some of it is just good sense. But in a union environment (and California is an extremely unionized environment), it would probably be impossible to be successful without having labor on board to build the trust that was needed to put it all together. This is one example of positive steps being taken to resolve the health workforce crisis that may serve as a model for others in the future.

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### III. CREATING A NEW WORKFORCE

# 5

## FINDING SOME ANSWERS TO INCREASING DIVERSITY IN THE WORKFORCE

Sampson Davis, MD  
George Jenkins, DMD

In late 2000, three African American doctors, all products of the Newark, New Jersey, inner city, formed the Three Doctors Foundation dedicated to increasing the awareness among inner-city children of education, mentoring, and expanding career opportunities. This venture is trying to combine and add to the kind of programs that the three doctors themselves were products of: the Pre-Medical, Pre-Dental Plus Program; the Access Med Program; the Martin Luther King, Jr., Scholarship Program; the TAG Grant; the Educational Opportunity Fund Grant; and the Pell Grant to promote health professions education among students from underrepresented minorities.

To provide some answers on how to increase diversity in the workforce, two of the three founding doctors, Sampson Davis, MD, a resident in emergency medicine, and George Jenkins, DMD, a dentist, have chronicled some of the challenges and difficulties they encountered in growing up in an economically deprived area, and pursuing careers in the health professions. Rameck Hunt, MD, a doctor in an intensive care unit, is the third founder.

### DAVIS:

George Jenkins, Rameck Hunt, and I were born and raised in northern New Jersey, where we are now practicing medicine. The three of us met in 1985 in the seventh grade at University High School, which is a small magnet school in Newark. Magnet schools are schools for some of the best students in a certain population who can then go on to college and graduate school.

At the time, we were still kids. We were not focused on going on for a higher education. There were also a lack of positive surroundings in our community as well as a lack of positive goals. We were used to a lot of negativity. There were a lot of drugs, a lot of violence, a lot of crime, things that we didn't necessarily want to be exposed to. But we were born into that situation, without choice.

## **A Sudden Opportunity: Medicine as a Career**

Then all of a sudden we were about to become high school seniors. A recruiter from Seton Hall University in South Orange, New Jersey, came to the school and told us about the Pre-Medical, Pre-Dental Plus Program, which focuses on helping minorities to become physicians, dentists, or pursue other careers in health care.

Probably my initial reason for going to college was that I didn't know what else to do. But I knew I wanted to help people. I knew I wanted to do good with my life.

I attended four years of college and attended medical school for four years. Many times I wanted to quit, because I had no idea why was I doing this. Prior to taking on the challenge of becoming a physician, I didn't know what a physician's job was. I didn't know what the day-in, day-out activities were. I was sort of doing this blindly.

It was not until I reached twenty-six years of age and started my first year of residency that I realized what a physician's job is about. Now I understand it.

One thing that Dr. Jenkins, Dr. Hunt, and I had was determination. We had discipline. We were dedicated. We wanted to succeed. We wanted that more than anything else.

I knew I wanted to help people. I knew I wanted to do good with my life. But what is it in life I want to do? In the inner city, there is a lack of what it is kids wants to do.

## **Casting Aside Negativity**

The three of us came together right way. Even as a child, when I would see someone doing something negative, I got a gut reaction: "This is not right. This is not the way life is supposed to be. I don't know what it is in life I want to do, but I know I don't want to do this."

If I saw a drug dealer, I would say to myself, "Here I am, ten years of age, and the dealer looks like he's eighteen or nineteen. How many sixty-year-old drug dealers do you see retiring, drawing a pension plan? This is not going to work. Somehow, somewhere I've got to find something else."

So I would go back to the huddle with Dr. Jenkins and Dr. Hunt, and we would play basketball, hang out, go out to different places, movies, and things of that nature. And we made our way through University High School, going from the seventh grade to the twelfth grade.

Then all of a sudden something hit us. Hold up! We're about to be seniors in a minute; what are we going to do from here? That's when a recruiter came to our school from Seton Hall University and spoke about a minority-gearred program focusing on developing minorities to become physicians and dentists, and go into health care.

When the Seton Hall recruiters came to our school, I was like, "Oh God, I don't know if I want to do this. Four years of college, and four years of medical school. I'm going to be old by the time I'm done." But then she said that much of it would be free. I said, "Okay, I'm there; I'll give it a shot."

I guess a lot of things happen in life that affect you indirectly, leading you to make sound decisions that lead to positive results. Probably, initially, my going to college was because I didn't know what else to do. I knew I wanted to help people. I knew I wanted to do good with my life. But what was it in life that I wanted to do? The problem in the inner city is a lack of what it is kids want to do.

People say it has changed. If you ask two hundred youngsters in a room what in life they want to become, there may be one who wants to become an astronaut, another a lawyer, a dentist, an architect, a businessman, an educator, et cetera.

What happens to these children? We have jail systems filled with people right now, and I'm pretty sure when they were five or six years of age, they did not raise their hand and say, "I want to be in jail when I'm nineteen." Something went wrong. We are losing kids along the way.

### **Working Toward a Diverse Workforce**

One way to help solve the problem about increasing diversity in the workforce is to create a positive atmosphere. I can speak about the urban environment because that's where I grew up, and it's what I know the best. Coming from that setting, I know that what we are trying to do now is give a face to education.

Kids love fads. They love something that they can gravitate to, something that is colorful, something that has a little style to it. We are trying to put a face to education. There's a face to sports: Mark McGwire, Tiger Woods, Michael Jordan, for example. But who is the face of education? No one that I can think of.

If we put a face to education, kids will start to say, "That looks kind of glamorous. Maybe I should give it a shot." They will start to gravitate more toward education. They will want to delve into it, and say, "I want to see what this is about."

When I was 10 years of age, I didn't have an ideal. With a face to education, a kid can have an ideal.

We go around the country speaking a lot. At one session, a nine-year-old boy raised his hand, saying he wanted to become an astronaut. I don't know the first thing about telling a child how to become an astronaut. But I realized we could link this kid to an astronaut. That's the type of chain that we have to create, one of positive influence.

Another need in the inner cities is educational supplies. In my elementary school in the '80s, we were using textbooks that dated back to 1968 and 1969. How in the world can children learn from those books? History had tripled or quadrupled itself by that time. If you want to run a race, you have to make it an even race. If you have to run with one leg tied, you won't win.



## **The Three Physicians as Role Models**

Part of what is important about what we did is move back to our city. We all still live in Newark. I walk down the street; I still have my jeans on; I still wear my T-shirts; I still wear the same style that the young ones wear so they can identify with me. And they say, "Wow, I never knew a doctor can dress like that. I thought I'd see you in a suit and a tie, and you would be square."

I explain, "No, I am a physician. But a physician is not me. I bring my own style and my own personality to what I do. I work in the same hospital where I was born." There is nothing more rewarding than taking care of someone with whom you grew up. The other day, one of my classmates from high school came in with his son, who had an ear infection. It was a privilege to take care of the boy. His father and I talked about our high school days for approximately fifteen minutes. It took about two minutes to diagnose his son's ear infection. I gave him some amoxicillin and vitamin A and sent him on his way. It's a rewarding feeling. There is nothing like it.

I had four years of college and four years of medicine, and I have to be honest: Many times I wanted to quit because I had no idea why I was doing this. Prior to taking on the challenge of becoming a physician, I didn't understand the job of a physician. I didn't know what a physician's day-in and day-out activities called for. I was doing it all blindly.

## **Improving the Learning Environment**

How can we increase diversity in the workforce? One is to have better textbooks. We also have to have teachers who want to teach, who come to work, in part, to express themselves and can bring their personality to what they do.

Then we are looking at an atmosphere filled with negativity. If you are born in a neighborhood where everyone is a golfer, nine times out of ten you are going to be a golfer. If you rebel against it, you will, in a sense, be put to shame. The three of us obviously went against the grain. What got us through was the bond that we had with one another. If one of us was going through a struggle we lifted him up. We carried each other through.

Part of the goal of the Three Doctors Foundation is to increase the awareness of education, to increase awareness of health prevention, to increase awareness of mentoring, and summer camps, and scholarships. That's because we believe that this is why God put us here.

The foundation is just six months old, and we have a lot of work to do. We are not trying to do this by ourselves. This is a joint venture.

I love my father. He has been there for us, but he and my mother divorced when I was about ten years of age. My parents are from South Carolina. Traditionally or culturally, women weren't supposed to work. When my father left, my mother was in her fifties, and she had to start at that age to learn how to take care of the family. We had to depend on public assistance to make it through. But \$600 a month will not get you far.

I had to step out and start working at fifteen years of age at McDonald's and also try to be creative in a sense, because many people in my community were saying, "Why are you carrying books home? Why are you studying?" I would have to think of creative ways to get my studies in order so that I could move on to the next level.

I'm going to die doing this. My personal goal is to change the whole attitude in the inner city toward education—to make it the thing to do, to make it the fad, just like playing video games, just like playing sports, just like rapping.

We have a book coming out in a year called *The Pact*. We are planning to work with musicians and other artists to produce a positive soundtrack because kids feel that you have to be on one side or the other. But education can also intermingle with music and with sports, and youth need to understand that.

### **JENKINS:**

How to get more minorities involved in health care is a million dollar question. I had to sit down and think about it seriously because the question itself and the issue it speaks to relates to the general problem that exists in our communities. I agree with Dr. Davis that the solution must be multifaceted because the problem is.

I have the unique opportunity to live on the same block where I grew up because it is four blocks from the hospital. However, when I went to Seton Hall, I lived on campus. I went on to professional school, then moved right back to my old neighborhood, so I was able to contrast, on a daily basis, how life was for me and how life was for my friends.

### **Tough Times**

For me, the two main ingredients are hope and support. Hope for a better future and the desire to just change our situation for ourselves and our family gave us the strength to fight through a lot of the difficulties that we had to deal with, having come from a disadvantaged community. It also helped me not become frustrated with the fact that a lot of my colleagues' situations seemed to be ten times more conducive to learning than mine.

It seemed to me that I had to worry about everything but my books. Our talent was our ability to ingest material and perform well in our schoolwork. The majority of my colleagues had to concentrate on their studies. I would breeze through all that and go home and worry about finances and how I was going to stay in school. There was nothing more frustrating than doing well in school and feel that any day they can just pull the rug out from under you.

It was just that hope for the future that helped us fight through it and keep going because, as you can imagine, if you combine a situation where you have no role models or resources, and you combine that with lack of hope, you probably wouldn't want to finish. Just having hope for the future really, really helped us get through.

## Helping Kids Hope

We like to get out and let kids see us, and try to give them some hope, to let them see our faces and see that there are young people with whom they can identify, who went to school and did what they were supposed to do, and surmounted all of the obstacles. It gives them the strength to say, "I can do it, too, because I see someone ahead of me who did it."

We were really blind when we got into our careers. I didn't know much about dentistry but I did get inspired from childhood trips to the dentist at the very school that I'm attending now. The resident quizzed me about teeth, got me interested in the profession. But if I didn't have that hope for the future, I couldn't have done it. It's a lot of years to try to go with limited resources.

Every year, it felt as if I was killing my mother, because she had to work two jobs in order to support my aspirations. I felt the best way to give back to her was to perform well and give her something to be proud of.

## The Need for Support

Kids need support. We need to support their academic aspirations at home, as well as at school. We also need to level the playing field so that they can run at the same pace as their colleagues because a lot of the programs that we were involved in are under attack. Funding for the premedical, pre dental program is in constant jeopardy. These programs provided some of our motivation because anytime we would feel like we couldn't do it, the staff made us aware that we were responsible for the kids behind us. We had to uphold the program in order for it to get funded.

That's probably what drives us. We came from nothing and already are trying to give back before we have even gotten.

Furthermore, we are so accustomed to working together to achieve our academic aspirations that we had to find something to work together on after we graduated.

What drives us to do what we do? We love to go out and visit young people and knock down misconceptions. In our community, you are a nerd if you always do your work. No one likes you. Or you are an athlete and everyone loves you, but you are not doing your work. We straddled the middle line and took the best of both worlds. We loved to have a good time when it is appropriate, but we also liked to do our work.

We had our own little support system because we were unique. We had to support each other. One of the lessons we like to promote is to try to find like-minded people, positive people who are going to influence you.

I could have easily chosen to hang out with two other guys that were into negative things. Instead, I chose two friends who were positive. If they were studying, I would feel I had to study. If two of us were getting decent grades, the other one felt he had to uphold his end of the bargain.

This always allowed me to have strength and steam because I had two other guys to look to. We inadvertently created our own support system. It turned out to be the best thing that any of us could have imagined. Just learning and bouncing ideas off each other turned us into who we are: just good people.

It also offset a lot of the disadvantages we may have had, coming from the inner city, because we filled in what we were missing.

Once, when I broke my leg, Dr. Davis drove me around, back and forth to school. When his car was stolen a couple of days ago, I automatically got on the phone to make sure he got to work and didn't miss a beat. Our support system is sustaining us to this day. We like to encourage young people to do the same. If you see someone in your class who wants to get into a particular discipline, get with those guys and try to help each other see it through. I'm almost certain that if I was by myself, I wouldn't have been able to make it, and the three of us try to promote this kind of support system because it worked so well for us.

## CONCLUSION

We would like to see a glimmer of change in our lifetimes because it's such a daunting and almost an insurmountable task. Until you address the problems in the inner city, you are not going to get people into health care or any other professional field because they are not going to have any hope. Who wants to believe that they can do something if they don't have examples around them?

So one of my major goals is to see a little bit of change and try to inspire kids. It's going to take dedicated people, such as ourselves; we come from the environment and can relate to it, and can also serve as the link to corporations and others in positions of power who want to help, but don't know how to help.

We feel that part of our job is to figure out ways to get these people to help. When we were approaching graduation, we felt that no one cared. Once we graduated, however, and we were asked to speak at a lot of places, we met a lot of people who genuinely want to help.

It's a tough job, and somebody has to do it, and I guess we have dedicated our lives to doing it. TV's *60 Minutes* called us to do a story, and the reporter asked, "How do you guys do it?" There are definitely a lot of things that we have to give up. But there is nothing better than, when walking into a classroom of one hundred rowdy little kids, having them become attentive and ask questions. Often little kids come up and ask for our autographs and things like that. It is our hope to start a movement that will resonate nationwide and get people to reach back to try to help others in their community.

We are in our late twenties now. We trust we have a few good years left in us. But we want to see some change before we get out of here. We want to say, "Wow! Things have gotten better."

# 6

## **MAKING EDUCATION AVAILABLE TO A NEW POOL OF STUDENTS**

Jean Johnson-Pawlson, PhD, NP-C, RN, FAAN

The purpose of the Partnerships for Training (PFT) project, which is funded by the Robert Wood Johnson Foundation, is to enhance the primary care workforce in underserved areas by taking nurse practitioner (NP), certified nurse-midwife (CNM), and physician assistant (PA) education to people living or working in those communities.

People taken out of those underserved areas and taught on a university campus don't always return to their communities. The other model is to have people who have never been in an underserved area work there with the hope that they will remain. Sometimes this works, and sometimes it does not. The PFT model is to take the education to people living in those communities because they are the most likely to stay.

### **PROJECT DETAILS AND PARTICIPANTS**

The budget for the PFT project is \$14 million over six to eight years, with approximately \$1.3 million going to each of twelve grantees. There were twelve grantees in the eighteen to twenty-four month planning phase. For the implementation phase, which ranges from four to six years, the number was narrowed to eight grantees.

This is, of necessity, a long-term project. Many people can relate to the problems of foundations expecting major change when they give you two, three, or four years of funding for a project. You barely get started. Fortunately, PFT has the luxury of longer-term funding.

### **ADDRESSING THE CHALLENGES**

This is not just a project where people go out into underserved communities and teach classes. It has been much more challenging in terms of the requirements for being a grantee. To be eligible for funding, three disciplines have to be involved. A grantee must offer programs for nurse practitioners, physician assistants, and certified nurse-midwives. The disciplines do not have a long

history of talking to each other. The PFT planning phase, therefore, included much communication and the breaking down of barriers. That's really what it took because there was a tremendous amount of resistance, which was manifested through excuses (e.g., our schedules won't fit; our accrediting bodies won't let us do this). Actually, none of that was really true. Once people began to trust each other enough to move forward, a great deal was accomplished.

Academic programs can't just send out brochures to the community and say, "Oh, we have this program, so come see us. We'll be glad to educate you." They have to connect with communities, work with the communities to identify potential students, and encourage the communities to support students in the program through, for example, computer support, time support, or child care support.

Another major piece here, which has been one of the most remarkable parts of this project, is technology. When the project started, grantees proposed doing video conferencing to specific geographic areas, where people could come to take courses. A big challenge has been to get faculty to use the Internet and Web-based learning, making them comfortable with people physically not on campus to take course work, and developing the technology infrastructure. This was no small task.

Almost all the faculty involved in the Web-based education have enjoyed it a great deal. We have had to work with many sites to help faculty establish boundaries; at first, many faculty wanted to be available to their students around the clock. But you can't keep that up.

In all, at least thirty-four academic institutions are participating in PFT projects spread over thirteen states (Arkansas, California, Colorado, Louisiana, Michigan, Minnesota, Mississippi, New Hampshire, New Mexico, North Carolina, Tennessee, Wisconsin, and Wyoming). The institutions are as follows:

■ Colorado AHEC Program Mountain & Plains Partnerships

- Regis University
- Red Rocks Community College
- University of Colorado Health Science Center
- University of Phoenix
- Beth El College
- University of Northern Colorado

■ Delta Health Education Partnership

- Alcorn State University
- Arkansas State University
- Frontier School of Midwifery and Family Nursing
- Louisiana State University
- University of Tennessee

- Duke University-East Carolina University Partnerships for Training Program
  - Duke University
  - East Carolina University
- Greater Detroit Area Partnership for Training
  - University of Detroit Mercy
  - Oakland University
  - University of Michigan
  - Wayne State University
- Minnesota Partnership for Training
  - University of Minnesota
  - Winona State University
  - Metropolitan State University
  - College of Saint Catherine
  - College of Saint Scholastic
  - Augsburg College
  - University of Wisconsin (PA Program)
- New Mexico Partnerships for Training
  - University of New Mexico
- San Joaquin Valley Health Consortium
  - University of California, San Francisco
  - University of California, Davis
  - Planned Parenthood
- Wisconsin Program (WIS-TREC)
  - University of Wisconsin, Madison
  - University of Wisconsin, Eau Claire
  - Marquette University

The projects are multistate, single-state, or specific geographic areas. They have done absolutely stunning work in terms of figuring out how to cross states, and handle technology, educational program recognition, and interdisciplinary issues.

## **FROM STAGE ONE TO FIRST GRADUATES**

There has been a trajectory of change in this project. At the very beginning, we had to get people to come together and talk to each other. The second stage was developing a curriculum that could identify the interdisciplinary courses, as well as the course work that was unique to each of the disciplines. The third

wave of work was both recruiting students and starting to offer the courses. Now we are into the phase of helping graduates get ready for clinical practice in underserved areas.

The first graduates did not fully experience online programs. The students currently enrolled are almost entirely online, although they all have something for which they come back to campus. But for the most part, we are not talking about Web-enhanced courses. We are delivering complete programs, in terms of the didactic portions, over the Web; key experiences, such as anatomy dissection for the physician assistants or health-assessment physical example testing for almost all students, require that they come back to campus.

In terms of trying to get some meaningful information, the project decided to get as much data on PFT and non-PFT students as possible. A pilot survey comparing the two groups was recently conducted, and the hope is to do annual surveys for at least the next five or six years to track the project's process.

The student and graduate data discussed below are only one part of the evaluation, which also include reviewing faculty, looking at clinical experiences, evaluating the organization of projects, et cetera.

## **SURVEY RESULTS**

Of the 68 PFT graduates, 52 responded to the survey, a 77 percent response rate. These respondents were then compared to the 133 non-PFT graduate respondents (the response rate is unknown at this point). There are also a number of "unknown" responses from 59 respondents who did not, for a whole variety of reasons, categorize themselves as either PFT or non-PFT.

Of the 246 current PFT students, 162 (67%) responded, compared to the 243 non-PFT students who responded.

Approximately 25 percent of both cohorts have been part-time. It is due as much to student selection as to a lack of programs offering part-time options. This is a major challenge for students who see full-time participation as limiting their opportunities. The notable issues here are the demographic characteristics of the graduates.

There are more part-time PFT students than non-PFT students. There also is significantly greater cultural diversity in the PFT category for both graduates and current students. There were increases in the numbers of black and Hispanic enrollees, so we are hitting a more diverse group of students.

The trend is similar for current students. A slight decrease in the current female enrollment is largely due to the impact of physician assistant students entering the cohort, the first time that PA students entered programs that were available through distance education.

The majority of current students carry a significant child care responsibility, probably because they are largely female. About 66 percent of PFT students report living with children for whom they are responsible versus about 43



percent of non-PFT students. One-fifth of PFT students are also responsible for elderly or disabled family members.

More PFT students (60%) than non-PFT (50%) live within an hour's drive of their family. However, among graduates, there is not much difference between PFT and non-PFT graduates in this category.

The primary reason for living in their current community, report both students and graduates, is that they have always lived there, a finding that is particularly important. These individuals already live in underserved areas.

Also interesting are the data that reveal a reluctance among many students and graduates to move to obtain an education. Of current students, 65 percent of PFTs and 60 percent of non-PFTs were very or somewhat reluctant to move; of graduates, the numbers were 53 percent and 67 percent, respectively. Yet, these students did come to campus. The question is, How many people are being missed who are reluctant to move and, therefore, stay home? A little more than 50 percent of the PFT students said that if distance education were not available, they would be unlikely to move.

As Web-based education developed for the Partnerships for Training project, non-PFT students have demanded the same flexible schedules and course work as are available to the PFT students. This issue has come up in every one of the PFT projects, and almost all have opened their courses to all of their students.

Nearly 90 percent of the PFT students said they were likely to remain in their current community for five years, and 80 percent said they were likely to remain for more than ten years. In other words, students living and working in underserved communities are saying they are going to stay there for a considerable period of time.

Our survey found that close to 77 percent of PFT graduates worked while in school, somewhat less than the 88.5 percent of non-PFT students who worked. One of the reasons is that more PFT graduates had scholarships that enabled them to go full time.

## **GRADUATE OUTCOMES**

At the end of the program, there was little difference between the grade point averages of PFT and non-PFT students, 3.67 versus 3.76. Most projects have done evaluations of independent courses such as pharmacology, health assessment, or pathophysiology. They have found virtually no difference in the performance of individuals in Web-based courses versus traditional, on-campus courses in terms of grades and how well students do.

There have been some benefits. People who have had some difficulty in learning actually have said that the Web-based education is very useful because they could keep going back to the material, something you can't do in a traditional classroom.

In terms of postprogram performance, PFT students take and pass certifying exams and obtain work as nurse practitioners, certified nurse-midwives, and

physician assistants at similar rates to non-PFT graduates. Among the PFT grads who responded to the survey, nearly 20 percent worked in a Federal metropolitan urban area (MUA); nearly 20 percent lived in one; and nearly 10 percent lived and worked in one. The percentages are probably low because the survey was sent out in May and June, when students had just completed their program and many had not started working yet. Similar low numbers were elicited from the non-PFT students. We really are getting people to stay in their community or go to an underserved community to practice.

How well did the PFT graduates feel they were prepared to practice? Almost all reported feeling very well prepared or somewhat well prepared. A very small percentage believed they were poorly prepared or not well prepared at all. We don't have data on how prepared the non-PFT graduates felt; we assume that the numbers are probably similar to those of the PFTs.

## CONCLUSION

As a result of the project to date, I feel very comfortable saying that Web-based education is a viable method of education. Also, when you can teach people who either live or work in underserved areas, you can probably count on them to stay in those areas.

Identifying these potential students, however, is a major challenge. There has been a lot of talk about needing a pipeline. This project is no different. All are graduate level, even the PA programs, which started out as undergraduate programs, are shifting to graduate level.

We must have a pipeline because we cannot expect people, particularly in rural areas where they often have only associate-degree options, to be able to step into this new situation. You must have long-term plans. So most of the grantees have worked to develop pipelines.

I also think there will be important lessons to learn from this project, such as developing technology infrastructure, partnering, and working with Web-based education. The lessons can be applied to a number of other challenges, including the nursing shortage.

The grantees have done a superb job. I am amazed almost every day by what they have been able to accomplish because they have the will and commitment to improve care for people in underserved areas.

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## IV. HOW TO FIX WORKFORCE PROBLEMS

# 7

## DEVELOPING STRATEGIES TO PRIME THE PIPELINE

Barbara Heller, EdD, RN, FAAN

There is no easy or quick fix for the health professions shortages we face today. However, it is essential that nursing and other health professions schools mobilize to come up with new ways of priming the pipeline.

First, we must change the way we think about a problem. The Chinese word for crisis is composed of two symbols, one meaning “danger” and the other “opportunity.” Academic health centers must seize the opportunities inherent in the crisis it faces today. It is now or never if we want to ensure the nursing and health professions workforce of the future.

One can either run around shouting that the sky is falling, or one can deliberately, diligently, and creatively do something about it. This requires knowing the stakeholders in nursing and health care, and scanning and understanding the trends and forces in the external environment that affect higher education, health care, and the health professions. Among the broad societal factors that come into play are the political environment, use of technology, economics of health care, population demographics, and predictions about Generation Y.

The crisis in nursing cannot be addressed single-handedly; the solutions absolutely require the development of public and private partnerships. Building new alliances and coalitions between the health care industry and health care institutions is key.

### FINDING OPPORTUNITY IN CRISIS

As Maryland’s premier, publicly funded higher education institution for nursing, the University of Maryland School of Nursing currently enrolls nearly 1,500 students in its baccalaureate, master’s, doctoral, and continuing education programs. It plays a major role in preparing the professional nurse workforce for the state and the region; indeed, the school produces 41 percent of the state’s nursing workforce, more than twice as many as the next largest nursing program in Maryland.

It is incumbent on us to continue to produce the numbers that meet demand. With health care the Number One economic engine in both Baltimore and the

state of Maryland, it is an awesome responsibility. Thus, as part of its strategic plan for 1999–2002, the nursing school has made workforce development a priority, committed itself to this priority, and outlined a number of strategies to achieve this objective.

## **BUILDING PUBLIC AWARENESS**

First among the strategies is advocacy and public awareness. Even in 1999, when only a few scattered articles around the country were mentioning the shortage of health professionals, the University of Maryland began to hold meetings with key players in the field, including hospital administrators, long-term care professionals, government officials, Federal and state legislators, representatives from the Maryland Hospital Association and the Blues, university presidents, and deans and directors of other nursing schools. The school's Board of Visitors, an external advisory board, which represents the industry and other entities, was a significant player in helping us set up and broker these meetings with some of these key players.

To alert the media to the seriousness of the crisis, we began a letter-writing campaign in 1999, contacting editors of local newspapers. The effort resulted in ongoing coverage in the *Baltimore Sun*, *Washington Post*, and *New York Times*. Our goal was to keep the workforce issue in front of the public. The media has tremendous power and influence, and we need them on our side to tell the health professionals' story as objectively as possible. This is particularly true for the nursing profession, which must overcome some of the outdated perceptions about the profession and thereby help burnish its image.

## **LOOKING TO THE LEGISLATURE**

The University of Maryland also attempted to find legislative solutions to the problem. We became actively involved in supporting an initiative passed in the 2000 session of the Maryland General Assembly addressing the critical shortage of nurses in the state. The result was establishment of a commission charged with determining the extent and long-term implications of the growing nursing shortage, and developing recommendations for reversing the shortfall. The measure passed with the assistance of five nurse legislators, three of whom are graduates of the University of Maryland School of Nursing. These nurse legislators had a lot of influence in helping to get the commission set up. (The message here is: Get your graduates elected to the legislature.)

I represent the school and serve as a vice chair of the commission. Following a series of regional meetings and hearings, the commission sponsored two bills in 2001. Both were signed into law by the Governor. The first bill enlarges the scholarship pool for nursing students. The second bill provides funding directly to schools of nursing based on the number of graduating students, with the intent of offering incentives and resources to schools of nursing to increase enrollments. This program will be particularly useful as nursing schools step up recruitment and enrollment initiatives.

The commission, which has a five-year lifespan, is now turning its attention to workplace issues. Each year, it seems that the commission is chipping away at the problems, tackling issues through legislative remedies. It also continues to make every effort to keep all legislators informed and involved. Briefings are also held with members of Maryland's congressional delegation. The hope is to exert influence at the national level for crafting solutions.

## THE IMPORTANCE OF MARKETING

Marketing is not an area in which the university excels. Indeed, higher education, particularly academic health centers, does not recruit actively. Rather, the task for years has been to screen people out. Now, suddenly, higher education has to rope students in. Of the six professional schools on campus—medicine, law, social work, pharmacy, dentistry, and nursing—only the law school has no problem with the applicant pool.

In response, we have begun to strengthen marketing, advertising, and media relations efforts. There was no budget for this task, but the nursing school received a \$1.2 million contribution of cash, services, and in-kind gifts from Gilded Integrated, a Baltimore-based advertising agency. Their pro bono work is helping the school develop a comprehensive marketing and media campaign, which includes advertising, graphic design, and publications to enhance the public image of nursing, promote nursing as a career, and increase awareness among middle and high school students about the career opportunities available in nursing for both men and women.

One challenge is confronting widespread negative perceptions and stereotypes about nursing that are largely characterized in the media (e.g., Hot Lips Houlihan of *M\*A\*S\*H*, Nurse Ratched from *One Flew Over the Cuckoo's Nest*, ditzy Nurse Betty, and, even more troubling, the male nurse in *Meet the Parents*).

Market research conducted by the school showed that males do not consider nursing as a career choice due to its female connotations. It was suggested in focus groups that if we change the name of nursing, then perhaps it would become more attractive as a field for men.

Perhaps most damaging to the reputation of nursing is how nurses themselves feel about nursing. Research shows that they would not recommend the career to either friends or family. They even ask the students when they are affiliating with the nursing school, "Why do you want to be a nurse?"

We have to recognize that we may be working at cross-purposes. According to national surveys, nurses see themselves as underpaid, overworked, and unappreciated. They have strenuous schedules, and some have to put in mandatory overtime. It is a 24/7 business and an unremitting grind, not a gritty, glamorous show.

We have learned that providing information about nursing must always be accompanied by a campaign to dispel misinformation. The school is using the results of its market research as a guide in developing a clearly defined brand, key messages for marketing and public relations, and advertising strategies for recruitment efforts.

A particularly challenging target market is made up of college-bound and even younger youth. The University of Maryland School of Nursing is now using more aggressive tactics to reach them, including direct mail, open-house events, community outreach, and radio spots. The school has sponsored the local Metro Traffic News, for example, to get the word out to one prospective candidate pool. It also has enhanced its Web site and is working hard to get public service announcements on radio and television.

The market research reveals that the words young people associate with nursing are *courage*, *hope*, and *determination*. And we no longer use pictures of nurses holding babies when we recruit because they are not useful for attracting the male population.

Another marketing angle was Nurses Week, when the school recognized nurses, alumni, and others in the field. It was a way to let them know they are appreciated.

## EXPANDING EDUCATIONAL OPPORTUNITIES

The school's efforts are not all image and hype. The school has committed to offering programs at rural sites through the Area Health Education Centers so students can go to school where they live and work. Many attend part time; many are heads of households and often single parents.

The nursing school also has a new, \$38 million, state-of-the-art instruction, research, and clinical facility in which the state has invested. Located in Baltimore, the facility is fully integrated for interactive technology, virtual reality, computer-based learning, and distance-learning classrooms. By harnessing the potential of distance-learning technology, outreach centers have been expanded along the Baltimore-Washington corridor, in western and southern Maryland, and on the Eastern Shore.

The high-tech industry has pitched in, providing various systems and two distance-learning classrooms. Partnerships with industry (not necessarily the health care industry) have improved the school's ability to deliver health care education to people in outlying areas.

Web-enhanced courses are integral to expanding education in the registered nurse (RN) to the Bachelor of Science in Nursing (BSN) programs. The school has worked for the past two years to put courses completely online; the program, exclusively Internet-based, will be offered beginning in the fall of 2001. Giving working nurses the ability to earn a degree anytime, anywhere, is just a click away.

We also have attempted to increase access by reducing financial barriers. The average undergraduate leaves our program carrying \$24,000 in loan debt, a sizable chunk for a student from a state institution, in addition to any debt accrued in the years before matriculating into the nursing program.

It has become obvious that every effort must be made to eliminate financial barriers to learning. The school has actively and successfully pursued scholarship funds and enhanced endowments through private fund-raising so it will be able

to provide incentives and financial aid to students who choose nursing as a career. Hundreds of thousands of dollars have come from the private sector, individuals, and the corporate world.

An innovative program, the Nurse Scholars Program, has also been developed in partnership with Baltimore's leading teaching hospitals, including Johns Hopkins Hospital, the University of Maryland Medical System, Bayview Medical Center, Mount Sinai Hospital, and Mercy Medical System. To qualify for this program, which provides financial support for paying tuition and fees, students must be enrolled as undergraduates in the School of Nursing; maintain a 3.0 grade point average; agree to complete their senior clinical practicum (a requirement of the program) at the hospital of their choice; and remain employed at the hospital for one year following graduation.

Each hospital must provide and commit to the selected clinical placement, provide a preceptor who is identified and credentialed by the School of Nursing, and match the clinical emphasis area of the student, e.g., trauma, critical care, pediatrics, neonatal care, women's health, gerontology, or oncology. The school has raised almost \$1 million for this program.

Eighty top students participated in the program the first time. The first year after graduation, all were placed in the two partner hospitals. Graduates give high marks to the program, praising the quality of the clinical experience. They have also benefited from the scholarship support. Employers, in turn, do not have to recruit students and are able to spend less time orienting nurses on the unit because they have spent at least six months with them.

The students in the program are different from the typical nursing school student. Their average age is thirty-one years, and 50 percent have already earned a bachelor's or master's degree in another field. They are career-changers. To meet their needs, the school offers more flexible scheduling and brings classes to where they are. More evening and Saturday classes have been added, classes run summer-fall-winter-spring without any break, and faculty vacations are planned differently from the traditional ways of planning for these breaks.

The E school has also designed an accelerated, second-degree option leading to the baccalaureate for eligible students changing their careers. This program provides intensive theoretical and clinical exposure in the briefest possible time (approximately 15 months), expediting graduation and entry into the workforce.

Furthermore, the school has developed two-plus-two and three-plus-two arrangements with liberal arts institutions that do not offer nursing but do offer the lower-level course work. Heretofore, if a student took the first two years at such an institution, he or she would then have to apply to the School of Nursing as a new student. Now, the collaborations require only one admission application by a prospective student, streamlining the process and keeping them tracking right through. However, it does require a great deal more investment and involvement on the part of the school, which has to advise these students for the first two prenursing years at all of our campuses.



Linkages with the community colleges have been expanded. Some offer dual-degree options to foster career mobility and create a visible ladder that permits qualified students to move from entry level to an associate degree and on through advanced practice. It's a new twist on the school's matriculation agreements in the state of Maryland.

Thanks to the Able Foundation, the School of Nursing was able to begin planning for a prenursing academy last year, that is, a separate school for nursing within a high school. We currently are in discussions with Carmen Russo, the superintendent of the Baltimore City Public Schools, about ultimately expanding it to a prehealth academy approach.

Nevertheless, nursing remains the cornerstone and signature program. The school conducts recruiting in the middle schools. It provides education for counselors and parents. It brings children to the campus so they can see what nurses do, what they look like, and what the work setting is like, and thus get excited about nursing. We are also trying to develop role models and mentorships to sustain the long time-frame between ninth grade and the junior year in college.

Another project, for which we thank the Division of Nursing of the Health Resources and Services Administration (HRSA), will aid in the recruitment of underrepresented minority students. HRSA recently gave the school a \$650,000 grant to help its Alliance for Building Careers in Nursing. This will increase the number of high school and community college students in the baccalaureate nursing program and also the retention and graduation of nurses from the school who enter practice in underserved areas. This program begins July 2001.

## **COLLABORATING ACROSS DISCIPLINES**

Despite articles and studies that show the public holds nurses in high esteem and sees them as very ethical, nurses do not feel respect within the hospital setting. Nurses complain that they do not feel part of the team, and that their input is neither sought nor valued when it comes to making decisions about the management of patient care.

It is obvious that future health care providers must be prepared for working with each other through interdisciplinary education. To accomplish this, we have to overcome such obstacles as scheduling problems or accreditation issues. Both a bottom-up and a top-down approach is needed.

To achieve collaboration, people have to be educated for collaborative practice and made part of the team. The School of Nursing has attempted to do this, and, fortunately, has received funding from The Robert Wood Johnson Foundation (RWJF) for several new initiatives designed to stimulate interdisciplinary learning and practice among health professions students.

RWJF's Partnership for Quality Education provided the impetus for nursing students and pediatric residents to share an educational and practice experience focused on managed care in an interdisciplinary team. An additional \$450,000 for the Collaborative Interprofessional Team Education Program, also from

RWJF, will help to further advance the interdisciplinary model of learning by including pharmacy and social work in addition to nursing and medicine. This program will develop a prototypical model of interdisciplinary education for collaborative practice.

The school is building a cadre of teams from the schools of medicine, pharmacy, social work, and nursing. Ultimately, we hope to add dentistry, although this practice has been the most recalcitrant of all practices to enter into this kind of collaboration.

The School of Nursing has left no stone unturned, and the efforts have paid off. In Fall 2000, after four years of decline, the school saw a modest 3 percent increase in enrollment. The admissions and enrollment management offices foresee a 40 percent increase in undergraduate applications for the Fall 2001 class.

This is a dramatic turn of events. The School of Nursing is bucking the trend. The school, however, cannot rest on its laurels, and is assuming leadership in establishing an interdisciplinary center for health workforce development. The primary mission will be to assist health care professionals, health professions schools, the health care industry, and public policy makers respond to the challenges of educating and managing an evolving health care workforce. Thus, the center will track data and provide aggregate information, informed opinions, model programs, and other resources to assist leaders of all health professions schools and the health care industry in recruiting and retaining students and personnel.

## CONCLUSION

How do we attract a new generation to health care? How do we hold on to this generation? How do we reinvigorate the field itself? The answer is to follow the three Rs: replenish, renew, and reinvent.

We must work bottom-up to **replenish** the workforce by informing young people about the range of opportunities open to people with a nursing or health care background.

We must work top-down to **renew** the workplace by developing new prototypes and collaborative models that encourage teamwork, and providing support for our providers, both new and experienced. It does no good to recruit and graduate more students if these students go to the hospital across the street but stay no longer than one and one-half to three years. This is a waste of taxpayer dollars. The educational institution must work with the health care industry to retain health care staff.

Finally, we must work with each other to **reinvent** both the image and the practice of health care in this complex era of change.

Now, despite the harbingers of doom and gloom, there is room for optimism about attracting the next generation to health care. In their book *Millennials Rising* (the term refers to the high school class of 2000 and those that follow),

authors Neil Howe and William Strauss describe the millennials as the next great generation.

They will rebel against the culture by cleaning it up, rebel against political cynicism by routing trust, rebel against individualism by stressing team work, rebel against social ennui by actually going out and getting a few things done. The millennials are the earnest types, more like the World War II generation than their parents or their older siblings.

There seem to be enough data to suggest that after a shattering period of cultural and technological upheaval, the younger generations are being drawn to efforts that rebuild the community, value loyalty, and enhance civil life. This is a group receptive to what is at the very core of health care: touching human lives and making a difference. If we are to be successful in recruiting the next generation into health professions careers, it is essential that we speak this language and reach these children with this message.

# 8

## **ESTABLISHING STRATEGIC ALLIANCES TO GET WORKFORCE MESSAGES TO POLICYMAKERS**

Richard Valachovic, DMD, MPH

The dental profession has faced some significant problems over the past few years that it is now trying to address as a profession. From a workforce perspective, seven dental schools have been closed since 1985. Taking into account other reductions in class size, we see a 30 percent decrease in the number of dentists being graduated compared to the mid-1980s. At that time, the number was roughly 6,500 a year; it is now down to 4,000.

The strategies of the American Dental Education Association (ADEA) for addressing some of these problems may help other professions deal with similar issues. Of particular note is reaching out to better educate nonhealth professions organizations and external constituents, including state agencies, to disseminate workforce messages.

### **GOOD TIMES AND BAD FOR DENTISTRY**

There has always been a significant need for dental care. It just hasn't always translated into demand. Now, with good economic times and a movement from a manufacturing economy to a service economy, as well as a time when appearance has very dramatic effects on the ability to earn money, dental care is becoming a significantly more important health care commodity.

One of the results is that we have moved from the golden age of dentistry into the platinum age of dentistry. Indeed, there has never been a more opportune time for entering the field of dentistry. As large classes are being cycled out, they are being replaced with small classes. The effects on the workforce as a whole, however, depend on how you look at the situation from a microeconomic perspective. Is there ever really a shortage? It's really just supply, demand, and the effect on price.

The reality is that incomes for dentists have gone up significantly. However, there is also a dramatic problem with access to care across the board. At least 90 percent of dentistry in the United States is provided in private practices. There

are not many portals of entry to access. More than 70 percent of dentists in the United States are in one-person private practices, that is, they are true cottage industries.

At the same time, dental caries, decay of teeth, and the sequelae of those situations remain the most prevalent poor health condition of childhood, five times more prevalent than asthma and hay fever, which most people consider to be the major child health problems. Furthermore, 80 percent of dental disease is found in 25 percent of the children, most of whom live at three times the Federal poverty level or below, where access is a significant issue.

## **THE SIGNIFICANCE OF STRATEGIC ALLIANCES**

As the American Dental Education Association has been trying to address the issues of access, and workforce issues in particular, it has been trying to get a handle on strategic alliances and opportunities that can affect policymakers. (A strategic alliance is one in which people are working together toward some tangible or valued result. It's not just about sharing ideas; it's about getting something done together.)

Policymakers are abundant, and it is necessary to involve them in such alliances. There are Federal, state, and local government officials, elected and otherwise: legislators and their staffs; people in governors' and mayors' offices; the Federal executive branch; and the judicial branch (which affects policy through court action). There are also nongovernment organizations (NGOs), the media, regulators, accreditors, and foundations. And if one talks about workforce, it's difficult not to talk about employers as well.

When you develop a strategic alliance with someone in the Federal, state, or local government, you create a one-on-one relationship with that person, and things can happen as a result. You can get language into bills, or you can get something done. The value that people find in holding these positions is that they want to provide leadership. They want to do the right thing. They want to do good.

When starting to make alliances that engage the people in policymaking positions, it is important to keep in mind that there is a great deal of turnover among them. But although there may be changes in staffing, and the people you have been working with are no longer there, the reality is that often these people move within related networks and economic sectors. They go from serving on congressional staffs to foundations, to associations, et cetera. But they are still your friends. They carry the message forward. Therefore, every contact remains valuable in terms of continuing a strategic alliance.

Given the significant workforce shortages in dentistry, nursing, pharmacy, and other health professions, it's probably time to get together to create strategic alliances that address the health professions issue in general. Coalitions, partnerships, and alliances are key. In this milieu, strategic alliances can be formed. The concern is not just numbers. The issues also encompass the type of workers and the diversity of the workforce.

## ALIGNING WITH A VARIETY OF STAKEHOLDERS

What the ADEA has done to date is start to build coalitions within dentistry itself. Although it is a relatively small profession with only 150,000 practicing dentists and 55 dental schools in the United States, there has traditionally been a great deal of tension between the academic community and the practicing community. It is important to identify a common ground.

The practicing community association of the American Dental Association (ADA) may have a variety of issues it wants to address, as does the ADEA. The challenge has been to identify those that overlap and take advantage of them, understanding that, on other issues, they might take opposite or alternative views. Working within dentistry, we have a common voice, and it is significant. I am able, for example, to go to Capitol Hill and say, "I'm here on behalf of the ADEA and the ADA."

ADEA has expanded its sphere of relationships, working actively to become part of the Association of Academic Health Centers' (AHC) Health Professions Education Council. We are also working with other executive directors and presidents in the Federation of Associations of Schools of the Health Professions (FASHP).

ADEA has also gotten involved with the Washington Higher Education Secretariat (WHES), the American Council on Education (ACE), the Association of Governing Boards of Universities and Colleges (AGB), and others to understand the relationship of the health professions to the parent universities. For many years, the academic health center was the potential cash cow for the rest of the university, but the balance is different today, and the presidents and trustees need to know what's going on.

At the same time, ADEA has been working with the U.S. Health Resources and Services Administration (HRSA) and the Health Care Financing Administration (HCFA) to create an oral health initiative, one of the few interagency agreements between HRSA and HCFA. The initiative addresses issues of access to care from the HRSA workforce perspective, as well as Medicaid and its impact on access to care from the financial end.

ADEA has also engaged many friends on Capitol Hill who have specific interests—not just members of Congress, but also staff who can get a member involved. Senators Jeff Bingaman (D-N.M.), Russell Feingold (D-Wis.), and Susan Collins (R-Maine) have all introduced bills that would help resolve the dental profession's issues of workforce and access.

Going even further, ADEA tried to expand its sphere to include the National Conference of State Legislatures (NCSL) and the National Governors' Association (NGA), coming up with a recommendation for a policy academy on oral health. Governors would be able to apply to the NGA to send people from their offices, as well as from their legislatures, to learn how they can work together strategically to improve oral health care in their state.

These policy academies are normally on topics such as capital punishment, welfare-to-work, and incarceration, and they attract five to ten people each. The one on oral health received more than twenty-seven applications from the states.

We are also going to foundations. The Robert Wood Johnson Foundation (RWJF) has a major commitment to health, although not to dentistry. But ADEA worked with others to encourage RWJF to address dental issues related to education, for example; How do we clinically educate students?

Another issue brought to RWJF concerns diversity: How can we do better at minority recruitment and retention? Only 5 percent of our students are black, and only 5 percent are Hispanic. RWJF's Board of Trustees will announce later this year that it is committing \$19 million to this project.

Working with AHC, we are even addressing the issue from a global perspective. With the Association for Dental Education in Europe, we jointly applied for funding to the European Union. We received grants totaling more than 500,000 euros to support a meeting in Prague. We brought together 250 dental educators from around the world to try to address issues of workforce and access and to learn from each other.

## **CONCLUSION**

ADEA continues to look for opportunities to translate coalitions, partnerships, and alliances into the concept of a strategic alliance that will yield valued, tangible results for all who get involved

# 9

## GETTING LEADERSHIP INVOLVED IN MULTIPROFESSIONAL ACTIVITIES

Frank B. Cerra, MD

The University of Minnesota is twentieth in National Institutes of Health (NIH) funding in the United States, and a well-recognized academic health center both here and abroad. However, the center has suffered from what can be called *siloitis*, meaning that individual disciplinary programs were kept isolated from each other. Indeed, the entire organization was isolated from the community for a time. It was a major grants crisis that helped mobilize the leadership and faculty into doing something different, namely, bringing interdisciplinary programs into the curricula at the various health-related schools.

This paper addresses some of the principles involved and activities undertaken in the effort to change the culture at the academic health center and promote interdisciplinary education.

### ANALYZING A POTENTIAL PROBLEM

The first step was admitting there was a problem. It was also a major step for leadership to become involved and deal with some of the difficulties the university was having with the community.

To define the problem, and also to build bridges, the University of Minnesota launched a number of activities. Survey and focus groups were conducted, and discussions were held with the chief executive officers (CEOs) of major health providers in the community. After the data were analyzed, the leadership said there was a problem: "The community does not think highly of us, and we do lack a connection with the community."

Then they looked at national data from the various organizations of academic health centers, medical schools, dental schools, et cetera (there are seven different health professional schools on campus) and analyzed the information.

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NOTE: This report on Dr. Cerra's presentation at the Eighth Congress of Health Professions Educators was delivered for Dr. Cerra by Dr. Vincent A. Fulginiti.



## **BUILDING BRIDGES**

The university also connected with the community in a variety of ways in order to ensure that a link would be there when it was time to take action. The chief executive officers of the major health corporations were also convened, putting in place a mechanism for dealing with the bridges being built between external organizations and the university's professional programs.

Internally, it was necessary to educate the president of the university and the Board of Regents. Once that was accomplished, they became both allies and advocates. In fact, the president has been an extremely strong health advocate a number of times, helping to push this agenda along.

Internal partnerships were developed between the various deans, between the deans and their department heads, and between the department heads and the faculty. A bottom-up strategy was developed, with program ideas bubbling up from faculty governance and faculty committees to the top.

## **BRINGING IN INTERDISCIPLINARITY**

An extremely important step was to allocate funds with incentives for the interdisciplinary programs; without funding, such programs will not go anywhere. For example, the 5 percent increase in the budget for the year 2000 was allocated in the following way: 3 percent for across-the-board increases for the faculty, and 2 percent specifically for performance and interdisciplinary programs. Ultimately, some \$34 million was allocated from various budget sources to interdisciplinary programs.

Following the data analysis and education of people externally and internally, the academic health center developed a true interdisciplinary curriculum. The first step was to decide what was common to all disciplines and then embed these components into the individual disciplinary curricula. (Most educators feel that a true interdisciplinary curriculum involves bringing the students together, and that is yet to come.)

A faculty retreat was held to engage the faculty and to get program ideas to bubble up. A grassroots effort also involved the students as advocates. Thus, there was pressure from the president and Board of Regents, pressure from the faculty, and pressure from students.

## **OUTCOMES**

The following outcomes resulted from these efforts.

- An alternative medicine curriculum was developed and became embedded into the silo curricula. The pace was driven by the students. The depth of that program was also analyzed.
- Biomedical integration was accomplished in all curricula, so that basic science and clinical information are now part of the courses of study.

- Three other activities—the so-called Workforce 2013, the blueprint for prevention, and the School of Nursing Foundation for developing nursing leadership—came out of this interdisciplinary effort.

During the data analysis phase, a severe problem with diversity surfaced, particularly the lack of black people in various levels of the health professions. We appointed an assistant vice president for education, who created an interdisciplinary educational program that is community-based, and she is developing approaches for partnering with the university to increase diversity.

## **CONCLUSION**

In some instances, turnover is necessary to achieve change. Dependent on the institution's culture is the decision as to whether top-down or bottom-up leadership will be the most effective; sometimes a combination of both is necessary, depending on the activity.

Prior to developing interdisciplinary programs, it is necessary to determine what is unique to each discipline and what is common among the disciplines that can be the cement for interdisciplinary programs. Interdisciplinary education is not new. In fact, it has a very rich literature, and the concept of interdisciplinary education outside of the health professions has been well recognized, well researched, and well implemented.

On many health professions campuses, there is no longer an argument about whether we should do it. It's how do we do it and how the environment can be changed to support interdisciplinary activities and education.

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## **V. CASE STUDIES: FINDING ANSWERS TO THE WORKFORCE CHALLENGES**

# 10

## **EDUCATION AND TRAINING PROGRAMS: MEETING THE CRITICAL SHORTAGE NEEDS**

Laura Beeth

Fairview Health Services, with 17,000 employees working at sites throughout the state of Minnesota and at one site in Wisconsin, comprises seven hospitals and thirty-seven primary care clinics, plus specialty clinics, nineteen pharmacies, and four home care agencies.

In today's health care job market, it is important to be a preferred employer. That is the job of the Department of Workplace Development and Career and Placement Services, which was established in 1995. There are now nine employees working systemwide.

### **A HUMAN RESOURCES PLAN**

The department has a human resources strategic plan that is key to workforce development. The plan includes the following elements:

- Recruitment—both short-term (i.e., a marketing plan) and mid- to long-term (i.e., diversity initiatives and scholarships).
- Retention—activities such as English-as-a-second-language (ESL) classes and career development on campus.
- Relationship management—for example, management training and communication strategies to make our managers the best possible.
- Employee ownership and investment—employees' stake in their hospital's future (i.e., we have instituted a Gallup survey to find areas for improvement in every department).

We also have five key departmental areas as described below.

#### **1. Career Development**

Career development was the first program established. Today, there is a career center at one of the metropolitan hospitals and another in the suburbs. We also

do outreach to employees at all facilities. Last year more than 3,600 people visited the career centers; they ranged from people in the most entry-level positions to vice presidents. Twenty percent were nurses.

## **2. Redeployment**

This service is for staff who might otherwise be laid off, as a result of a merger or loss of a contract, for example. In every case, their skill sets and transferable skills are assessed to try to place them elsewhere in the system. In one case, the recent loss of a health care contract might have cost the jobs of about 400 people. As a result of redeployment, only seven people had to be laid off.

## **3. Disability Placement**

Many people coming for career development services have a permanent medical restriction. To help them find suitable employment, we have hired two qualified rehabilitation counselors who work with them on a weekly basis, identifying transferable skills and trying to place them within the system. If that doesn't work, we contact our state vocational rehabilitation services. Last year, fifty-eight people with disabilities were placed in other jobs.

A return-to-work program is part of the disability placement services. If an employee with a sprained ankle or broken arm wants to work, we will find him or her employment for up to twelve weeks. If the disability becomes permanent, the employee is put into our disability placement services. Last year, 225 people, who otherwise would have been lost to the system, were placed.

## **4. Workforce Planning**

Fairview has taken the lead in researching trends in Minnesota, as well as nationally, to see what can be done from a community standpoint. For example, last year, we offered one hundred scholarships and sponsored seventeen on-site training programs. We are actively involved in many of our statewide initiatives. We are constantly asking, What can we do with our neighbors? What can we do with our students? Workforce planning is all about relationship-building for the future.

## **5. Job Coach**

Many people coming into Fairview's workforce have never worked before (e.g., those coming out of a welfare-to-work program or newcomers to America). We therefore instituted a mentoring program, assigning these employees to work with volunteer job coaches on campus.

## **STRATEGIES FOR WORKFORCE DEVELOPMENT**

The department also works with people on an individual basis to ascertain where they want to be in health care, in general; where they want to be at Fairview, in particular; and where they want to be in the future. The purpose of

some of the strategies developed to help Fairview employees is to get people more engaged in looking at their transferable skills.

New Americans who work for Fairview can take on-site ESL classes, plus second-stage ESL classes to help them polish the skills they learned in the first class. It's essential to help employees on site because they can't afford to stay after work, take a bus to a class after work, or get extra day care if they have to leave home after work hours. So we try to make it easy for them to access the skills they need to be good employees and be able to move up the ladder. We also pay them to go to class.

### **Student Outreach**

We make an effort to reach students K-12 by giving presentations to Cub Scout groups, having employees read to students at area schools, and making presentations on health-related topics to parents.

Working with the *Minneapolis Star Tribune*, Fairview sponsored Voyage into the Future, a career exploration program for high school students in the state. It was a good way to let students see what it is that health care systems do. Nine thousand students participated in junior and senior high school, along with parents and four hundred teachers. Because Fairview partnered with a major newspaper, it generated a great deal of public attention throughout the state.

The program included an all-day tour of the Fairview facility so they could observe how a health care facility operates. The staff took an interest in the students and worked to give them valuable experiences.

Another student-oriented initiative underway is a partnership with an area college to teach students who are interested in the health care field. Three days a week the students come to the Fairview Southfield campus to take classes and get shadowing experience for which they receive college credit. We hope to expand the one-semester program into two years for juniors and seniors. The goals of the program are to promote the multiple careers available in health care, particularly at Fairview, and to help the students make good career decisions.

### **Reaching Career-Changers**

Workforce planning also involves talking to people who are in the market for second careers. Many of the students in two-year registered nurse (RN) programs, for example, are in their thirties.

### **Community Partnerships**

In addition to helping high-potential groups, we also work with people who face barriers to getting work. We are currently working with the Jeremiah Program in our inner cities. The program has a shelter for single women with children under the age of four. The women may stay there for two and a half years. People from the community health department share ideas with them about staying healthy. They also are taught job-seeking and interviewing skills,

and receive help in building resumes and in finding out where there are job opportunities. We tell them about our scholarship and training programs. And we mentor them along the way.

Another partnership is with the Teamster Service Bureau Contextual Learning Project, a Federally funded project that partners with employers to help displaced, dislocated workers.

For example, we helped people who lost their jobs because of a plant closing. Instead of trying to duplicate training programs already underway, we developed a new one using the plant workers' transferable skills. We worked with one of our universities to bring our surgical-instrument processing tech program on campus. Participants can work in the central supply area and eventually prep the trays for surgery. A Teamsters grant pays 100 percent of the training costs and 50 percent of the salary that the participants earn while working. Fairview pays the other 50 percent of salary plus benefits throughout the training period. The people stay on as employees when the program ends. This same program is also offered to external applicants.

## **Education and Training Programs**

Fairview is currently partnering with more than eighty schools in Minnesota, including our university (our main partner), and Minnesota state colleges and universities. Last year alone, more than twenty different educational programs were offered either on site or in collaboration with neighboring colleges.

Scholarships used to be Fairview's best-kept secret, but to let more people know about this opportunity, Fairview is promoting these awards on our Web site, in information sent to the schools, in articles in the newspaper, and at job fairs. Last year, about 160 scholarships were awarded.

### *Nursing Assistant*

Three levels of training for nursing assistants are available at Fairview: the state course, a refresher course in acute care, and advanced nursing care for people on an acute care floor.

### *Health Unit Coordinator*

For the health unit coordinator training program, Fairview partners with one or more institutions, depending on the need. On-site classes include both book learning and clinical practice labs with some of Fairview's best health unit coordinators. This program has been so successful at Fairview's Southfield and Ridges campuses, it is offered on an ongoing basis.

### *Perioperative Nurse*

The perioperative nurse training program runs for nine to twelve months full time with an enrollment of five to eight RNs at a time. Fairview pays for all training and also pays them full-time wages while they are in the program. The

nurses also sign a two-year employment agreement to work at Fairview upon successful completion of the program.

#### *Allied Health Professional*

We offer radiology technologist scholarships and partner with a couple of area schools to bring on clinicals and so on.

Fairview also has a fully funded grant to bring people into the system to work as medical secretaries and medical receptionists. A phlebotomist program is also offered.

#### *Surgical Instrument-Processing Technician*

A surgical technician program is an important feeder system for Fairview and for other health care systems. When the state of Minnesota was closing one of our key surgical technician programs a couple of years ago, we worked with the legislature to keep the program alive. Fairview and other institutions contributed \$167,000 in matching funds to a Minnesota Skills Partnership grant, actually doubling the program. Now there are twice as many students graduating.

#### *Medical Laboratory Technician*

Fairview currently offers scholarship clinicals for medical lab technicians. Minnesota now has only two. So Fairview will partner with a college to begin such a program.

#### *Dietary Aide and Environmental Services Aide*

We work with one of our community partners to offer training as dietary aides and environmental services aides. Participants can start in an entry-level position and, through the career resource center, move into other positions once they gain further skills.

#### *A Variety of Programs and Services*

In sum, programs range from entry level to advanced, and scholarships are available in many areas. In some cases, nursing students work in entry-level positions and then stay on when they graduate from nursing school. For example, a nursing student from the University of Minnesota can, through our nursing assistant program, receive free training and full-time wages during the training program. There is also extra help in areas such as ESL. Furthermore, nurse managers are willing to let these students work extra hours during the summer and then cut back when they go to school. And while they are employees, they get tuition reimbursement to help them pay for their nursing education as well.

A great deal of research and planning goes into each program, from identifying a need and marketing the program, through screening, testing, and interviewing applicants. Managers or their representatives are always involved in choosing



candidates. We carefully follow the students' progress and survey them upon completion of the program. We also survey their managers at three, six, and twelve months to see how these programs can be improved.

## STATEWIDE INITIATIVES

Because the problems in our health care system are widespread, Fairview can't work on them in isolation. We work with partners in the community, as well as in the state and nation on a number of efforts.

The Healthcare Education-Industry Partnership Council is a statewide initiative funded by the Minnesota Legislature. In existence for about two years, this successful program is designed to look at taking health care education through the Minnesota state colleges and universities, and working with industry on workforce efforts.

This program brings together the following: the Minnesota state college system, leaders from all of our major health care providers, the state government, the University of Minnesota academic health center, private colleges, and our trade association, the Minnesota Hospital and Health Care Partnership Council. They work together on state health care workforce needs.

Fairview has another effort underway to bring the whole state together with administrators. The Minnesota Center for Rural Health and the Minnesota Department of Health are also working together on these workforce initiative efforts in their areas.

Many of the professional associations have set up the Long-Term Care Health Force as part of the Health Care Partnership Council targeted at marketing and advertising programs that can make a difference at the Legislature.

The National Institute of Health Policy, which is looking ahead at our workforce efforts in 2003, is also looking far into the future because the problem is not going to go away.

The Health Care Partnership Council has developed an assessment tool for government and industry to use for working together with educational facilities to identify workforce needs. A state policy group and the Minnesota Nurses Association are also engaged in workforce efforts.

We're also concerned about providing easy access to programs for people who want to stay in their communities. How can we help employees maximize their abilities, instead of having them work in entry-level areas?

Among the other considerations are looking at a health care core curriculum at both the high school and college levels, and at career ladders for people with articulation agreements so they do not have to start over but can transfer into new programs if they change careers.

On average, a person will hold at least ten jobs and probably have three different careers in a lifetime. It is, therefore, important to look at their transferable skills, and what we can do to help them move along.

Fairview is also looking at building capacity through K-12 linkages. Minnesota is the first state to have a state Web site, and Fairview will have a health care channel on the site that identifies all the health care educational programs, classes, stories, and marketing areas. In essence, it will be a tool for promoting health care careers. Employers will link their Web sites to ours.

## **CONCLUSION**

I believe that health care is not just another industry and that we need to go out and promote health care careers. We need to have proactive strategies for working together with people and making a difference in their lives and in the lives of the people they will be serving.

# 11

## **CONNECTING THE HEALTH CARE INDUSTRY TO A NEW POOL OF EMPLOYEES: WELFARE-TO-WORK PARTNERSHIPS**

Tracy R. Poyser  
Charlotte Warren

In 1997, Illinois Governor Edgar asked the chief executive officer of Northwestern Memorial Hospital in Chicago to participate in the state's welfare-to-work initiative by hiring twenty welfare recipients. On its first try, Northwestern was only able to hire three people.

On the second try, the hospital exceeded its goal and hired thirty-four people, but they did not stay. Northwestern found it was hiring people with interviewing skills, not true skills for getting the job done.

In the spring of 1999, Northwestern was introduced to the Office of Applied Innovations (OAI) of DePaul University, which matches people about to come off the welfare roles with jobs. It was the beginning of a pilot program marking the hospital's first big success in the welfare-to-work area. The two papers that follow discuss the ensuing partnership from the vantage point of each participant.

### **POYSER:**

OAI was just launched by the university as an independent 501(c)(3) operation. This action is in line with DePaul's urban mission to take community-based organizations, make them independent, and make them progress beyond what they can do at DePaul. OAI became independent in mid-April, and will continue to work very closely with DePaul on its initiatives.

In this paper, we discuss not so much what OAI does, but how this community organization has partnered with the health care industry in connecting the hardest-to-employ individuals in highly underserved areas in Chicago to a career plan and opportunities that will lead them, in the long term, to sustainable lifelong careers and make them independent, rather than dependent.

## **Employing the Hard-to-Employ**

All of OAI's successes in efforts like this are with industry-specific programs built on proactive employer-industry partnerships that OAI creates. The organization reaches out to a wide variety of community-based organizations in Chicago. It is very closely linked with the local initiative sponsored by the National Welfare-to-Work Partnership discussed further in the companion paper that follows.

In terms of welfare-to-work, it is important for a health care provider, or other service provider, to implement employability skills training for hard-to-employ adult populations, including new Americans. The pool of new Americans represented by former or current recipients of Temporary Aid to Needy Families (TANF) is truly a hidden resource for the health care industry.

## **Finding a Health Care Partner**

OAI's ideal employer partner would be an organization with a compatible corporate and human resource philosophy that looks at entry-level positions, the only positions that can usually be considered for this population, and sees these positions as a stepping stone up. In a pilot initiative, OAI ideally likes to see a single employer with a large number of jobs that are accessible, both in terms of transportation and child care issues because they are the most important barriers to overcome in many instances.

OAI likes to find employers who see the organization as an extension of the human resources (HR) and workforce development teams, rather than as a provider that puts people in an entry-level job and then stops. For the welfare-to-work effort to succeed, OAI mainly needs to know that its case managers and career counselors are dedicated to the clients, have access to them on an ongoing basis after placement, and have access to the manager level and the supervisor level.

Northwestern Memorial Hospital was an ideal employer-partner. This was especially significant since they opened a major new facility in downtown Chicago in the spring of 1999, about six months after OAI received a Department of Labor first-round, competitive welfare-to-work grant that allowed the organization to combine its resources for a major pilot effort.

## **Customizing Curriculum to Jobs**

OAI started by selecting environmental services (ES) as the occupation most conducive to matching the largest number of clients. The effort started in about January 1999, with OAI meeting with the Northwestern Memorial team of HR supervisors and management personnel to design screening criteria.

One of the prerequisites for customizing a preemployment program at OAI to a specific employer or employer group is a commitment from that employer to hire everyone accepted into the training program provided, of course, that those individuals have successfully completed all requirements of the program.

OAI also made certain that its instructors knew as much as possible about the requirements of ES jobs at Northwestern. This included actually having them learn the use of floor cleaning machines so they would get real, tangible knowledge of what the clients would have to deal with.

OAI then customized its normal job-readiness curriculum, integrating the elements that would normally be part of orientation and training once an individual is hired. This saved Northwestern a great deal of time and effort, and made sure that the start-up crew was actually ready to work from day one.

### **Recruitment**

While all of this discussion and preparation was going on with Northwestern, OAI started its recruitment and outreach efforts into the community. The primary referral source for welfare-to-work is the Illinois Department of Human Services (or the Department of Human Services offices anywhere), which identifies recipients about to fall off of the face of the earth if they do not find employment.

Because of the size of the group needed (about 50 new employees for the class), OAI conducted a massive recruitment drive. The drive reached into churches, community centers, and, most important, to other service providers funded by similar grants or conducting similar initiatives in Chicago. This was to make sure that they were funneling all of their clients through OAI. This, again, made it easier for Northwestern to deal with just one service provider instead of the twelve or fifteen competing with each other.

OAI interviewed 480 applicants at three locations. About 50 percent dropped out in just the prescreening when they found out about drug-testing and criminal background checks. This constitutes another challenge in welfare-to-work: Health care has very stringent requirements when it comes to employing individuals with some form of criminal record, thereby narrowing the target population somewhat.

After the first round, OAI selected roughly 125 individuals on the basis of both their attitude and success in passing a screen that included a test of adult basic education to determine their skill level. Of these, 64 were selected for thorough interviews with Northwestern. Northwestern picked 54, and 47 graduated.

### **Training**

What OAI did in this particular employability course (which mirrors what the organization does for other industries), is try to replicate, as much as possible, the demands of the workplace. In this case, for example, the class ran from 7 a.m.-3:30 p.m., thereby paralleling one of the shifts that ES workers at Northwestern would have to work.

On the first day of class, students sign a contract in which they agree to accept all of the terms and conditions that OAI places on them. A major condition is attendance, and the second unexcused absence will lead to a termination of that individual in the class.

Obviously, OAI will try to find out what the problem is, and refer the employee to other programs. But the point is to make sure that candidates understand not just the world of work, but the world of work at Northwestern very thoroughly before they get into their jobs.

There was a mix of instructors focusing largely on employability skills, which include self-esteem, getting along with supervisors, critical thinking skills, money management, and dealing with domestic issues that they need to take care of at home so that they can reliably continue to work.

Another part of the mix were guest speakers and participants from the Northwestern team who would make working at Northwestern a tangible, exciting opportunity for the OAI clients, make them part of the corporate culture, and give them an idea of what they could expect. It also included the end of the training, where the potential employees worked with actual physical equipment and trained on site to get ready for work.

The forty-seven graduates then had a graduation ceremony to which they were allowed to invite their families and loved ones. A wonderful community activist delivered the invocation. The Mayor's Office of Workforce Development was represented. Most important, senior management of Northwestern presented the graduates with their first letter of employment. They have now become role models for everybody else in the organization. Anybody involved in such a program needs to be aware of the benefit of creating a milestone event of some kind. Northwestern has been fabulous in doing that.

### **Support Services**

Case management is one of the most important keys to retention. The grantor, the Department of Labor, mandates six months of retention. OAI does not feel that this comes close to being long enough.

All of the programs at the Office of Applied Innovation mandate up to two years of career guidance after an individual is placed. This is because, at the start, guidance usually takes the form of crisis intervention. Although every client has an individual career plan, the first three to six months deal more with making sure that the person is just retained *in* that job and *on* the job.

After this period, with the length depending on the individual, OAI guidance starts shifting into career advancement, looking at the transferable skills that clients may have developed that need to be enhanced with some form of training—for example, computer training or additional courses in ESL.

OAI works very closely on site with Northwestern to do this. In fact, with roughly 140 people now employed at Northwestern through the OAI program, a case manager visits on site twice a week, for a good portion of the day, to make the rounds, talk to clients, and talk to the managers to see whether anything needs to be addressed.

In general, the client trusts the case manager a bit more initially than the supervisor on the job, especially if there is a domestic problem. OAI tries to

intervene and make sure a brewing crisis is identified before it erupts and leads to dismissal. As a result, the retention for the first group after the first year was roughly 88 percent.

Since the initial focus on environmental services, OAI and Northwestern have expanded the welfare-to-work program to include patient-care technician training, customization for material handling, and transportation. OAI is also able to fund individualized additional career advancement services for its clients through grants from both the Department of Commerce and Community Affairs and the Welfare-to-Work Partnership link.

OAI has learned over time that the most important aspect of bringing in hard-to-employ individuals and filling the health-care pipeline with this population pool is to focus on long-term retention and long-term case management. It is also important to engage a strong community partner or group of community partners that will work with you.

#### **WARREN:**

Northwestern Memorial Hospital is an academic health center in downtown Chicago and a major referral center for the Midwest. Its roots go back more than 135 years, but it was officially established in 1972 through the merger of two major institutions in Chicago. In 1999, the center opened a new facility, which has 492 beds, 92 of which are intensive care. About this time, Northwestern started to meet with the Office of Applied Innovations to establish a partnership in a welfare-to-work program.

#### **Some Words from a Program Beneficiary**

Below is a testimonial from Odessa Robinson, one of the employees who came to Northwestern through the welfare-to-work partnership with OAI. Ms. Robinson has been with Northwestern since Spring 1999 and serves as a role model for employees at the institution and also her community.

My name is Odessa Robinson. I [want] to tell you all what I have accomplished since I started working at Northwestern Memorial. Some time ago, all I did was sit at home day after day, waiting for my check from public aid. I was depressed and unmotivated, and each day I grew more frightened about my children's future.

My oldest son, Ronnie, was getting bad grades in school, and I was too unmotivated to help him succeed. Children learn by example, and my example was teaching him all the wrong things. Then one day I was accepted into DePaul University's training program for Northwestern. I learned about time management, customer service, and cleaning techniques. I also learned how to be patient and respect my coworkers and supervisors.

After three weeks of showing up on time every day for training, I got a job in environmental service. When I started working at the hospital, things

began to change. Each day my confidence grew, and I began to get my life in order. Ronnie's grades improved dramatically, and when I asked him why, he told me it was because of me. He said that when I didn't have a job, I would break my promises all the time. I used to feel bad because I knew I couldn't keep the promises I made.

But now I always keep my promises. Now that I'm working, I don't depend on public aid. I can give my kids the things that other kids have. I take care of my kids out of my own pocket. I teach them how to be responsible. In fact, now Ronnie talks about getting a job and taking care of his mama.

When I first started this job, all I did was clean bathrooms. Every day for four months I cleaned bathrooms, bathrooms, bathrooms. Then one day my supervisor told me that I had graduated and become a floater. I work all over the hospital now, cleaning all different departments. Now I know this hospital like the back of my hand. I know it so well that my supervisor asked me to show the new people around. Nobody knows this hospital like I do.

I'm good at my job, and I'm proud of my accomplishments. I have been working at Northwestern for one year and three months, and this fall I will start computer training at City Colleges. I love my job, and I want to thank with all due respect, Ms. Lilly McDonough, for helping me and others get through the training for Northwestern. I want to thank her and the other people at OAI: Wallace Brown, Ava Brown, Alva Dillon, and my managers for their patience, time, effort, and words of encouragement.

I have learned that you can do anything you want as long as you put your mind to it and never give up. Thank you, OAI and Northwestern for giving me this opportunity.

Obviously, there is a need for a pipeline of entry-level health care workers, represented by Odessa, who will become Northwestern's future lab assistants, pharmacy technicians, patient-care technicians, materials handlers, operating room assistants, and cell-processing technicians.

## **Benefits to Northwestern**

What does Northwestern get out of the welfare-work program, altruistically and practically? Altruistically, the institution is committed to the community that it serves, not only to provide the best quality of care but also to serve patients and improve the overall health of the community.

Northwestern promotes the welfare-to-work program because of the practical benefits, too. It makes good business sense. Some examples follow.

1. The center is addressing a major staffing need, and also increasing employee retention. The mission at Northwestern is to give the patient the best possible experience while at the hospital. Tied in with this mission is an HR strategy to employ the best people. The center aims to attract, develop, retain, and empower the best people for jobs.



2. A training program such as the OAI program fits with the mission of the HR department, namely, higher retention rates. The retention rate has been between 80 to 86 percent since the start of the welfare-to-work program. Why are these welfare-to-work candidates retaining their jobs better than some other employees? It is not clear, but possibly people who haven't had a lot of opportunities in their lives hold on much tighter when they get a choice.
3. The support network behind them is also a big factor: their OAI case manager, their family, their community, their service provider, and BizLink (the latter discussed more fully below).
4. The new employees are raising the bar. These new, enthusiastic employees are showing up some of the old timers. When the new people came into the Emergency Room, for example, and were going the extra mile, one of the old employees said, "Oh, no, no. We don't do that. Stop."
5. The hospital saves money and resources. After the initial investment, and once the partnership was developed and the relationship between the program and the organization established, no further investment was needed. All the work is up front.
6. The hospital saves money, including the expense of drug tests and staff interviews. Thus, HR knows they are already Northwestern material by the time the department has to determine if there is a fit.
7. Northwestern has also found that some of the work in one area of the hospital can be applied to any area of the organization. OAI, for example, is taking Northwestern's training program for food service (which wasn't much to begin with) so it can be used for its job candidates.

### **Meeting Challenges**

In terms of challenges, Northwestern Memorial Hospital needed to come up with strategies to make sure that the program didn't compromise its high standard care. Some of these strategies are listed below.

1. Establishing supervisor buy-in and input into the process, starting at the employer-level—In some other programs, the community organization runs the curriculum and the training and delivers a package that the employer can use to its advantage. This doesn't work. You need the managers. You need the supervisors. In other words, you need the show-stoppers, the people who will make or break the program. They need to be involved from the get-go.
2. Recognizing that community efforts complement traditional hiring practices—Screening of candidates, for example, should not adopt a generic approach; it must be for a specific institution. OAI asked the questions and found out the information specific to what a Northwestern employee needs.
3. Benefiting from customized preemployment training—Many community organizations provide general training for their candidates that consists of life skills and customer-service skills. What Northwestern is getting are candidates who already know the culture at Northwestern, know what's

expected of them, and know the tasks that they are going to have to complete on the job.

4. Increasing the bottom line by decreasing turnover, for example, by generating loyalty among employees—Northwestern shows that it does care about them.
5. Improving quality service—Another retention strategy.
6. Working with Bizlink, which is part of the national Welfare-to-Work Partnership, a bipartisan organization now in the phase two of its initiative—The first stage was to get people interested in welfare-to-work, and to place candidates. The second phase is to develop them via career paths and promotion possibilities in the organizations where they are now employed, and get them into higher positions.

There are five BizLink satellite offices in the nation. Their mission is unique: to serve business. They are there to encourage the leadership of the management team. They are there to supply the HR administrators with tools for developing and maintaining these programs.

Indeed, Northwestern found that the focus needs to be the business plan. This focus has kept the hospital on track. An employer does everyone a disservice when it doesn't stick to that business plan.

7. Finally, the successful development of the employees—Accomplished at Northwestern through a strategy of constructive and supportive service, case management through OAI, its service providers, and targeted appropriate training for people to develop into the jobs that they want to pursue.

The training is not just generic but is actually customized training with access to career ladders. The training strengthens their skills, their customer services, and their professionalism. All this ties into the mission of having the best people.

In January 2001, Northwestern launched the Northwestern Memorial Corporate Academy. The aim is to develop and retain employees, and the welfare-to-work program fits in perfectly with the academy's work.

## **Lessons Learned**

### *What does work:*

- Northwestern streamlined the number of agencies it was working with. Trying to work with many different organizations was wearing on the HR department. There were too many agendas involved, and, furthermore, it wasn't Northwestern's program. It was more a community program. In the partnership, OAI served as the clearinghouse that all of the community organizations could go through.
- The customized training covered conflict resolution, communication skills, the chain of command in a very hierarchical institution, and the culture at a major academic health center.

- Aggressive case management cannot be generic. It has to be specific. People have to recognize and address the real problems, and also make them known if the program is going to get past the obstacles.
- Open feedback and, with it, trust, is important. OAI and Northwestern have developed a seamless project. There is no agency, no client in this relationship.
- You need to establish a champion. The vice president of support services was the perfect champion to get this program started at Northwestern. Support must come from upper management.

*What doesn't work:*

- Being an alarmist, and looking too hard for problems instead of realizing there are going to be problems much like those with any entry-level workers and moving past obstacles.
- Compromising standards. Some organizations are making special allowances that compromise their guidelines. You don't have to compromise your standards. Northwestern has never had to do so and gotten very qualified candidates.
- Looking out for skills and style. The more aggressive the candidate, the less patient he or she was in dealing with other people (their nature is not gentle-enough) and math skills (the tests administered for Northwestern did not do the job). Finally, Northwestern Memorial Hospital shares these lessons and its experience with the community and hopes more organizations can take advantage of the untapped pools of candidates in the communities.

# 12

## **AN OUTSIDER'S VIEW OF THE WORKFORCE: LESSONS FROM THE MEDIA**

Michael Berens

Nursing is the Roger Maris of medicine. Roger Maris was a baseball player who broke Babe Ruth's homerun record. Because of the influence of the media, the public, and the powers-that-be, even though he broke the record, they list his number with an asterisk. Basically, they tried to mitigate the record. I think there is an asterisk after nursing right now.

### **A TROUBLED TIME FOR NURSING**

In compiling a series of articles on the health workforce that ran recently in the *Chicago Tribune*, I have been in dozens of hospitals in the last months. In California, I attended a private meeting with about fifty nurses, where they candidly discussed what is going on in their workplace. They talked about patients left in the hallway for hours because there were no rooms available. Or, rather, rooms were available, but there were no nurses to staff them. They talked about medication errors that they were making, which they said were due to staffing issues.

### **Labor Conflict**

This is a turbulent time in nursing. A labor war is going on across America, and the American Nurses Association (ANA) is fighting vigorously for membership. Several years ago, the California Nurses Association disengaged from the ANA and formed its own union. Also recently, Massachusetts nurses disaffiliated from the ANA. What we are seeing now is the creation of a rival national union to ANA, not to mention the other unions out there, all going after nurses for membership more vigorously than ever before.

What this has done, to some extent, is fuel more media attention to the plight of nursing. This has an impact when it comes to determining what kind of career one chooses. All manner of publicity is in the marketplace, which provides some food for thought. Some examples from this avalanche of material include:

- The Service Employees' International Union (SEIU) is promoting a booklet, *The Shortage of Care*, which has a lot of what many would classify as semihorror stories from nurses.
- The president of the ANA, in November 2000, allowed herself to be arrested on the steps of a Washington hospital where she was protesting short staffing and mandatory overtime. This was obviously a calculated public relations move by the ANA to show its membership that it cares, and to bring attention to the fact that nurses are more willing than ever to go public.  
Historically, nurses have maintained silence, thinking that they could make changes quietly and within the workplace. Many now are finding that this is not the case.
- In May 2001, the SEIU delivered thousands of pairs of nursing shoes to Congress to provide a graphic illustration of the number of nurses missing from the workplace.

## Medical Error

The lead paragraph in the *Chicago Tribune* series was very blunt and summed up the project. The paragraph started:

The overwhelmed and inadequately trained nurses kill and injure thousands of patients every year as hospitals sacrifice safety for an improved bottom line.

We spent about ten months touring the nation to support this kind of statement. We went through millions of computerized records from a dozen Federal and state agencies, including information gleaned from the MAUD database. We obtained every disciplinary action for every nurse over the last ten years in every state.

These detailed records allowed us to start tracking the potential impact on the public if there was a breakdown in nursing. Obviously, it generated a lot of calls from colleges and nursing educators, some of whom were very upset with the series.

One of our core findings was the specific number attached to injuries and deaths. The Institute of Medicine (IOM) has reported that 90,000 deaths and 45,000 injuries can be attributed to nursing error. Other vague numbers, extrapolated from some very limited and old data, are also available.

The *Tribune* tried to attach a specific figure to the problem that could be backed up with documentation in each and every case so that each and every death had a name, age, and date that correlated with it. Some people remarked that they thought the number was low. The number is probably much higher, as health care expert Lucien Leape would say about the IOM numbers, but it was the number we could verify.

## Workplace Issues

There is reluctance to acknowledge that there are widespread health care problems across America. Many good hospitals are doing well, but even more are not.

### *Overwork*

We profiled one sad case involving a Chicago boy. The boy had fallen down the steps and hurt his head. He had a little bump on the forehead. The mother, who was a nursing aide, decided to take him in for X-rays just as a precaution. The boy was active, running around, eating Oreos, and drinking a Coke in the emergency room.

The doctor did a physical examination and could find nothing particularly wrong. He ordered a CT scan just to be safe, at about midnight. The doctor went home, and the attending in the ER went home, leaving a registered nurse basically by herself in a fairly large, prestigious Chicago hospital.

This nurse was working the fifth day of twelve-hour shifts. She had only been on the job two months. They had told her to do a conscious sedation, even though she had never done one by herself before. She attempted to do it, something went wrong, and the young boy died.

What was interesting about this case is the question that remained: Is this the case of a bad nurse, a bad system, or a bad hospital? As for legal ramifications, the nurse settled the case for a couple of million dollars, and the hospital settled for a couple of million dollars.

In the newspaper series, we asked, Why was this nurse left alone? Why was this nurse told to do a procedure that she had never done before? Why was she working five consecutive days of twelve-hour shifts? What was going on in the workplace?

### *Scarcity of Staff*

One of the controversial points that we made in this series, the concept of which is more accepted now, was whether there really is a nursing shortage or whether there is a shortage of nurses willing to work in hospitals. This country is seeing a mass exodus of nurses from hospitals.

Statistically, there are actually more registered nurses (RNs) today than last year or the last few years. However, one of our key findings was that there are actually fewer registered nurses working in hospitals today per patient than ever before. In fact, hospitals have quietly downsized their RN workforce. What used to be, for example, a 90–95 percent RN-care ratio is, in some hospitals, as low as 55 percent.

Another key point in the series was that while nurses were making mistakes and people were dying and being injured by the thousands, there was another component to the problem. It is important to acknowledge that, nationwide, more and more nurses are coming forward, willing to go on the record and tell their stories about what is happening.

Another profiled case occurred in a Kansas hospital. A woman went into distress and tried to get a nurse but could not reach one. There was only one nurse for about fifteen patients on that shift, and she was tied up with another patient.

The patient in distress went into a coma for a while. She stopped breathing. She suffered irreversible brain damage. She now communicates via a card with letters on it. She points to the letters to talk with her family.

This, again, was another example of what apparently is very common. There are just not enough nurses on duty in hospitals. And this is another issue that people who are looking at career options hear about in the press. Who wants to be part of this kind of workplace?

### *Instrument Problems*

We looked at a multitude of issues, including instrument problems that occur with the use of fusion pumps, one of the main tools of nursing. A registered nurse, Cathy Kloninger, came forward in our series. She talked about how she made an infusion pump error with a small child. Fortunately, the patient was not permanently injured. She told us that she had mistyped the dosage amount on the keypad.

Ms. Kloninger is an excellent nurse; she has been a nurse for a decade, and she continues to be an excellent nurse. She made a mistake, and we cannot pretend that it does not happen. She provided one of the stunning quotes of the series. She is a very professional, conservative, reserved nurse normally, but she said, "Look, I'll tell you what's happening. This [kind of mistake] is very common in this profession." I have heard this kind of quote by nurses from California to Massachusetts.

### *Cross-Training*

Another interesting finding of the study is the fact that some hospitals are substituting registered nurses with nurse's aides or, in what is called cross-training, with the housekeeping staff. On days when there are just not enough nurses, they bring in the housekeeping staff and allow them to pass out pills.

At one Chicago university hospital, a three-page memo outlined duties that the nurse's aides were allowed to perform, including working with sutures and open wounds and performing certain types of diagnostic tests. It was a pretty elevated duty list compared to many places.

This cross-training received a lot of national attention. It was just one sentence in this series because we were not writing about nurse's aides. However, it is another aspect of what we are seeing in hospitals. They often experiment with the care ratio to try to find out how few registered nurses they can get by with and still provide quality care. The problem is that it is an experimental process, and often times it does not work.

A terrible burden of stress is placed on nurses. The demands for their attention are great, and every mix-up can be fatal. I have talked to hundreds of nurses who tell incredible stories. In fact, one told me she wakes up praying that the nurses do not kill someone that day. They are really that scared.

As an example of the issues raised by Chicago hospitals using cross-training, I talked to a patient who said a nurse delivered his medication one day; the same

day another woman came in to empty the trash and do the blinds. The next day this other woman was wearing a nursing-style uniform and delivered his pills. The unions are against cross-training, but it is the reality of hospital staffing.

We followed another nurse, Janet Dotson, in our series. When I first met Ms. Dotson at a disciplinary hearing for nurses, she was being charged in the negligent death of a patient. She is a master's degree nurse and has about a decade of experience.

Ms. Dotson works as a temp-agency nurse, and she parachuted into a hospital one night. Even though her specialty is pediatrics, they had a shortage in the geriatric section of the hospital, so they put her with the older patients. She had fifteen patients on the night shift, her first time on the unit. Without orientation, she was slammed right in, given the charts, a quick overview, and a briefing, and told to take care of the patients.

She had a patient with a standing order for nitro as needed. The patient experienced some pain. She gave the nitro as outlined in the doctor's orders, but about three hours later the patient went into arrest and died. The patient was an elderly woman with severe problems and had been in the hospital for more than three weeks. Whether this patient would have died regardless of the quality of care is unknown.

Ms. Dotson was charged with negligent nursing care in the death of this patient. She went to another hospital and continued to work. Charges are still pending against her, and the state of Illinois has recommended that her license be revoked for life.

## **NURSES SPEAKING UP**

Officials from the University of Illinois at Chicago and I sat down and talked after the series ran, and they have instituted a lot of changes. The directors are hiring more registered nurses, which they say is having a tremendous impact on the quality of care. They have undertaken a spruce-up of the hospital, with signs and decorations. And they have brought nurses together.

Basically, the directors said they were talking to the nurses more than ever before. They were empowering the nurses to try to change the workplace. As a result, there has been tremendous change at the university.

Allison Goodman, another registered nurse, decided to take things into her own hands because she was upset with the way her workplace operated. She kept a diary for three years, every day recording every incident of every mismedication, of every late medication, of every wrong medication. She kept every e-mail, every memo. She is probably a hospital administrator's nightmare in the sense that she saved everything and then turned it over to me.

Ms. Goodman was fired from the Kansas hospital before I wrote the story for helping the family of the woman who communicated with the card. Ms. Goodman, contacted by the family attorney, said she would tell the truth: There was a problem with staffing.



At this particular hospital, I got about 10,000 pages of documents on how the hospital chose its staff, including what kind of financial formulae are applied. Obviously, it is somewhat complex and fluid. The bottom line, however, is that the hospital was staffed based on census, never acuity, even though it did have a policy for staffing to acuity.

I would urge health professionals to walk into any hospital and see what there is to see. It can be eye-opening. I was in a hospital in West Palm Beach recently. It is a beautiful, rich place, and there are bugs in the cafeteria. A trash can was overflowing. I watched the night shift janitor walk by, upset because the first shift did not empty the trash. He decided not to do it either, and left it for the next morning. It is those kinds of little breakdowns that make you wonder sometimes how a hospital operates.

## **EDUCATORS' DILEMMA**

To maintain perspective, I talked to a lot of nursing educators. One felt that the newspaper series only made people not want to go into nursing. I would submit that the problems started well before my series, and I doubt if the series has had a great impact on enrollment.

Four nursing programs in Illinois are on probation because the majority of their students are failing to pass the national exam. That appears to be a record number of programs on probation. I have talked to nursing educators about this. In some instances, universities, in an effort to reach out to a different population than those they typically served, have changed the curriculum. Some would accuse them of actually softening the curriculum as a way to get more students in and keep them in for a while. Two more programs are on the verge of being placed on probation in the state of Illinois; they are not the large programs, but they are university based.

Nursing educators are faced with an avalanche of nursing stories right now, and nursing educators and people trying to recruit new nursing students are going to be faced with this kind of publicity. It will grow as we move forward.

## **CONCLUSION**

Nurses make up the largest health care profession in the world, and by virtue of that, are among the most important in the health care field. The message I would try to give potential nursing students is that now is the best time to be a nurse, despite all the problems. This is because nurses are empowering themselves more than ever.

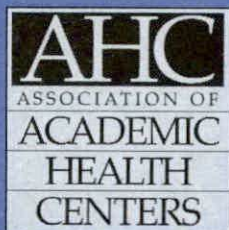
Nurses today have a great opportunity to change matters. That is why so many are speaking out about the problems; they are trying to solve them and take a little control.

Nursing educators can find good programs and help promote them not only among the students, but also among the public. Potentially, media are going to latch onto the negative stories.

A prominent nursing educator from Illinois called me and told me the newspaper series was terrible. She said patients were questioning student nurses as to whether they were registered nurses. She was livid that her students were being subjected to those questions. I understood her point of view but, on the other hand, I was pleased that the public was asking questions about who was taking care of them. It is very confusing if the person caring for them in a hospital is an aide or student. Obviously, we all want the best care.

This is the time for nurses to seize control, to take power, to empower themselves. Furthermore, the demand for nurses is high. It is a great time to go into nursing. Maybe that's the message that educators need to reinforce in order to change the future.





**Suite 720**  
**1400 Sixteenth Street, N.W.**  
**Washington, D.C. 20036**

**202/265-9600**  
**FAX 202/265-7514**  
**[www.ahcnet.org](http://www.ahcnet.org)**