Launching 2009: A Focus on Strengthening the Work Environment

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Thriving in the VUCA World of Healthcare

VUCA* World
V -- Volatility
U -- Uncertainty
C -- Complexity
A -- Ambiguity

*U.S. Army War College, Carlisle PA

Seven Irrefutable Trends

What a Tangled Web We Weave.....
What have we learned?

- Once again, there are no “silver bullets,” much of what needs to be done, we already know.
- We have leaders, but not enough leadership.
- Too many #1 priorities = mismanagement of TTT.

Prioritizing time, talent & treasure

- Work “IN” the business delivering current services, processes.
- Work “ON” the business improving current services and processes.
- Work TO “ADVANCE” the business moving the enterprise to new ground.

What have we learned?

- The unions are listening to healthcare employees.
- Effective change leadership and crucial conversations are not healthcare competencies.
- Improving the work environment to reduce vulnerability does work.

General Satisfaction Trends in Healthcare

- Relationship between employee turnover and profitability * VHA, 2001

- Relationship between employee turnover and patient care * VHA, 2001
Does having a union create a better work environment? *(Satisfaction changes at four hospitals unionized after 2003)*

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<thead>
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<th>Hospital</th>
<th>2002 Scores</th>
<th>Current Scores</th>
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<td>#1 - physicians</td>
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Project Objectives

- Identify the essential work environment factors, behaviors and practices that contribute to a less vulnerable work environment
- Compile these factors into a prototype that can be applied in any facility
- Measure organizations against the prototype

The Original Cohort Studied

- Ten facilities
- Identified based on demonstration of positive performance:
  - Nursing staff turnover rates
  - Nursing staff satisfaction
  - Physician satisfaction
  - Financial performance
  - Patient satisfaction
  - Quality indicators

Additional assessments completed:

- Facilities: 71
  - One-hour interviews with Senior and middle level leadership: 1,634
  - Two-hour focus group meetings: 540
  - Total participants: 5,567

High performing organizations with low vulnerability had common practices in 5 platform areas:

- Senior & Mid-level leadership effectiveness
- Communication/voice
- Nursing staffing ratios and staffing practices
- Culture/Employee recognition
- Compensation practices

What is your organization doing to prepare?
6 New Year’s Resolutions for Healthcare Organizations

1. Enable more lantern carriers
2. Develop physician leaders
3. Simplify and focus the organization
4. Ensure accountability from the Board to the front line
5. Develop a 5-year workforce plan
6. **Renew efforts to strengthen work environment and reduce vulnerability**

Overview of Today’s Sessions

- **AM Session:**
  - Leadership practices for a healthy work environment
  - Survival of the mid-level clinical leader
  - Coaching clinical leaders
- **PM Session:**
  - Voice
  - Effective staffing practices
  - Culture of empowerment and accountability

Always begin with leadership…

Followers need three basic qualities from leaders: they want direction, they want trust, and they want hope.

--Warren Bennis

Leadership: What’s working

- **Visibility**
  - Visibility of senior leadership is key, however needs to be the “right” visibility:
    - Differing expectations about what visibility means: Do you see us, or do we see you?
    - Desire for more spontaneous dialogue & connection
    - Structured without the appearance of structure
  - Visibility of front line leadership imperative:
    - Scope narrower at front line so more “in the trenches”
    - Mid-level leaders spending less time in meetings, more time managing people and operations
    - “Hands on” but intentional about how and when

Leadership: What’s working

- **Style**
  - Situational but predominantly collaborative/facilitative
  - Micromanagement and autocratic styles used only with cause

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<thead>
<tr>
<th>Style</th>
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<td>Participative</td>
<td>Group</td>
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<tr>
<td>Free Reign</td>
<td>Employees</td>
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Leadership

Employees

Employees

Leader

Employees

Manager

Employees

Employees

Manager

Group

Employees

Manager

Manager
Leadership: What’s working

- Observable leader behaviors align with expressed core values
  - Leaders are highly visible & demonstrate unstructured approachability
  - Follow through is consistent, promoting trust
  - Leaders show “human” side and demonstrate work/life balance
  - Leaders know and call employees by name
  - Balanced messaging regarding finance

- Indoctrination of new leaders includes orientation but relies heavily on coaching, role modeling, assimilation from peer group
- Selection of new leaders is defined and structured
- Mid-level leaders have high morale and strong peer network for problem solving and support
- Management development is ongoing and employs a variety of methods

The Survival of the Frontline Manager: A Crisis in the Making

- More than 75% of hospitals assessed have key front line manager vacancies
- Toughest positions to recruit for: ICU, ED, Pharmacy and Surgical Services managers/directors
- The “time to fill” middle management positions is lengthening
- 6 key issues are driving dissatisfaction, burnout and turnover among frontline managers

#1: Role Issues

- Scope
  - Setting managers up to fail
  - High performers rewarded with more work, poor performers enabled
  - Budget driven decisions
- Sandwich role
- Good soldier vs. insurgent
- Up from the ranks
- Fighting the fire vs. uncovering the cause

#2: “The workload is killing me”

- Uncontrolled bureaucracy:
  - Meetings
  - Paper work
  - Redundant reports
  - Rework caused by ineffective planning
- Lack of real prioritization at the senior leadership level
- Self-imposed powerlessness
- Ineffective management skills
- Pressure to perform
- No think time
#3: Common pitfalls
- Fear of delegation:
  - Loss of stature—they’ll get the credit.
  - Loss of control—they may screw it up.
  - Reluctance to overburden staff—momma management.
- Reluctance to seek help (imposter syndrome).
- Lack of conscious comportment.
- Reluctance to give (and get) constructive feedback.

#4: Development of new & upcoming managers lacking
- Inadequate (or missing altogether) management orientation
- Inadequate (either in amount or type) ongoing management development
- Need for a clear program to build bench strength

#5: Diminished incentives
- 24/7 on-call responsibility
- Back up for staffing holes
- Narrowing gap between staff and manager pay
- Nobody likes me

#6: Lone wolf syndrome
- Isolation, especially in ED, OR, Women’s Center management roles
- Format of typical management meetings is information-giving vs. problem solving, dialogue
- Networking, team building, retreats seen as “frivolous,” expendable costs

Conclusion: These issues are leading to burnout and turnover among mid level managers, just at a time when the healthcare industry needs leadership more than ever before.

Best practices to improve the retention and engagement of front line managers
Attributes of successful leaders in “hard-to-fill” specialty management positions

- Strong experience in specialty area
- Able and willing to “jump in” when needed and does so—but selectively, with intention
- Easily moves between suit and scrubs
- Strong in approach, confident, mature
- Deals effectively with physician issues, and has consistent administrative backing
- Firm, consistent management of scheduling, HR policies

Best Practice #1: Establish a leadership prototype

- Describe the desired leadership practice in concrete terms
  - Values
  - Practice standards
  - Performance expectations
  - Competencies
  - Describe leadership style

Apply the leadership prototype

- Hire to the prototype
- Hold managers accountable to the prototype
- Develop individual development plans that are in sync with the prototype

Best Practice #2: Assess/adapt the role of the nurse manager

- Start with scope: trend toward narrower scope
- Assure managers are closer to operations
- Explore new unit leadership models (CNM/Physician; CNM/CNS)
- Clearly articulate the manager, coordinator and charge nurse roles

Changing role of the charge nurse

- Ensure CNs have authority with responsibility
- Operations-focused
- Management responsibilities
- Outside of staffing plan
- CN criteria:
  - Demonstrated clinical competence
  - Informal leader
  - Positive attitude
  - Strong organizational and coaching skills
  - Team player

Best Practice #3: Achieve appropriate workloads

- Senior leadership must effectively set organizational priorities and improve planning to influence the cascade of work
- Conduct annual, facility-wide audit of meetings; ruthlessly eliminate redundancy, non-value work
  - Purpose
  - Facilitation
  - Membership
- Time management skills, begin with getting organized
- Make sure no one is on call 24/7
**Best Practice #4: Develop new AND current managers**
- The investment is worth it
- Include leadership and management
- Integrate basic core education with experiential learning
- Utilize different methods for ongoing development:
  - Structured education—theory, best practice
  - Practical application methods
  - Just-in-time coaching/feedback/mentoring
  - Expectation for self-directed, continuous learning

**Best Practice #5: Build Bench Strength**
- Identify and begin “tapping” those with raw potential, provide early leadership experiences while in staff role
- Provide structured pathway, concrete opportunities (planned and spontaneous), including management fundamentals and experiential learning
- Create a multi-track professional ladder; include a management track
- Tap nurses with raw potential; provide early leadership experiences while in the staff role
- Increase leadership opportunities for CNs, along with support, mentoring
- Restore prestige in the job by putting back some of the perks

**Major Differences Between Clinicians and Managers**

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<thead>
<tr>
<th>CLINICIANS</th>
<th>MANAGERS</th>
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<tbody>
<tr>
<td>Doers</td>
<td>Planners, designers</td>
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<td>1:1 interactions</td>
<td>Group interactions</td>
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<tr>
<td>Reactive approach</td>
<td>Proactive approach</td>
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<tr>
<td>Require immediate gratification</td>
<td>Accept delayed gratification</td>
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<tr>
<td>Deciders</td>
<td>Delegators</td>
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<tr>
<td>Value autonomy</td>
<td>Value collaboration</td>
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<tr>
<td>Independent</td>
<td>Participative</td>
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<tr>
<td>Patient advocate</td>
<td>Organization advocate</td>
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**Laser Coaching**
- Intense, 1-hr sessions produce focused actions for immediate application
- Assessment tools used to hone in on specific areas
- Single, complete “ala carte” sessions

**Performance Feedback Tools**
- Myers Briggs Type Indicator
- Thomas Kilmann Conflict Mode Inventory
- 360 degree feedback interviews
**Group Coaching**
- Affinity group of leaders taps combined energy, experience and wisdom of individuals
- Focus is on new role, common skills needed to succeed in role
- Sessions combine teaching & coaching

**Best Practice #6: Strengthen Leadership Team Performance**
- Create opportunities to network, problem solve, dialogue, build relationships
- Strengthen the performance of the team through **team** skill building:
  - Team decision making.
  - Conflict management.
  - Team communications.
  - Problem solving.
  - Planning.

**Best Practice #7: Work Life Balance**
- Write down your personal vision statement & core values
- Carve out “think time”
- Always have a back-up plan
- Become comfortable with being uncomfortable
- Reframe how you think about your situation: change your self-talk
- Get organized
- Be more intentional about how you spend your personal time
- Care for yourself physically

**Take Home Resolutions:**
- Short term actions I resolve to do immediately
- Longer-term actions I resolve to begin working toward

**PM Session**
- Communication/Voice
- Staffing/Workload
- Culture of empowerment & accountability

**What is Employee “Voice?”**
“Do employees in this organization have a voice?”

-- Senior Leadership: “Absolutely”
-- Employees (& many middle mgrs): “Not really”

Senior Management feels employees have a “voice” because:

- There are opportunities for staff input
- They hear complaints, regularly
- They have responded to complaints by “fixing,” “teaching” or both

What is “Voice?”

- Sense of having impact, not just input
- “Empowerment” is legitimate—i.e., there is clarity re: where the decision is being made and the parameters for input are known
- Sense of having some control over issues important to employees, not just issues chosen by management
- Sense of having the ability to communicate and contribute without fear of reprisal

Employee voice depends on leadership voice

“Remember daughter, never grow a wishbone where your backbone ought to be.”

Behaviors observed in cultures where voice is not supported

- Good soldier behavior
- More information shared in hallway meetings or in meetings after the meeting
- Desire to be ‘team players’ overrides willingness to engage in debate, analysis and critical thinking
- People go along to get along: Group think
- Fear of retribution is stated & demonstrated
- Stronger leaders convey decisions as “done deals,” thereby squelching debate

Employee Voice: Essential Factors for a Culture to Support Voice

- Leadership style and communication behaviors support voice
- Mechanisms are in place for employees to raise issues
- HR is perceived to be employee advocate
- Middle management perceived to be effective
- Personal comfort with voice
“Nothing can prevent you from learning the truth so much as the belief that you already know it.”

--Jon Hart

Typical “retribution” for upward communication:
- Emotional, defensive reactions (typically non-verbal)
- Verbal statements to shut down communication
- Social shunning
- Actions to sideline or discipline outspoken employees

Communication/Voice: What’s Working
- Positive message strategy: Proud, positive, repetitive messages of organizational confidence expressed
- Leaders create every day opportunities for face-to-face interaction to promote communication and dialogue
  - Scheduled
  - Appears spontaneous

Leaders markedly increase communication (all methods) during times of change or strife
- Leaders spend time together planning & rehearsing communications during difficult times to ensure consistent messages

Dialogue for problem solving and relationship building is a core part of every routine meeting; information giving is handled via email or written communication
- Some type of employee/management advisory council exists in majority of organizations studied

5 Reasons to institute employee advisory groups:
1. Build employees’ sense that their concerns are being heard by senior leadership
2. Increase leaders’ awareness/sensitivity to specific employee concerns
3. Increase employee participation in decision-making and problem-solving, thereby increasing engagement & buy-in
4. Reduce employees’ sense of being victimized by difficult changes; build support for changes
5. Counter potential union accusations that employees have no voice, are at the mercy of Administration and need union protection
Why do EAGs fail?

- Lack of commitment & buy in at the top
- Un-met expectations: decision making vs. advisory role
- Empowerment perceived to be a charade
- Input confined to issues employees perceive to be unimportant; “important” topics are avoided

“I may disagree with what you have to say, but I shall defend to the death your right to say it.”

--Voltaire, 1700’s

PM Session

- Communication/Voice
- Staffing/Workload
- Culture of empowerment & accountability

The realities of the staffing issue

1. The nursing shortage looms on the horizon: major supply/demand imbalance
2. Organizational trends are exacerbating the staffing/workload issue.
3. A growing body of research shows a strong relationship between nurse staffing levels and patient (and workforce) outcomes.

Organizational trends exacerbating the staffing issue

- Increasing work intensity
  - Rising patient acuity
  - Increased use of technology
  - Shortened LOS
- Continued/ increased pressure to reduce costs
- Cuts/shortages in ancillary/support service areas
- At-risk middle management
- Productivity factors:
  - Green and gray staff
  - Reliance on agency staff
  - Reliance on floating

More research is linking staffing with outcomes
Nurse staffing and quality care

Study by Linda Aiken & colleagues (2002):
- >10,000 nurses in 168 PA hospitals surveyed
- Conclusions:
  - For each additional pt. assigned to an RN above a 4-pt threshold, a 7% increase in mortality & failure to rescue occurred (impact: increasing ratio from 1:4 to 1:8 in PA would result in 1,000 additional patient deaths yr; in CA 2,000 additional patient deaths per year)
  - For each additional pt. above the 4-pt threshold, a 15% increase in RN job dissatisfaction & a 23% increase in risk of RN burnout occurred.

Healthcare Advisory Board, "State Regulation of Nurse-to-Patient Ratios" Nursing Executive Center Issue Brief, 2004

What the research also says....

Aiken’s research demonstrates the practice environment has an independent influence on nurse/pt outcomes (i.e., hospitals w/fewer nurses can achieve excellent outcomes by creating a positive practice environment)

Suggested actions to more effectively manage the staffing issue

Manage the staffing issue

Choose your words carefully:
- "Fix" vs. "manage"
- "Staffing" vs. "scheduling"

- Staff/staffing denotes the workforce or employees who are recruited and hired to provide a service or perform a specific job
- Scheduling denotes the setting up, planning, preparing a calendar to designate which employees will work when.

- Avoid the common management responses:
  - Stopping the dialogue
  - Denying the issue
  - Shifting the blame
- Expect the common staff responses:
  - Powerlessness
  - Shifting responsibility: someone else should fix the problem
  - Tunnel vision: it's all about numbers
- Key objective: Move the dialogue beyond the numbers
Staffing Practices:
What’s working...
- Organizations consistently meet the widely accepted norms for nurse/patient ratios
- Some organizations are extremely lean in “overhead positions” in order to meet clinical staffing needs
- Consistently high occupancy rates help to stabilize staffing
- Support staff enriched to help with throughput, improving financial impact
- Charge Nurses are routinely out of the staffing pattern & responsible for operations management

PM Session
- Communication/Voice
- Staffing/Workload
- Culture of empowerment & accountability

What is empowerment, really?
1. Some organizations promote empowerment, then try to get results by command and control leadership styles
2. Some organizations promote empowerment, neglect to define parameters or expectations and ignore accountability

“Real” empowerment happens with clear goals, agreed-upon guidelines, relevant feedback and supportive structures and systems
The Athenian Model of Empowered Citizens
- Alignment with a shared higher purpose
- Shared sense of ownership in Hospital’s destiny
- Participatory structures (teams)
- Belief and trust in the individual is balanced with service to the community
- Mission, culture, values are expressed in day-to-day practices by every “citizen”
- Equal access to participation
- Focus is on outcomes over process
- “Citizens” demonstrate cherished values of personal behavior

Cherished values of personal behavior:
- Individuals accept personal responsibility and accountability
- Attitude and behaviors are always an individual’s choice
- Every citizen has an obligation to challenge processes or behaviors that threaten the community

The best way to inspire people to superior performance is to convince them by everything you do and by your everyday attitude that you are wholeheartedly supporting them.

—Harold S. Greeneen, Former Chairman of ITT

The empowered organization:

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<th>AREA</th>
<th>OLD INDUSTRIAL MODEL</th>
<th>EMPOWERMENT MODEL</th>
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<tbody>
<tr>
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<td>A formal position</td>
<td>An individual choice</td>
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<td>Management</td>
<td>Control things &amp; people</td>
<td>Control things, empower people</td>
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<tr>
<td>Structure</td>
<td>Hierarchical, bureaucratic</td>
<td>Flatter, flexible, fewer boundaries</td>
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<tr>
<td>Motivation</td>
<td>External, carrot-and-sticking</td>
<td>Internal—whole person, personal choice</td>
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<td>Communication</td>
<td>Primarily top-down</td>
<td>Open: up/down/side</td>
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<tr>
<td>Culture</td>
<td>Social rules/mores</td>
<td>Principle centered values; individual responsibility</td>
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Culture and Employee Recognition: What’s working
- Positive team relations & peer pressure
- Positive message strategy, building organizational pride
- Respect for personal lives demonstrated:
  - schedules and time off requests
  - leaders model work/life balance
- Medical staff behavior positive/managed

Culture/Employee Recognition: What’s working
- Leaders consistently express & demonstrate appreciation for staff
- High accountability without fear, punishment or blame
- Regular, frequent activities planned to promote community, spirit, fun & a sense of “belonging”
A key challenge for healthcare leaders: *Lead change and create a culture of accountability without raising vulnerability.*

Accountability is different from blame, in that it assumes no right or wrong.

Accountability is the ability to:
- Acknowledge the truth about the results that have been created
- Accept ownership of the choices that drove the results
- Declare a path forward consisting of the choices that will be made in the future

Essential components of good accountability
- Expectations and parameters that are clearly communicated and understood
- Support and encouragement for staff trying to change their skills or behaviors
- Training on new skills or behaviors
- Attention and prompt feedback
- Consistent and prompt actions taken when standards not met

The impact of doing nothing
- Employees lose respect for a supervisor who ignores problems
- Some may assume the negative behavior is acceptable and try it
- Departmental productivity suffers
- Morale suffers, vulnerability rises
- When confrontation finally occurs, management must defend earlier decisions to avoid and current decision to confront

Questions, comments, discussion?
The time to prepare is now…..

*If not now, when?*

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