

Memorial Central Hospital



Employee Focus Group Report

Presented: February 21, 2008

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Background & Methodology:

In January 2008, employees of the recently acquired Memorial Central Hospital (MCH) participated in a series of focus groups moderated by The Crossroads Group, Inc¹. These focus group sessions were intended to probe employee perceptions at the one year anniversary of the December 2006 acquisition of Urban Hospital System (Urban Network) by University Health System (UHS). Randomly selected employees were assigned to and participated in one of seventeen (17) focus groups representing various shifts, departments, and specialties. Most focus groups were functionally or departmentally homogenous to facilitate focused discussion and to gain insight into issues relevant to individual areas. The majority of employee participants were former Urban Hospital System employees. Job categories represented included administrative/officials, clinical professionals (nursing and allied health), non-clinical professionals, para-professionals, technical, clerical, and service maintenance for all possible shifts.

To kick off the project, an employee participation letter was drafted in collaboration with senior Human Resources leadership. This letter is presented for reference in Appendix A. Key points communicated in the letter include the purpose of the focus groups, the confidentiality of individual responses, as well as scheduling and room set up information. To avert any possible bias (or perception of bias) in the employee selection process, invited participants were selected by a random number selection process provided by The Crossroads Group. Twenty participants were then invited for participation in each of the focus groups via a letter hand-delivered by MCH Human Resources.

Participants arrived fifteen minutes early to each session and all sessions ended punctually. At the commencement of each group, ground rules were communicated to all participants. These included a confidentiality promise from the Crossroads Group regarding individual identities, a request that participants not divulge information shared by their peers, a demonstration of mutual respect at all times, and a willingness to accept divergence of opinion. Participants were generally very appreciative of the opportunity to share their concerns and opinions openly. Most of the focus groups were attended by employees with many years of experience working in the facility².

Focus group sessions lasted one hour each and were conducted on January 7th, 11th, 18th, and 23rd, 2008. A total of 112 employees participated in the focus groups, representing almost 15% of the total eligible MCH employee population. Mark Robledo, the President and founder of The Crossroads Group, was the moderator for all seventeen focus group sessions³. A *Discussion Guide* was developed to guide the flow of discussion. Discussion questions were open-ended, allowing participating employees to respond with top-of-mind feedback reflecting issues and concerns most pertinent to them. Primary topics of discussion included the initial change management process, drivers of turnover, employee satisfaction and engagement, and future loyalty intentions. These and other topics were probed for root cause perceptions as well as constructive and actionable feedback.

¹ *The Crossroads Group is an organizational development firm which has provided focus group facilitation services for UHS in 2006 and 2007 and specializes in team facilitation, as well as custom employee and patient survey applications.*

² *One participant stated that she had been working at the facility for forty-two years. Many other had two or three decades or work experience.*

³ *Mr. Robledo is a healthcare team facilitation specialist, having served University Health System on numerous occasions and has facilitated thousands of team hours in process improvement, focus group, and strategic planning settings. Mr. Robledo also specializes in patient satisfaction reporting and improvement for hospitals and clinics, process improvement, and employee and physician survey administration and reporting.*

Introduction:

The general employee sentiment across and within groups varied widely, with some employees demonstrating contentment and satisfaction, while others expressed high levels of dissatisfaction. The following pages present the key findings and overall themes derived from the combined focus group sessions, with representative verbatim comments included. The information contained in this report is intended to accurately reflect the current situation at MCH. Information is presented in a manner which is intended to be accurate, detailed, fair, and objective while supporting a targeted and effective follow-up response which will help improve employee satisfaction, effectiveness, and future retention. Recommendations are also included in the latter section of this report.

The following report summarizes the most consistently recurring themes identified across one-hour focus group sessions. An effort was made to capture a high level of detail related to root causes, which is reflected in this report. Information presented represents current employee perceptions, which *may or may not* be accurate. Some of the information which employees shared seems to be based on what these employees have heard from other employees, rather than on factual evidence or formal communication.

While employees voiced many concerns, they also often expressed recognition that a transition of the magnitude and complexity of the UHS acquisition “takes time”. Many of the challenges faced are commonly encountered when integrating two very distinct cultures and processes. Some of the perceptions that exist have their roots in poor communication and handling of employee concerns during the pre-UHS period. Employees felt somewhat betrayed and abandoned by their former employer, and entered into their relationship with UHS with very *high expectations* and hope for a brighter future. In many ways, these expectations have not been realized. Many employees are disappointed with administration, various systems and processes, and the union which represents them⁴.

Employees often compared their current situation either to their past under Urban Network *or* to the situation of their peers at “main campus”. Generally speaking, as it relates to tangible *extrinsic* factors and motivators of satisfaction, employees tend to compare themselves to University Main campus. As it relates to *intrinsic* rewards and cultural comparisons, employees tend to compare themselves more often to their former situation at Urban Hospital System.

Employee feedback is summarized in the following topically arranged pages. Topic areas represent major top-of-mind themes. Specific verbatim comments (italicized and indented) are also included to supplement presented information.

From Urban Hospital to Memorial Central-The Transition Phase:

Employees are widely cognizant of some of the positive aspects of their transition from Urban Network to UHS. Employees are glad to have ended the period of uncertainty associated with the pre-acquisition time period and even the one year post-acquisition probationary period. Many employees were fearful for their jobs due to the low census levels during the latter stages of their employment with Urban Network. Employees also stated that it was very evident during the latter stages of Urban Network’s ownership that administrators were unwilling to invest in the hospital.

⁴ *Many employees are disappointed with their union and the role the unions have played in representing them as employees. Several employees stated that the union membership was not worth the fees deducted from their paychecks.*

During the first year of UHS, many investments were made to enhance the facility and upgrade the grounds, for which employees are very grateful.

Employees are generally very positive about the benefits and pension package offered to them as new UHS employees. This was seen as an almost universally positive aspect of their employment. Employees are also positive about the increase in patient volume which has occurred since the acquisition, provided that they are afforded the materials, equipment, and staffing resources which they feel are needed to meet the demands being placed upon them.

“It seems like our volume has doubled or tripled since we became Memorial Central.”

While grateful for the opportunity to retain their long-term employment at the facility, employees also shared regarding perceptions which appear to have established a *negative first impression* for some. Several employees expressed the feeling that new administrators arrived with an “air of superiority”, which created distance between employees and their new leadership team. Some employees also stated that they felt like they were “being herded like cattle” through UHS processes, with little sensitivity shown to them as individuals. Others described the process for adopting them into the UHS family as somewhat “harsh and heavy handed” or even “militant”. These and other negative initial impressions sowed the seeds for current discontent and perceptions that the hospital has not been fully adopted and integrated into the UHS family. Many also felt very insecure as it relates to their future with UHS due to the probationary period. This had a particularly detrimental effect on some of the longer-term veteran employees.

“The physicals and drug tests were very stressful and unpleasant.”

“We felt like cattle going through to the slaughter house.”

“Some main campus employees do not even respond to a ‘bello’ in the hallways.”

While understanding the loss of seniority due to a change in the parent organization, some employees were disappointed that they were beginning as new relationship as probationary employees. Some considered the probationary status to be an affront to the many years of loyalty which they had demonstrated, albeit to a different employers. Some employees also felt that their pay status assignment did not reflect their years of service or their potential for earnings had they independently applied as an employee for the first time within the UHS system.

“We were not sure for a long time if they (UHS) were going to keep us (Urban employees)...we were in limbo.”

“We’re still not paid at the level that we would be paid had we gone to the main campus and applied for a job.”

Staffing is almost a universal concern at MCH. Some employees stated that there were early initial improvements to staffing levels (leading to high expectations), but these were quickly dissipated in the months that followed when departing employees were not replaced. Some employees also indicated that they were under the impression that UHS began “tightening” financially by cutting staffing levels after a only a few short months.

“When they (UHS) first came, everything was great with staffing...but after a little while everything went back to the same old thing.”

Other determinants of job satisfaction during the transition period were also elaborated on during the focus group sessions. For example, many employees indicated that they would have appreciated a much greater level of bi-directional communication between themselves and administration during the early months. Employees also shared that while benefits packages were seen as enhanced, some individuals were upset that their employee status or their insurance benefits were either incorrect or missing information due to apparent processing errors. Subsequent attempts to correct these errors were met by lengthy delays, generating very high levels of dissatisfaction and anxiety, and causing some individuals to leave the organization. Several employee focus group participants also expressed concern that they had pending errors which had *still* not been corrected or resolved.

“I was without insurance for months.”

“For people with dependents, the cost of insurance tripled or quadrupled...which is why many of them left.”

“When I was hired, I was supposed to receive a certain pay rate but received another. A year later, this has not been fixed.”

Being very sensitive to the first impressions of their new owner, some employees shared that they were hurt by some of the language used by administrators to describe Urban Hospital System . For example, employees referenced a still-remembered statement that was made during the transition period that “Urban was so poor in quality that local residents would not have taken their dogs there”. Given the number of years these employees had worked at Urban Hospital System , they found this and other negative statements regarding the Urban facility to be hurtful and threatening to their job security. These statements rapidly circulated through “the grapevine”, contributing to the perception that UHS leadership was not pleased with the former Urban Hospital System employees.

“UHS perceives that Urban was ‘a mess’, so they don’t listen to us.”

“I think that there is a lack of respect shown towards us.”

“I felt like probationary period was a ‘weed-out’ period.”

Most employees who participated in the focus groups recognize that the transition of the hospital is still in progress and that “things take time”, particularly for such a large entity. With the exception of a few individual matters which were unresolved, the general tone was one of patient expectation of better times as they look forward to the day when they can feel completely adopted into the UHS family. Employees also told us that they are looking forward to seeing some of the stated promises made to them (regarding equipment and IT resources) realized.

One of the biggest challenges expressed by employees involves the adjustment to the new forms and documentation which they need to use as part of the UHS system. While understanding regarding the required utilization of UHS documentation, in some instances employees would like to receive greater training on *how* to properly complete documentation. Several employees would like to be able to share regarding how to adapt some aspects of documentation to their hospital. These employees suggested a review of certain documentation to ensure an appropriate “fit” for MCH, as

certain aspects of the new UHS documentation do not pertain to MCH and create additional paperwork or delays.

“Process used to work a lot faster under Urban. We have a severe lack of support...processes are disorganized.”

“I sent several employees to an Oncology certification and it took me six months to get the paperwork completed.”

“The doctors need education regarding the coding process.”

Policy decisions affecting employees often do not reach them. Quite often during focus groups, we heard employees say “I did not know that” regarding basic policy information. A few times, employees within the focus groups (particularly UHS transfers) would inform their peers regarding information that they were not aware of. According to some employees, meeting requests also often arrived “last minute” causing difficulty managing their schedules.

“If there is a change in policy, we learn about it via word-of-mouth.”

Compensation & Benefits:

Compensation and benefits was usually one of the first top-of-mind topics brought forth by employees. Many employees are quite satisfied with their current earnings as compared to when they worked for Urban Network, particularly those in the lower ranking positions. However, opinions varied on this topic. The issue was usually not whether earnings had increased (usually the case), rather conversation centered more on whether earnings had increased *to the degree expected* or *on par* with their peers at main campus.

“Considering our options, UHS was a good thing for us.”

“The benefits package is better now.”

“I got a nice little raise to bring me up when UHS came.”

There is a widely shared perception that working at UHS main campus pays more than working at MCH, for comparable positions and experience levels. Apparently, employees have voiced this concern in the past and been told that the differences are attributable to the fact that the main campus is a different type of facility. Employees in-turn counter that MCH is a more challenging place to work than the main campus given that they enjoy fewer support resources (than at main), have reduced staffing levels (unfilled positions), and are experiencing an ever-increasing volume of high acuity patients. If anything, according to employees, they should be compensated at the same level or higher than their main campus peers.

“Our pay scale is way less than at Main...and we do it all here.”

“I transferred an employee here from main. Despite a demotion, this employee still earns more than the persons he reports to here.”

One of the primary sources of dissatisfaction relates to payment categories and classifications. We encountered numerous instances where employees stated that they are misclassified, despite numerous efforts on their part to correct. Several employees stated that they still did not understand how to interpret pay-stub information. Employees who are “maxed” into step 12 are dissatisfied and do not understand how they could have reached their maximum payment classification within such a short period of time.

“We don’t grasp the step system.”

“Why am I at the maximum step already? I just started with UHS.”

“Payroll rules are wrong and often filed incorrectly.”

Staffing Levels and Agency Utilization:

In addition to compensation comparisons with University main, inadequate staffing levels is one of the most universal and prevalent concerns. Employees appreciate the guaranteed hours, as Urban Network would send staff home when census levels were below a certain level. However, employees would like more access to overtime. Also, the perception exists that the staff at the main campus have things “easier” due to the higher levels of specialized auxiliary support, full staffing levels, and better nurse and tech patient ratios.

“Guaranteed hours are great, we used to have to flex staffing a lot.”

“In ICU we need PCTs, auxiliary staff and secretarial help.”

“We’ve been cross-trained to wear a lot of hats. Main campus staff are not.”

Further complicating matters is the fact that some MCH employees resent that fact that their supervisory staff are not willing or able to offer assistance to front-line staff when staffing levels are short and employees are burdened. Employees are aware that they are not supposed to stay late or work “off the clock”, but they find themselves torn between a desire to finish the day’s work (by staying late off the clock) or leaving things undone and facing the repercussions the next day.

“We stay off the clock to finish all the work we have and miss lunch on a regular basis. If not, the work doesn’t get done and we are disciplined.”

“We need a supervisor in Medical Records who can roll up their sleeves and work.”

“I wish our Supervisors were more present to provide coaching and problem solving and help us do actual work. Our Supervisors don’t even know how to do what we do.”

The prevalent use of agency staff is highly unpopular among employees. Agency staff and UHS floaters are often perceived as being so specialized that they are not able to perform the functions of highly cross-trained employees who have been performing a myriad of activities for years. According to employees, many agency staff are either unwilling or unable to perform necessary tasks, even after valuable time is spent orienting them. Employees expressed a strong preference for utilizing internal staff overtime hours instead of using agency staff or floaters. There is resentment due to the fact that this often does not occur. Employees also state that agency staff performance

management is lacking. There is a reluctance to report or discipline poor agency staff performance and that these staff are not being held accountability for maintaining established standards of performance and care.

“Agency staff come and say ‘we don’t do that where we come from.’”

“We keep hearing ‘no overtime, no overtime, no overtime...but why can’t we use our own staff instead of agency?’”

“Many employees are overwhelmed and on ‘shut-down’ mode.”

The perceived root of the staffing problem is the process for recruiting, hiring, and on-boarding employees. Beginning with the posting of open positions, this process is extremely slow and inefficient, often requiring months to fill open positions. As a result, remaining staff are feeling frustrated and in some cases “burnt out”, potentially exacerbating the turnover cycle. Several staff attributed delays in filling positions to a “hiring freeze”, general process inefficiency, or the lack of sign-on bonuses similar to what competing entities are offering.

On-the-Job Materials & Resources:

Feedback shared regarding equipment resources often varied. Some staff are very grateful for upgrades and significant investments made into the hospital infrastructure, while others were frustrated that they had not seen expected improvements in their areas.

“We’re busier than ever and resources have not increased.”

“We thought that when UHS came, they would bring us new equipment. I have yet to see new equipment.”

“Whoever cries the loudest gets the service.”

“When we (clinical areas) do not get what we need, it’s a huge deal.”

Some employees shared that they felt trapped between the strong administrative mandate regarding service excellence, and the inability to meet this objective due to a lack of resources. Compounding this frustration is the fact that employees feel that they have very little voice or say in terms of *how* to improve patient care. Previously shared concerns regarding resources had not yet been resolved.

Of all the equipment needs which were cited, none was more frequently mentioned by employees than wheelchairs. While several employees acknowledged that new wheelchairs had been procured, they also stated that these wheelchairs have quickly vanished. The result is frequent delays as well as frustration for patients and staff.

“Wheelchairs have been ordered but they disappear within days. We have to go from floor to floor looking for these.”

Several other types of equipment resource needs were also specifically referenced. Employees would like to see resource disappearance prevented, and a process in which broken or missing equipment can be quickly repaired or replaced, particularly when doing their job effectively depends on this resource availability.

“The Operating Room is getting more equipment little by little.”

“Our computers, scanners, and printers routinely do not work. I have to beg for I.S. help.”

“I need a chair for my job (physical therapy) to get patients in and out of bed...but there are no functional chairs.”

“The ED vacuum tube system (for lab tests) has been broken for over a month”

“We are lacking stretchers for the patients.”

“If my printer breaks, we won’t replace it.”

“We have pipes which have been leaking forever.”

Some of the concerns expressed by employees involved peripheral areas of the hospital, not specific to their areas of work.

“The cafeteria is too expensive and understaffed. Tables are not clean and the microwave is almost always dirty. Restrooms also need to be cleaned and stocked.”

“Would it be possible to move the morgue to a less visible location?”

“Why did they close the exit gate in the garage? This makes it difficult for us.”

“What happened to our gift-shop? Please put in a real gift shop (for patients and visitors)”

Employee Safety Concerns:

Several employees voiced safety concerns due to either hostile or mentally ill patients, visitors, or local residents. More specifically, some behavioral health employees are concerned with high patient acuity, the physical arrangement of patients in the rooms, the lack of security in the unit, and the high utilization of female (rather than male) employees. Other areas where safety concerns were specifically mentioned include the Emergency Department as well as the parking garage. The current contracted security service is considered highly ineffective as either a deterrent or for the resolution of security issues when they arise.

“The security guards we have are not respected by patients at all.”

“We have mostly female staff in Behavioral Health areas. Some of these patients are acute. We need more males.”

“We need a little more security in the multi-level garage.”

The Administrative Relationship:

The perceived relationship between employees and the administrative team is a vital aspect of the employee relationship. Employee focus group participants shared both positive and negative feedback regarding this relationship.

While MCH employees did not speak negatively of the administrative team per se, they did share more indirect concerns related to communication. Specifically, many employees feel that communication from the top down is at times too short and abrupt. They do not feel that administrators always have “an ear” to listen to their concerns and respond accordingly. Many employees are also not fully satisfied with the quality of the responses which they have received from administrators when they have brought forth concerns and/or questions, at their own perceived risk (at times).

While examples of immediate and short-term emergent matters being handled very effectively by the Senior Administrator were cited, there is a general dissatisfaction regarding the degree to which *chronic* long-term issues (such as staffing or perceived inequalities with main campus) are being addressed. Employees are particularly frustrated when they perceive that they are not receiving help in the areas which affect their day-to-day work environment or ability to provide care.

While receptive to the Town Hall meeting concept, many employees do not feel that it is worthwhile to truly express themselves at these meetings. Most employees feel that these meetings are an opportunity to hear administration but not to provide any significant feedback or questioning. Other employees would like to see these meetings offered at different times of the day, to better accommodate their schedules. This is particularly true of night shift, who feel that it is difficult to attend early morning meetings after a twelve hour night shift.

“It’s not for us to express concerns in Town Hall meetings. It’s for us to listen. A guy from Radiology expressed himself once and is no longer here.”

“The Senior team needs to show more humility and listen to those who have been here for a long time.”

“We do not receive full explanations to concerns.”

Employees also perceive that MCH administrators are not always able to provide solutions to issues because their hands are tied as well. There is a common perception that the answers to questions or concerns reside beyond the walls of MCH facility at the main campus, and communication linkages between MCH administrators and the main campus are not always effective.

In general, employees would like to see an administrative team that is more visibly engaged with the various areas of the hospital and more accessible when needed. They would like to see administrators walking through their departments and demonstrating genuine receptivity towards questions or concerns in a manner which is perceived by employees to be open and non-defensive. Most importantly, employees would like to see faster results and follow-through beyond what are perceived as the standard scripted answers.

“When we share concerns, we’re given scripted responses like ‘this is a community hospital’ or ‘that’s just the way it is.’”

“Be open to new and different perspectives. Would you provide us with a response other than ‘that’s just the way it is...’?”

“They (administrators) seem very removed and distant. We are told what the rule or policy is but then left to figure it out on our own.”

“Some leaders are visible...others are invisible.”

Employees also stated that in some respects administrators were bringing more accountability to the hospital. This was most evident through the increased emphasis on clocking in on time (and the consequences associated with not doing so) and completing proper documentation. As it relates to the clocking in on time, some employees found this to be petty and difficult to consistently achieve over time (due to traffic and other potential delays) while others found this to be a necessary aspect of accountability.

“Administration is much more focused on the clock than in the past.”

“It seems that administrators often focus on the little things rather than the major issues.”

The Human Resources Department is considered the gateway to the resolution of a number of important compensation and staffing issues which are very critical to employee satisfaction. Dissatisfaction with staffing levels and quality, compensation, and problem resolution processes, (described previously) is often blamed on the Human Resources Department. The Human Resources department at MCH is perceived as being unable to resolve employee concerns. Many employees perceive this issue to be rooted in a process “disconnect” between MCH Human Resources and the main campus. In spite of this general sentiment, the current HR Director did receive praise from some employees for her personal efforts to address some individual employee concerns.

“Don’t go to HR...it is futile. They are a lame duck”

“I was full time, then per-diem. I want to have a part time position and the paperwork has been signed off but it’s been at main campus for six months.”

Work Environment/Culture/Teamwork:

At the core of dissatisfaction for many employees is a difficulty adapting to the significant cultural change associated with the transition from a private entity to a public one. Many employees stated that they had been through other private-sector hospital transitions in the past, but that none had ever been nearly as profound as the one that they had experienced with UHS. The most frequent comment made is that the hospital had lost its “warm family” feel. This is perceived to be a result of employee attrition (many long-time veterans leaving), new UHS staff, and the imposition of the UHS culture upon the organization.

“When we were Urban, we worked as a team, like a family. This culture has been lost.”

Several employees also mentioned that not all employees are on the same page when it comes to work ethic and patient care. Employees who considered themselves to be ‘high performing’ claim to be frustrated by the current hiring standards (particularly for nursing), a performance management system which does not reward “above-and-beyond” performance, and a high utilization of inferior (in terms of attitude and capability) agency staff. According to employees, *consistency* is lacking,

particularly as it relates to patient care. As mentioned previously, one solution strongly advocated by most employees to improve staff performance is to allow for overtime opportunities to be offered within their own ranks prior to bringing in poorly suited outside agency staff. As alluded to earlier, enhanced performance management and accountability was also recommended.

“Managers should hold their staff accountable for a higher standard of performance.”

Most employees seem to work well with one another, particularly among the “old guard” of former Urban Network employees, they just feel that they need more help. However, some friction apparently exists between nurses, CNAs, and technicians with many nurses apparently unwilling to do the more menial tasks (according to some techs) and techs providing nurses with help only upon request and “with attitude” (according to some nurses).

“Some of the techs act as if they are doing us (nurses) a favor when we request assistance.”

We also observed and heard about a slight divide between some of the former Urban Network employees and the newer University employees. This was evidenced by the different perspectives offered by both groups during focus group sessions. At times, representatives from both of these groups would also sit on opposite sides of the room. In general, employees who are familiar with the UHS system (through working at main campus) appear more comfortable and content with their current situation, while former Urban Network employees are generally less content and were more expressive in their sharing of concerns.

“There’s a huge divide between former Urban employees and new UHS employees.”

Employee Performance Management:

Performance management is an area in which there was a wide divergence of opinion, often largely dependent on the behaviors of the individual manager or supervisor to whom the employee is reporting. Generally speaking, there is a hunger among employees for more *intrinsic* recognition and positive feedback. Many employees perceive that they only receive feedback when performance falls short of expectations (which are sometimes not defined in advance), and there is rarely any positive feedback for work well done or extra effort. Reward and recognition is considered to be a thing of the past.

“We are not shown the right way, then we are reprimanded for not doing things right.”

“The only feedback we ever receive is negative feedback.”

“Good performance is rewarded with more work, more blame (when things go wrong), and more pressure.”

“Nobody every compliments the staff...there is a major lack of positive feedback.”

Staff who do perform “above and beyond” the call of duty feel that they are sometimes taken advantage of by less motivated peers. They also find themselves assuming increasing responsibility levels but are frustrated by the fact that their title and/or compensation does not increase commensurate with the increase in scope and/or responsibility. These employees shared that they have little to show for their increased responsibility other than increased workloads and a greater share of the blame should things go wrong.

“Some of us have additional responsibilities and are on-call into the evening. Wouldn’t it be fair to provide compensation for this?”

Employees are generally feeling more optimistic about job security following the initial one year probationary period. However, some employees also feel pressure from the strong emphasis on patient satisfaction. They feel that one patient complaint can easily lead to an unfair termination. A few employees feel that the treatment that they are experiencing from superiors is reflective of the fact that they may not be truly wanted by the organization.

“Are they trying to make us want to leave?”

Some employees commented on the heavy-handed manner in which they are “coached”, often publicly. According to employees, some supervisors and managers routinely embarrass staff in front of their peers (or other shifts) when expectations are not met. While behaviors may change in the short-run, this generates a very high level of resentment among these employees, particularly when they feel that they were not told in advance of the expectation.

“If you are going to give us (3pm-11pm shift) a tongue lashing, please do not do it in front of the first shift.”

Patient Satisfaction/Service Excellence:

As alluded to in the previous pages, patient care is an area of concern for many employees. Employees are clearly receiving the message from senior leadership that patient care and service excellence are core strategic objectives for the hospital. However, some employees are concerned that *employee* satisfaction is not being given equal weighting and that this area must be addressed as well to ensure quality and patient satisfaction.

“Patients are not going to want to come (to MCH) if we aren’t happy.”

Several focus group participants felt that they have needs and concerns which directly impact patient care, and yet are not being addressed. They thus feel handcuffed and pressured to deliver a level of care which cannot be provided due to either insufficient communication or resource shortages.

When asked if they would recommend MCH to friends or loved ones for care, most employees quickly said they would not. Most cited the “inconsistency” in the quality of care as the main reason, feeling that not all caregivers are providing the same quality care. Some employees also mentioned that it is difficult to secure specialist physician care and hard to transfer patients out of the facility, particularly to main campus, when needed.

“I would come here (as a patient) only if I could hand-pick the staff caring for me.”

“Patient care is not of the caliber that we’re used to.”

“RNs need to keep closer watch over their patients.”

“We do not have the specialists that patients need.”

“Some of our staff are heartless.”

Physician behaviors were also cited by some staff as a source of patient dissatisfaction. This primarily results from a lack of visibility with their patients and/or “chart rounding.” In addition, a high percentage of patient admissions travel via the Emergency Department (ED). Inpatient staff informed us that the experience in the ED is often so negative (primarily due to delays) that patients admitted through the ED are often in a “hostile” frame of mind.

Employees also stated that transferring patients to University Main campus is like “pulling teeth”. Some went as far as to say that the physicians practicing medicine at MCH “no longer even try” to transfer patients to main campus, because it has become such a frustratingly difficult endeavor.

“We expected MCH to be a funnel to main campus.”

Departmental or Functional Area Focus Groups:

In addition to the general focus groups consisting of employees from a broad range of different areas, we also facilitated several focus groups consisting of strong representation from particular high turnover departments or job categories. These include groups consisting of the mid-level managers as well as representatives from Admitting, Radiology, Emergency Services, and Telemetry. The feedback from these focus groups is shared in the following pages:

Mid-level Managers:

A successful transition for the experienced mid-level management core (i.e. Administrative Officials) is a key to the successful transition to Memorial Central Hospital. While offering much potential due to their experience, desired loyalty, and impact on their subordinates, challenges remain if UHS is going to successfully integrate this group within the UHS family.

On the positive side, the mid-level management employees cited increased benefits, increased patient volume, more realistic productivity expectations, and not having to flex their staff as a positive aspects of their new relationship with the University Health System. They also cited the enhanced documentation standards (e.g. timeliness and thoroughness) as an initial stressor (for their employees), but one which staff were adapting to. They mentioned that the union was initially used as a negative tool by certain “bullying” employees (who were union savvy), but that as they have become more educated, this situation has greatly improved.

As a group, the change management process has been a difficult one for the managers. A number of these employees have already left MCH, affecting the morale of the remaining group as well as of those reporting to them. While many former Urban Network employees in the hospital are aware of and sympathetic to the concerns of the managers, a minority of employees also expressed gladness that the union has afforded them a greater level of respect and leverage vis-à-vis their managers and that these managers need to “get used to” their new working environment.

The managers exhibited a strong sense of responsibility for handling the needs and concerns of their staff, as one of the primary concerns shared relates to the correct compensation of their employees. Managers as a group are *highly* frustrated by their inability to effectively resolve recurring issues on behalf of their employees. They are also frustrated by the amount of time spent dealing with *recurring* issues and the time that these activities take away from their other responsibilities. Aside from acute

HR process delays, managers would also like for MCH HR to be able to make routine check and pay scale corrections in-house and to have checks printed at MCH rather than at main campus.

“Some permanent staff are being paid per-diem. Some part time staff are still classified as full time.”

“Some employees are not categorized. The PAM form process is a black hole. I am continuously repeating myself with the same things.”

“Please hold main campus accountable for the functions which they are responsible for.”

As with other groups, the hiring process was also cited as a major source of frustration by this group. Delays in hiring are acute, and managers have to essentially conduct service recovery to apologize to new hires that make it through the system. Delays create a poor first impression for these employees, cause delays in paycheck receipt (as start-dates are delayed), and sometimes result in the loss of a heavily recruited and newly hired employee.

While much of this frustration is directed towards the MCH HR department, and the perceived inability to resolve issues within that department, there is a growing perception that the problems are rooted in broader processes related to the integration of MCH Human Resources with main campus.

“Please let our H.R. department do a lot more of the work that we need done.”

“It has taken me 13 months to post a position...my staff are getting tired.”

“I should not have to apologize to our new hires for all of the delays that they have experienced in the process of being hired.”

“I have candidates...I just can't get them in.”

Like their subordinates, managers also mentioned perceived pay inequalities between main campus employees and MCH employees. More than a financial issue, this perception creates the impression among MCH employees that they are *less valued* than their peers at the main campus.

“The staff at main will have higher salaries and then come and talk with our staff about it.”

Another primary source of frustration for the manager group involves a perceived *lack of control* over their daily work activities and schedule. These seasoned managers acknowledge that they expect to be held accountable for their performance and their results, but feel powerless at times to make the decisions which will affect those results. They feel that much of the operational (day-to-day) autonomy they once had as managers (and as a hospital) has been taken away from them and moved off campus. Many routine requests have to be handled by main campus and slip into what is perceived to be a “black hole”. As a result, this impedes their ability to effectively and efficiently manage their employees, vendors, and patient relationships. “Last minute” meeting requests (sometimes involving travel to main campus) made of themselves or their staff also frustrate their planning efforts and contribute towards a feeling of lost control.

“At the end of the day I go home feeling like I am not doing a good job for my employees. What used to be done in ten minutes now takes months.”

“Five minutes before a meeting, they send the whole department...but we have patients to care for”.

“Sometimes the meetings (at main campus) are only 30 minutes, yet I may lose three to four hours of my day in traffic”

This group prefers to be managed *by outcomes*, while having more autonomy with regards to *how* to generate expected results. Some of the perceived reduction in autonomy has created the impression that University main does not trust these employees. These managers would also like to have a greater voice in decisions which directly affect their areas.

“Provide us with more autonomy and more open communication...you will see that we are very capable.”

“We cannot run our departments like we are in charge. I have emergencies and they don’t even answer the phone when I call for help.”

Many of these managers still compare the UHS culture to what they knew for many years as part of Urban. The transient nature of many of the senior leaders under Urban Network caused these managers to run their areas somewhat autonomously, with a high sense of perceived teamwork between each other and their staff.

“If something needed to get done, we all rolled up our sleeves and got it done.”

“They (senior administrators) were here today, and gone tomorrow...we had to run it (department).”

When asked to describe the current culture in their own words, they shared the following:

“Overwhelming, demanding, complicated, bureaucratic, inconsiderate”

“The word ‘mandatory’ is way over-used.”

Title changes are also a source of dissatisfaction for this group of former “Directors”. While roles have not changes, the title change is perceived as a demotion. This hinders their career marketability and ability to seek employment elsewhere, should they transition beyond the University Health System.

“I’ve been a ‘Director’ for many years and now I’m a ‘Manager’.”

While physicians were not included in the focus groups, some of their concerns (according to managers) include frustration with the use of agency staff (and related quality concerns alluded to previously), the credentialing process (which is now off-site and perceived as bureaucratic), and Operating Room supply issues. Regarding the credentialing process, we were told that this process was creating a negative initial impression for physicians, negative word-of-mouth among physicians, and making it more challenging to recruit new physicians. It was also mentioned that physicians are not pleased with some of the new medication formulary changes and “see through” these financially-driven decisions.

The Admitting Department:

A large number of Admitting Department representatives participated in one of the focus groups. This group was very expressive as a whole and had a number of very specific and high-priority concerns. While staff shortage concerns driven by turnover are prevalent throughout the hospital, the admitting department has been affected by one of the highest turnover rates over the past year. Admitting staff stated that they are on the verge of burn out. They also feel that they do not receive enough day-to-day operational help from their supervisors, who are not able and/or willing to “roll up their sleeves” and work when help is needed. As a result, the admitting department perceives that it is virtually impossible to complete “a day’s work” well, given the work load and the short staffing levels. Admitting staff also shared that they often do not receive the information that they need to do their jobs well. These employees are also very hungry for positive recognition from management.

“We are way understaffed for the work we do...we are insurance verifiers, financial counselor, utilization reviewers, bed controllers, transporters, and do a host of other things.”

“We feel like ‘nobodies’ and ‘replaceables’. It would go a long way if you made us feel like valuable members of the team.”

Admitting staff depend on a close working relationship with the Emergency Department staff. However, teamwork between the two areas seems strained. Staff shared that they are on the front-line of an over-crowded Emergency Department waiting area filled with sick and often hostile patients. The perceived support offered by other departments is inadequate. Patients come to the admitting staff to resolve issues and needs which they are not able or trained to address. When help is needed from ED staff, it is often not readily available within the time-frame expected.

“Patients think we are nurses. We get yelled at by them in the waiting area.”

“I saw a girl collapse on the floor with blood. The nurses took their time in attending to this situation, even after we alerted them.”

“No one is available for the patients in the waiting area. The nurses are in hiding and do not respond to help us when there are urgent clinical needs.”

“Patients think that we are an information desk. They also think sometimes that we are the gatekeepers to the doctors and are holding them back”

Admitting staff who work in the Emergency Department described what they perceive to be highly unsafe working conditions in their work area due to the volatility of patients. Security guards described as being “slouched”, taking personal calls, playing video games, and routinely disappearing from their posts. According to staff, security staff are not trained in how to de-escalate situations or provide even minimal levels of customer service or service recovery.

“I am scared. We need armed police. We are too exposed. Security guards are not respected by anyone, we have no protection.”

“Our parent hospital has police at main campus, we need the same here.”

The Emergency Department:

While some aspects of the Emergency Department such as the new Director and cosmetic changes to the department were cited in a positive light, ED staff also shared a number of concerns which are deemed to have driven the recent surge in turnover. The main concern in the ED relates to staffing. According to ED staff, many of the staff who have left have not been replaced. Staff-to-patient ratios are considered to be too high. Much of this dissatisfaction is fueled by comparisons made by staff who have worked at main campus. Like other areas in the hospital, ED staff also spoke negatively about agency staff. The time that ED staff have to invest orienting agency staff is often not worth the perceived return provided by this staff.

“We have heard that Memorial Central Hospital has consideration for the acuity of patients when assignments are made.”

“Even when new employees are hired, we don’t see them for two or three months. Sometimes we lose them due to the delay.”

Like other areas of the hospital, Emergency Department staff expressed dissatisfaction with the fact that their peers at the main campus generally earn more than they do and have more staff resources. As in other areas, those employees who had reached the highest step in their pay scale were particularly dissatisfied by the fact that they could not look forward to future increases.

“I could earn more doing the same thing elsewhere.”

“Someone from main told us that the ED staff there are each are getting a \$2,000 bonus.”

When probed regarding the relatively high levels of turnover last year in the Emergency Department, we were informed that many employees were either released (often “for good reason” according to some employees) or had left due to the salary and/or staffing concerns which were being expressed. One employee was also extremely concerned about the health insurance plan he was enrolled in due to the fact that insurance providers were reduced to two (AvMed and University Plan) and these plans were more restrictive in nature.

Like other areas of the hospital, equipment concerns were mentioned as a source of process inefficiency, delay, and dissatisfaction. Specifically, staff described wasting time searching for blood pressure cuffs, pulse-ox equipment, stretchers, and wheelchairs.

To improve patient flow, some ED nurses said that they would like to see more consistent support provided by the techs. The support from tech to tech is described as “inconsistent” and RNs would like all techs to be “fully trained and on the same page”. ED nurses would also like to receive a more timely response when providing report to inpatient RNs for patients being admitted. According to ED RNs, they often have to attempt to contact the receiving RN “3 or 4 times” before being able to establish contact and give report. On a separate note, it was also mentioned that employees who use the Emergency Department as patients, *demand* special treatment and shorter wait times, putting further pressure on staff, and potentially irritating waiting patients.

The Radiology Department:

The Radiology department has had the highest number of departing employees, with eighteen employees being discharged over the past year⁵. When asked about this attrition rate, many Radiology focus group participants responded that many of these employees had been “fired” during the probationary period. The former director (under Urban Network) was described by a participant as having left “a mess” which had yet to be effectively cleaned up. According to these same employees, conditions in the department are difficult because these departed employees had not as of yet been replaced.

This department also perceives that there is a leadership vacuum which has not been filled by the recently departed manager. Many of the employees (within the focus groups) did not seem to be on the same page with regards to policies, procedures, and/or role expectations. Radiology employees seemed to be seeking direction as to standard operating practices and how they are to do their jobs. Some employees suggested that they often do not learn about expectations until they do something the wrong way and are then reprimanded for it (often in front of others). These employees were also frustrated by the fact that they had not received their employee handbooks (as of focus group date) but were expecting these to be provided to them shortly.

“In Radiology, a lot of long-time employees were fired during the first year. We still have not replaced them.”

“There is no blue-print as to what is expected of us.”

“We are told to check our e-mail for vital information...the problem is that we have not been told how to access our e-mail.”

Many of the same staffing concerns shared by other areas of the hospital were voiced by Radiology staff. Specifically, these staff would like to have a streamlined process for allowing internal department staff to fill staffing needs with overtime staff. When asked what the keys to future retention and engagement are in this department are, the most common responses were related to equipment, pay comparable to main campus, and the filling of staff positions.

As it relates to equipment, these staff were pleased with the recently added ultrasound, echo-cardiogram, MRI, and CT equipment. However, the Flouro 1 room was mentioned as in need of a chest stand and a room which is completely shut down due to a broken chest unit was specifically cited.

From a transcription perspective, it was mentioned that doctors are not listening to the reports available through the dial-in service because “they don’t know how to use this”. Instead, doctors are calling the transcribers and routinely interrupting their work to access this information.

As in other focus groups, the “orphan syndrome” term was used. When probed for more detail, some employees feel that the management style they were experiencing was one of imposing change rather than seeking participation or buy-in from employees in decisions which affect them. Some employees also stated that they have not been visited as a group by anyone from administration.

“Our schedule was imposed on us. Had we been consulted, we would have informed them that staffing hours did not correlate with peak demand times.”

⁵ “Exit Interview Analysis. Separations by Occupational Categories” document provided by MCH HR.

“We do not participate in TownHall meetings because the time of these meetings is during one of our peak times. Can these be offered at another time?”

Staff also expressed frustration with other areas of the hospital, including Human Resources and the Admitting Department. HR is considered insufficiently responsive to needs and upstream admitting processes delay the Radiology schedule. Admitting causes patients to arrive late, poorly informed, and without insurance matters fully resolved, affecting their downstream processes and patient satisfaction.

The Telemetry Floor:

The representatives from the Telemetry floor shared similar concerns, though the tone was less vociferous than some of the other functional areas and departments. The primary concerns expressed related to staffing levels and ratios, inconsistent quality of care delivery, relationships between nurses and techs, and compensation.

Like many other areas of the hospital, Telemetry staff were focused more on their compensation and staffing ratios as compared to University main campus than to Urban Hospital System . On the Telemetry floor, a wide-spread impression exists that nursing ratios are “5 to 1” at main campus, while they are “up to 7 to 1” at MCH. This “inequality” is perceived as unfair and is a major area of concern. These employees also mentioned that these difference are not justified (from their perspective) by the fact that MCH is a community hospital. Employees also described their frustration with how long it takes to post and fill open positions as well as the prevalent use of agency staff.

“I had a great image of UHS...I thought things would improve from Urban.”

“When our parent facility first came, it felt like a school teacher was coming with a ruler in-hand. They have gotten a little better since.”

“The pay is less here than what it is at main campus. Everyone knows this. Also, the nursing ratio is more favorable at main.”

When it comes to culture, comparisons are more frequently made with Urban than with University main. Employees describe a feeling of lost camaraderie and teamwork, which used to be more prevalent.

“Morale is not what it was with Urban but has gotten better recently.”

“We used to have things like Christmas mugs and t-shirts, things felt warmer.”

Nurses also described the increased level of accountability with regards to certain types of documentation. Overall, this was not perceived as highly favorable or unfavorable, just a current reality. Conversely however, some employees described nursing hiring and performance standards which were not up to par with those at other hospitals.

“There is more accountability now with regards to documentation.”

"I would not come here as a patient. The nursing standards are lower than at other facilities."

Surprisingly, some nurses cited job security as a concern, feeling that they might get axed for poor patient satisfaction scores or comments due to the strong recent emphasis in this area by administration.

The Accounting Department:

Though not an area of emphasis, the Accounting Department was specifically mentioned by some employees. The primary concern here involves the inability to print checks at MCH, and the resulting delays associated with processing payments to external vendors and/or physicians. As a result, good long-time vendors are dissatisfied (sometimes placing MCH on a "credit hold"). Possible discounts for timely or early payments are also forfeited. Some employees also stated that physicians have expressed dissatisfaction with payment delay as well.

"I get a lot of calls from angry vendors."

"Our bills are not getting paid timely...many vendors are not happy."

The Lab:

Though not heavily represented in the focus groups, lab personnel also shared some of the concerns which they were experiencing. Like other areas, staffing concerns were prevalent and overall satisfaction in the lab appears low. Lab personnel also discussed equipment concerns as well as the frustration associated with doing "extra tasks" over long periods of time and not being rewarded or compensated accordingly.

"We are short staffed. By the time candidates are processed, they find something else."

"Equipment has been promised and not delivered."

"I'm worried about a massive walk-out if things do not improve. I hear it in my department and on the elevator."

The "Orphan" Syndrome:

As mentioned, one term which was quite prevalent across many of the groups is the term "orphan". The word "orphan" is apparently widely used by employees to describe their collective relationship with UHS and was used numerous times (unprompted) by employees during most of the focus group sessions.

Among former Urban employees, many of whom have been employed for decades, their perspective is not that Urban management treated them better than UHS management. On the contrary, Urban management is often described as one which had a high level of administrative turnover and was looking to sell a neglected facility to the highest bidder due to market demographic changes. For the most part, discontent lies in the fact that MCH employees are comparing themselves to University main campus, rather than to their former parent. This is evidenced by the fact that even if an employee at MCH received a raise relative to what they earned at Urban, if this amount is less than what they *could be* earning at main campus, compensation is a source of dissatisfaction.

The issues here are complex and extend well beyond mere financial and benefit extrinsic remuneration. At the core, the issue for many employees involves perceived self-worth and a desire to feel appreciated by UHS for their experience, contributions, and loyalty. There is also a longing to feel “trusted” as part of the UHS family and to have this trust demonstrated through responsiveness to needs, listening, and greater localized control over day-to-day work activities. Employees are continuously comparing the “lot in life” of current UHS employees with that of their own, in whatever ways imaginable. *Any* areas where there is a perceived inequality (staffing ratios, compensation, work load, autonomy, etc.) as it relates to their main campus peers is a source of potential dissatisfaction and grapevine conversation.

The fact that UHS initiated focus groups for the employees was seen as a very positive step towards greater integration, but many expressed a “we’ll see what comes out of this” attitude towards the focus groups.

“We’re not on the same page, are we really UHS?”

“Computer systems are not integrated. Policies and procedures need to be integrated with this hospital. Some cannot be used at this facility because we do not have the staff structure to follow these policies.”

“Sometimes we’re like Urban, sometimes like UHS South, sometimes like main...sometimes we’re ‘all one’. It depends on the situation.”

“It is difficult to get in touch with the main campus. They often do not answer their phones.”

“We want to make this work, we just want to do it together and be treated equally.”

“How come the people who come here to lead are only from UHS?”

In summary, there is a strong perception that the “grass is greener” at University main campus when it comes to compensation, staffing, resources, and employment in general. Patient care employees at MCH also consider themselves general more capable than their peers at main campus due to the fact that they are able to “wear many more hats” than their more specialized co-workers at main campus, yet they earn less.

“We multi-task, UHS Main employees do not.”

“I was at main campus and noticed that there are many resources and task force group teams that most of us are not tapping into.”

“Some formularies are inferior here. We don’t get the same prices on medications. Nexium can be had for \$.32 at Main...here it costs \$1.80.”

“There is a general over-riding philosophy that whatever happens at main is better than here for employees.”

Comparisons were numerous and often fueled by information provided by agency staff and floaters who are well familiar with the other facilities they work in. Comparisons relate to education, compensation, amenities, and other areas:

“Transporters make more money over there than they do here. I’ve tried to transfer but was denied.”

“At UHS Main, I.T. tickets are closed in 30 hours or less, here it takes 2-3 weeks (due to short staffing).”

“Their (UHS Main) cafeteria is so much less expensive than ours.”

“They are offering free classes to RNs downtown that we would have to pay for (class and materials).”

“It’s not that Urban was better, it’s that we want to be like UHS Main.”

Educational training and peer groups offer opportunities for MCH to integrate with their peers and their parent system. Yet often, these opportunities are not capitalized on. This is apparently the result of a lack of awareness among most MCH employees regarding the types of training and development opportunities which are available. Also, some employees would like to see more of these opportunities made available at MCH, so as to avoid the lengthy commute and time away from a busy work schedule.

Results Summary:

Based on these focus groups, we believe that while the challenges are significant, there exists the willingness and desire on the part of employees to integrate with their parent system. The reservoir of talent, skill, and loyalty offered by many of the former Urban employees is great and can be leveraged successfully. Mid-level managers must be fully integrated and engaged, and the relationship between this group and administration must be fortified and cultivated.

We did not get the sense from participating employees that they had given up or were in despair. The recognition that things take time was prevalent and there is a clear window of opportunity (from the employee perspective) to respond to the issues raised in these focus groups. Employees provided detailed and specific information related to their concerns. The UHS response to the issues identified will have a direct affect on their level of engagement and commitment as employees, as well as their future loyalty to the organization.

Recommendations:

To address many of the thematic concerns presented by employees, The Crossroads Group recommends the following actions for inclusion and development in an action plan to address identified employee concerns. These recommendations are intended to not only improve employee satisfaction, but to also impact resulting outcomes related to patient satisfaction and general organizational performance, and should be supplemented by other internally directed initiatives.

1. **Hiring and H.R. Process Improvement:** Charter a facilitated process improvement team to document the current “as-is” hiring process (delays and process fail-points highlighted). Address root causes of delay, develop solutions, and implement an improved process with clearly defined and measurable process expectations.⁶ Establish baseline measures (time-to-fill, vacancy rate, etc.) and make a concerted short-term effort to fill open positions. Assess

⁶ The Crossroads Group offers extensive experience facilitating process improvement team. Founder Mark Robledo also has HR process experience, having facilitated a hiring process improvement effort for a major regional bank in 2007 as well as for Deering Hospital in 1999.

productivity measures related to patient volume vis-à-vis staffing levels to confirm the validity of staff concerns related to being overworked due to increased patient volume and steady or decreasing staffing levels. Identify all employees who have errors and/or emissions related to their status as employees. Proactively correct these items. Establish and implement processes which are able to facilitate rapid customer-centric solutions for employees who have legitimate HR concerns and/or need resolution.

2. **Hospital System Integration:** Address the employee perception that University main campus “has it better” by providing information demonstrating the numerous commonalities between the two systems. Continuously communicate and share information regarding challenges or initiatives which are being address at a system-wide level. More effectively communicate educational opportunities and task force opportunities which are available to employees at both campuses. As demand and interest warrants, provide UHS educational opportunities at MCH. Identify areas where current employee perceptions do not correspond to actual circumstances. Include these areas as part of communication strategy.
3. **Policy and Procedure Education:** Identify where employees and/or departments are still not clear as it relates to UHS policies, employee handbook information, and other standardized items which are vital to effective performance and/or satisfaction. Develop an action plan to address these areas and make training and/or reference materials available. Ensure that the on-boarding process is comprehensive and addresses hospital-wide as well as department-specific policies and procedures. Offer a “refresher” orientation for those employees who are in need.
4. **Agency Staff Utilization:** Establish and/or communicate and enforce a policy that temporary employees (from UHS Main Campus, staffing agencies, or elsewhere) are not to share information related to their current or formerly work-in facilities and the policies and practices thereof with employees of MCH. Ensure that agency staff are fully capable of handling the responsibilities in their respective work areas. Communicate this competency standard assurance to employees. Ensure that there is a unit-specific agency staff orientation process and performance management process ensuring that expectations are clearly defined and that there is a process for disciplining or removing agency staff who do not meet requirements. If financially viable, increase overtime opportunities for current staff who are interested and eligible.
5. **Equipment, Supplies, and Repairs:** Ensure that established par levels of all vital supply and equipment inventories are being maintained. Review the current “work order” process to ensure that established time frame expectations for repairs are understood by all parties and being met. Develop long-term solutions which address the wheelchair issue. Establish, with input from departments, the number of wheelchairs needed in each area of the hospital to delivery quality patient care. Supply areas as needed. Conduct periodic (monthly) by-location inventory count of wheelchairs. Assess whether root cause of wheelchair issue is intra-hospital movement or wheelchairs being taken from the facility. Implement measures to address root causes. Assess and address other specific supply and/or equipment issues identified in this report.
6. **Service Excellence:** Develop and implement a formal service excellence program, with clearly defined expectations and behaviors related to service excellence. Provide service

excellence and service recovery training to all staff who interface with patients. Train admitting area staff with regards to dealing with waiting area patients. Assign a patient liaison or advocate to the Emergency Department waiting area. We recommend utilizing a behavioral role definition tool in conjunction with a specially designed job description for this critical, yet challenging role. Establish and enforce regular RN and tech rounding on patients as well as scripting. Ensure that patient satisfaction data is shared with staff and that low-scoring survey constructs, particularly key drivers of overall satisfaction, are addressed.

7. **Meeting Efficiency:** Where possible, provide greater advance notice to employees regarding meetings in which their participation is required. Also, explore the option of providing Town Hall meetings at different times of the day. Encourage participation and feedback from employees, per clearly defined guidelines. Ensure that substantive responses, as well as measurable progress updates (where applicable), are provided to employees for thematic or ongoing concerns⁷.
8. **UHS Policies and Procedures:** Assess the current level of employee understanding regarding processes, policies, and procedures. Ensure that all employees are clear regarding expectations and that forms and documentation are consistent with UHS while at the same time appropriate to MCH. Provide a manner in which specific employee questions or concerns related to this topic can be communicated and addressed, both hospital-wide and at the unit level. Ensure that managers and supervisors understand and fully disseminate vital information.
9. **Process Ownership:** Identify opportunities to decentralize key tasks and process activities to MCH. In some cases, process efficiency will improve and employee morale will improve, as ownership and trust are delegated to competent staff. Where processes are centralized at main campus, ensure that linkages to MCH are intact and that process expectations are defined and that internal customer service standards are maintained.
10. **Employee Performance Management:** Conduct a 360 Degree evaluation survey for managers and supervisors to assess employee, peer, and direct report perceptions related to management skill. Provide coaching and guidance as needed. Provide management development skills training for mid-level managers and supervisors. Emphasize employee performance management and leadership development topics. Charter a reward and recognition team to recognize employees who routinely go “above and beyond”. Define objective criteria, a system for measuring, and rewards associated with meeting these expectations. Train managers regarding the importance of as well as how to provide employees with positive feedback (intrinsic rewards) for the daily observed behaviors which are in-line with strategic and operational priorities (e.g. service excellence, efficiency, etc.).
11. **Process Improvement:** Identify processes (e.g. patient flow, credentialing, etc.) which are experiencing recurrent delays, rework, and/or general inefficiency which is detrimental to organizational objectives. Prioritize processes in order of severity, frequency, and impact (Failure Mode Effect model) and address highest priority processes through process improvement methodology.

⁷ We recommend exploring the opportunity to improve productivity and reduce commute times by utilizing teleconference technology for certain meetings. Conduct a cost-benefit analysis to compare investment cost with labor-hours and productivity.

12. **Security and Safety:** Address employee security concerns. Establish clear performance standards and expectations for all security personnel. Firmly enforce these standards. Determine if current contracted security service will be able to meet expectations and standards.

In conjunction with the development of an action plan which addresses these and other concerns brought forth by employees, we also recommend the inclusion of targeted outcome measures to assess the progress of initiatives. These outcome measures should include “hard” measures such as turnover rates and time-to-fill rates as well as “soft” measures related to employee perception survey scores⁸ as well as future focus group results. These measures should correlate closely with initiatives and be reported on a regular basis to various stakeholders and correlated to an action plan which documents the administrative response to the addressed concerns and includes specific actions, timeframes, responsible parties, and resource requirements.

We recommend increased levels of communication to employees, particularly as it relates to communicating that they are valued members of the UHS family and have been heard through the focus group process. Specific issues raised, as well as the administrative response to these issues, should be communicated via multiple communication channels.

⁸ In addition to focus groups, the Crossroads Group provides client organizations with customized employee satisfaction and organizational effectiveness surveys which can be administered via telephone, online, or on-site terminal.

APPENDIX A: EMPLOYEE FOCUS GROUP INVITATION LETTER:

January 2, 2007

Dear Memorial Central Hospital Employee:

Congratulations on your first year anniversary with the University Health System. It has been one year after the successful transition of your employment with the University Health System. This past year in some cases has been challenging as you integrated with a large complex healthcare system and assimilated to a new culture, new policies and procedures, changes in processes and protocols and new systems.

At this point, we have engaged the services of the Crossroads Group, Inc., a third party organization to conduct a focus group with a random sample of employees that is cross-representative of our workforce to obtain feedback pertaining to your employment with the University Health System.

You have been selected to take part in a focus group facilitated by The Crossroads Group. This one-hour session is designed to provide you with an opportunity to voice your opinion to UHS leadership, address any outstanding questions or concerns regarding your continued successful employment with Memorial Central Hospital and to continue the successful integration of University North within UHS.

The focus groups will be confidential and feedback information will only be shared in aggregate to the Senior leadership team. Individual responses will be kept confidential.

Please plan to attend below listed focus group session in the Auditorium:

January 10, 2008 8:00am – 9:00am

Please arrive 15 minutes prior to your appointment. The focus groups will begin on time. Beverages and refreshments will be served.

We value your opinion and look forward to your involvement and contributions as we continue to make improvements.

Please RSVP by _____ via Phyllis Harrison, Manager, Human Resources Capital Management at PHarrison@UHSmiami.org or _____. Ms. Harrison is the primary contact if you have any questions related to the focus group. Participants who have been randomly selected are expected to attend focus group session.

If you represent our leadership team, we are asking that you do everything possible to support the active participation of your staff selected for the focus group.

We thank you in advance for your participation in this very important process.

Sincerely,

Jane Sanders, Sr. Vice President

Memorial Central Hospital